OVERCOMING BARRIERS TO MORE EFFICIENT AND EFFECTIVE VA STAFFING

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BEFORE THE

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OF THE

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Friday, May 15, 2015

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

The subcommittee met, pursuant to notice, at 11:09 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [chairman of the subcommittee] presiding.

Present: Representatives Benishek, Roe, Coffman, Wenstrup, Abraham, Brownley, Takano, Kuster, and O'Rourke.

Also Present: Representative Costello.

OPENING STATEMENT OF CHAIRMAN DAN BENISHEK

Dr. BENISHEK. The subcommittee will come to order.

Before we begin, I would like to ask unanimous consent for my friend, colleague, and member of the full committee, Congressman Ryan Costello from Pennsylvania, to sit on the dais, participate in today's proceedings.

Without objection, so ordered.

Thank you for joining us today for today's subcommittee hearing, "Overcoming Barriers to More Efficient and Effective VA Staffing."

As a physician who worked fee-for-service at the Iron Mountain VA, Department of Veteran Affairs, Medical Center for about 20 years, I know firsthand how rewarding it can be to take care of veterans at the VA. And having the privilege of caring for veterans on a daily basis was really wonderful for me.

Regardless of how fulfilling VA employment often is, the Department's ability to effectively and efficiently recruit and retain qualified medical professionals to treat veterans is seriously fractured. For example, in my district, the Sault Ste. Marie Community-Based Outpatient Clinic in Sault Ste. Marie, Michigan, has not had a physician on staff for at least 2 years.

VA has attributed that to the difficulty of recruiting physicians in rural areas. And while I understand that difficulty, I think VA's overly bureaucratic hiring process is also a significant factor in its inability to recruit a physician for multiple years running.

The Iron Mountain VAMC, the Sault Ste. Marie CBOC's parent facility, was unable to post the opening for a physician directly. Instead, all job postings under Iron Mountain's purview are filtered through a human resource office in Milwaukee, Wisconsin, several hours away in another State. In my understanding, all VISN 12 facility job postings are run through this one office in Milwaukee.

What is more, despite repeated assurances by VA officials the Department was actively recruiting for a physician in the Sault—in Sault Ste. Marie—we call it "the Sault" in Michigan—I have yet to see a single advertisement for that position besides a blurb on the hospital's Web site, leaving me to wonder whether the VA knows what effective recruiting is supposed to look like.

As important as effective recruitment is, effective retention of existing employees is also critical. But according to the 2014 Best Places to Work survey published by the Partnership for Public Service, the number of VA employees resigning or retiring has risen every year since 2009. And it is not hard to see why: The survey results rank VA 18 of 19 large agencies overall, 18 of 19 in effective leadership, 19 of the 19 in pay, with the Department's overall score last year being the lowest VA has received since the report was first published in 2003.

When a VA medical center is improperly staffed and when a qualified candidate chooses to look elsewhere for work or when an existing provider makes the decision to leave the VA, it is our veterans that lose out. The growing physician shortage is causing the healthcare marketplace to become more and more competitive, with the Association of American Medical Colleges projecting a 91,000-physician shortfall by 2025.

If the VA is going to keep pace with the private sector in recruiting and retaining the high-quality providers that our veterans deserve, immediate action must be taken to improve retention of existing staff and ensure that qualified candidates for new or vacant positions are quickly identified, recruited, hired, and brought aboard.

Critical to that and to all of VA's plans regarding the delivery and quality of care is making sure that those on the front lines providing direct patient care are not only involved but leading the efforts to make the VA healthcare system stronger.

To that end, I am proud to have representatives from the National Association of VA Physicians and Dentists, the VA Physician Assistant Association, and the Nurses Organization of VA on our first panel of witnesses today.

The input you as well as the rest of our witnesses will provide about the daily reality you and your members face at VA facilities across the country every day is invaluable. I thank you and all of our witnesses for being here this morning.

And I now yield to the Ranking Member, Ms. Brownley, for any opening statement she may have.

OPENING STATEMENT OF RANKING MEMBER JULIA BROWNLEY

Ms. BROWNLEY. Thank you, Mr. Chairman. And thank you for calling this hearing today on VA staffing.

Section 301 of the Veterans Access, Care, and Accountability Act, signed by the President last year, mandated the VA shall submit a report assessing the staffing of each medical facility of the Department. This hearing will investigate this report and how the VA is doing in evaluating the staffing needs around the country in respect to the care of our veterans.

In its report, the VA cites the need for an additional approximately 10,000 full-time employees to supplement the approximate 180,000 employees that currently work in veterans' healthcare. I am looking to find out from the VA how both numbers were arrived at.

One issue is that last year Secretary McDonald quoted a number of 28,000 positions needed to fully staff VA healthcare. Now we are down to just over 10,000. The staffing report concurs with the inspector general's report listing the top five occupations that are most critical: medical officer, nurse, physician assistant, physical therapist, and psychologist.

One occupation not listed because it is not technically healthcare-related is human resources. These are the people that hire and fire and generally keep a facility fully staffed. I am interested in hearing how the VHA will be streamlining its hiring process and getting more people to work in a reasonable timeframe to treat our veterans.

Veterans in my congressional district face barriers to accessing care due to VA staffing issues. Ventura County is home to over 47,000 veterans, and our local CBOC, which provides primary care and mental health services, struggles with staff retention. There are high turnover rates for physicians and medical support staff.

The CBOC's primary-care team is down to just one physician, two nurse practitioners, and one physician assistant. In addition, our county veteran service officer is concerned that veterans are not using important wraparound services because there is no primary-care social worker on staff. Over the past 5 years, the number of veterans seeking mental healthcare at the CBOC has doubled. And the VA has been working hard to meet the growing demand, but we still seem to be in a place where we are not fully staffed.

I know that staffing issues facing Ventura County are ones that can be found across the VA system. I look forward to hearing how VA is using the funding provided in the Choice Act to increase the Department's workforce and high-demand occupations so that the Nation's veterans have timely access to the high-quality professional care that the VA is known for.

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

Dr. BENISHEK. Thank you, Brownley.

Joining on our first panel is Joan Clifford, immediate past president of the Nurses Organization of Veterans Affairs; Dr. Samuel Spagnolo, the president of the National Association of Veterans Affairs Physicians and Dentists; Rubina DaSilva, the president of the Veterans Affairs Physician Assistant Association; Jeff Morris, the director of communications and external affairs for the American Board of Physician Specialties; and Dr. Nichol Salvo, member and employee of the American Podiatric Medical Association.

Ms. Clifford, we will begin with you. Please proceed with your testimony.

We allow everybody 5 minutes. So there should be a little light there that when it goes red that means you are up. Thanks.

STATEMENT OF JOAN CLIFFORD, MSM, R.N., FACHE

Ms. CLIFFORD. Thank you.

Chairman Benishek, Ranking Member Brownley, and members of the subcommittee, on behalf of the nearly 3,000 members of the Nurses Organization of Veterans Affairs, NOVA, I would like to thank you for the opportunity to testify on today's important and timely subject, VA staffing.

As the Department of Veterans Affairs undergoes systemwide reorganization, to include the many challenges of implementing the Veterans Access, Choice, and Accountability Act, staffing must be at the forefront of its evaluation.

I am Joan Clifford, deputy nurse executive at the VA Boston Healthcare System, and I am here today as the immediate past president of NOVA. NOVA is a professional organization for registered nurses employed by VA. NOVA's focus is professional issues.

NOVA is uniquely qualified to share its views on the ability of VA to efficiently and effectively recruit, onboard, and retain qualified healthcare professionals to treat our veteran patients. As VA nurses, we are in the medical centers, community-based outpatient clinics, and at the bedside every day.

We have identified retention and recruitment of healthcare professionals as a critically important issue in providing the best care anywhere for our veterans, and we would like to offer the following observations.

NOVA believes that the underlying issues reside in the lack of a strong infrastructure for human resources, insufficient nursing education opportunities, and the complex application system, namely USAJOBS, that VHA uses for hiring staff.

VHA is facing a shortage of corporate experience and insufficient HR staffing to support the multiple priorities required for hiring healthcare professionals. The complex hiring process, with systems that do not interface, lead to extended waits for job offers. At times, this results in candidates accepting non-VA jobs and puts VA back in the hunt for qualified candidates.

Limited knowledge of direct hiring process for registered nurses, resulting in unnecessary recruitment delays, and VA processes and policies for obtaining recruitment and retaining incentives contribute to delays in hiring personnel. Reclassification and downgrades of some occupations, such as surgical technicians, who are brought in at the GS–7 level and have recently been downgraded to GS–5, are making it impossible to competitively retain and recruit. A lack of knowledge on how to maximize the locality pay law has resulted in inconsistent application of the law, an obstacle to hiring and retention.

NOVA asks that the ceiling on nurse pay be increased to prevent compression between the grades in order to remain competitive.

Ensuring an infrastructure to sustain programs that produce nursing graduates who honor and respect veterans' programs is vital. The Office of Academic Affairs has supported a wonderful R.N. residency program across some VAs, but funds are limited, potentially impacting the recruitment of future hires who flock to these programs.

The nurse practitioner residency program is currently a pilot and will require continued funding to pay for resident stipends and educational infrastructure. NOVA believes it is a good investment, as hiring nurse practitioners will increase access and enable additional services to veterans needing care nationwide.

Ongoing support for tuition reimbursement and loan forgiveness programs to help nurses defray the cost of education if they work for VHA and support for VA nursing academic partnerships is needed.

An area of concern is the use of advanced practice nurses, which at this time is subject to State laws in which the facility is located. VHA is advocating full practice authority, which would result in all advanced-practice-registered nurses employed by the VA to be able to function to the full extent of their education, licensure, and training, regardless of the State in which they live and work.

Legislation has been introduced, H.R. 1247, the Improving Veterans Access to Care Act of 2015, which is the model already practiced by the Department of Defense, Indian Health Service, and Public Health Service systems. NOVA, together with other national nursing organizations, are calling on Congress to support this legislation, which would begin to address critical needs within VA facilities by improving wait times and access of care to all veterans.

VA employs over 90,000 nursing personnel, which is about a third of its healthcare workforce. NOVA believes that there is no greater time to have representatives from the Office of Nursing Services at the table as VA reorganizes the way it provides care and services to America's heroes.

Improvements and careful review of the process of downgrades across VA, increased training and utilization of the locality pay law, revising the cap on the R.N. pay schedule to eliminate compression, as well as establishing a more user-friendly application process and supporting human resource offices across the Nation, will go a long way towards correcting the challenges VA faces with staffing.

NOVA once again thanks you for this opportunity to testify, and I would be pleased to answer any questions from the committee.

[THE PREPARED STATEMENT OF MS. JOAN CLIFFORD APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you very much, Ms. Clifford.

Dr. Spagnolo, please go ahead.

STATEMENT OF SAMUEL V. SPAGNOLO, M.D.

Dr. SPAGNOLO. Mr. Chairman, we have submitted a written testimony, and I would ask that you have that entered into the record. And I will try to keep my few comments here fairly brief.

Thank you for having us here, and thank the distinguished members of the committee for having us here. We certainly appreciate it.

I am here as a practicing physician, with more than four decades with the VA. And I am here also as the president of the National Association of VA Physicians and Dentists, usually referred to as NAVAPD. I might add, too, that I am a veteran, having served for 2 years of Active Duty in the United States Public Health Service.

The National Association of VA Physicians and Dentists is a 501(c)(6) nonprofit organization that is dedicated to improving the quality of patient care in the VA healthcare system and ensuring the doctor-patient relationship is maintained and strengthened. I appear today in pursuit of that purpose.

This year is NAVAPD's celebration of its 40th year. NAVAPD believes that a key means of enhancing care of veterans is by employing the best physicians and dentists. NAVAPD believes it is essential for physicians to be involved in decisions regarding delivery and quality of healthcare.

During my many years with the VA, I have witnessed firsthand many changes in the VA—some good, some not so good. I have had the opportunity to meet nearly all the Secretaries of the VA over the last 40 years. I got to know several of them very well, and a few I have seen as patients. I believe all of these individuals have been good people and all of the best intentions. I am sure Secretary McDonald, who I have also met with, also has good intentions.

Notwithstanding the good intentions of these good people, however, the role of the physician within the system as a leader of medical care has greatly diminished over this same period. Today, most physicians and dentists feel like their opinions are neither helpful nor requested. At many centers, physicians and dentists are no longer even considered professionals but referred to simply as "workers." These observations come from our members—VA docs and dentists, men and women who want to help improve veterans' care.

In the late 1960s and 1970s, nearly all VA medical centers were led by directors who were physicians. Today, very few medical centers have physician directors. The position now called the VA Under Secretary of Health was known as the chief medical director. At that time, there was a direct line from the chief of staff at the medical center to the chief medical director. Issues of delivery and quality of medical care were raised and addressed by medical professionals. Today, chiefs of staff report to a clinical specialist at the VISN centers.

In more recent times, there has also been a strong movement to eliminate the need even to have a physician in the role of Under Secretary of Health. I ask, would it be wise or even possible to run the Defense Department without generals and admirals in leadership positions? We are not saying there is no role for nonphysicians in the administration of hospitals or medical care. We are saying, however, that medical judgment should be based on years of education and patient care.

Physicians are being loaded with additional duties more appropriate for nonphysicians, such as typing, filing letters, followup calls, patient reception, and preparation. Similarly, it is not cost-saving nor efficient to have physicians routinely escort patients from waiting rooms to exam rooms and having them help the patients get undressed.

There is a growing trend to add nonphysicians, and there is a growing concern that a veteran may never be seen or treated by a physician while in the VA healthcare system. Veterans are seen by non-M.D. doctors without ever realizing they have not seen a

medical doctor. We believe this is dangerous for patients and their families, and it may also raise some ethical issues.

The VA is currently considering a change in its nursing handbook. Under the proposed handbook, there will no longer be any physician oversight for the process of sedation and providing operating room anesthesia by certified registered nurse anesthetist. The proposed change provides no guarantee this will provide safer patient care. Additionally, LPNs with little or no psychiatric experience are taking the place of psychiatrists during intake counseling and assessments in some psychiatric departments.

Taking care of patients and providing excellent care has a lot to do with providing the basics and using a lot of common sense. For example, when patients are asked what is important to them, you will hear simple, straightforward, commonsense questions, such as: Will I be admitted quickly? Is the room clean? Is there a bathroom in the room? Does the call button work, and does someone answer and arrive quickly when I need them? Does everyone speak so I can understand them? If I need help to eat, will there be somebody there to help me? Do my doctors and nurses spend time explaining things so that I can understand what is happening? Unfortunately, patient surveys indicate that none of the above questions are being answered very well in the VA.

Although the crisis last year in VA did focus on access to care, this is but one small piece of the total package. Getting timely initial access is of little value if it takes months to get your hip replaced or have a lung cancer removed or a colonoscopy screening because there may not be sufficient physicians or adequate access to the operating room. Timely access must be assured throughout the course of care, not just on the initial visit.

VA is referred to as a healthcare system. At best, it is a collective of hospitals and other medical facilities operating under a common umbrella. The operational standards at every facility appear to be different. There must be unification and simplification of process across the organization to achieve an order of efficiency and common outcomes. When you have seen one VA, you have only seen one VA.

In this regard, we have seen no recent operational structural changes that would increase the efficiency of physicians and dentists in the VA. Changes announced by the current Secretary are not being consistently implemented in local facilities, perhaps because the facility leaders have not understood that these changes are mandatory——

Dr. BENISHEK. Doctor, you will have to clean up your time here.

Dr. SPAGNOLO. I am—one sentence left.

Dr. BENISHEK. Okay. Good.

Dr. SPAGNOLO. Hearings like this are important and helpful, and the VA appreciates the—NAVAPD appreciates the opportunity to be here today. We want to help fix the medical care problem. The unfortunate truth, however: It is far easier to throw money at the situation than it is to fix it.

Thank you, Mr. Chairman.

[THE PREPARED STATEMENT OF DR. SPAGNOLO APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Doctor.

Mr. Morris, you have 5 minutes to come across with your testimony.

STATEMENT OF JEFF L. MORRIS, J.D.

Mr. MORRIS. Chairman Benishek, Ranking Minority Member Brownley, and distinguished members of the Health Subcommittee, the American Board of Physician Specialities thanks you for the examining the issue of overcoming barriers to more efficient and effective VA staffing.

Veterans should never be shortchanged in their medical care. Recruiting qualified and highly skilled physicians to work within the VA health system is needed now more than ever. What many do not know is that physician politics, along with existing discriminatory and monopolization practices of the American Board of Medical Specialties, are keeping excellent physicians out. What is indefensible is that they are not denied because of their training, education, or experience. These highly skilled physicians are being denied employment solely based on their choice in board certification.

Dr. Robert M. Weinacker is a prime example of this very discrimination going on within the Administration. Dr. Weinacker, a veteran himself, was a Green Beret and former member of Special Forces. He was even handpicked as battalion surgeon to lead the medical treatment of 400 of our Special Forces. He wanted to work at the VA. He applied for seven positions and was never even called back for an interview.

This was not due to his training. Dr. Weinacker, a graduate of the University of Alabama Medical School, is residency-trained in radiation oncology and is a fellow of the American Academy of Radiology. In addition to his medical profession, Dr. Weinacker is also an attorney in hospital administration, with a focus on waste, fraud, and abuse.

The only barrier that prevented Dr. Weinacker from working at a VA was his choice in certification. He chose—each position required ABMS certification only. Dr. Weinacker chose ABPS, and, because of that choice, he is consistently denied the opportunity to take care of his fellow veterans.

We are here to ask the VA to cease their discrimination of ABPS physicians such as Dr. Weinacker. Behind this discrimination is the fact that most people do not understand what board certification is. Board certification is a choice and an indicator that a practitioner has demonstrated their mastery of the core body of knowledge and skills in their chosen specialty.

Currently, there are three recognized multispecialty certifying bodies: the American Board of Medical Specialities, the American Osteopathic Association, and the American Board of Physician Specialties. ABMS, the largest of the 3, is made up of 24 individual specialty bodies, making many believe that they are all different entities. This structure has hidden the monopoly that ABMS has been establishing, making many believe they are the only one.

ABMS is not the only higher standard board. There are others that meet or exceed their standards. In fact, ABPS is the only one of the three to have received an independent affirmation of the high standards of its exams through an exhaustive review process performed by Castle Worldwide.

Since 1994, ABPS has approached the Department regarding these discriminatory staffing issues creating barriers to hiring skilled physicians. Each time, the Administration would protect the ongoing monopoly and respond that they had no plans to recognize anyone else.

In 2011, ABPS returned to the Administration to stop the discrimination and further explain that we were a part of the current standard of certification. They again refused to see the issues.

All these discussions were led by former Under Secretaries of Health Drs. Petzel and Jesse, along with Dr. Karen Sanders—all board-certified by the very same organization keeping ABPS and other highly skilled physicians out.

What is most confusing is that, under the GI bill, ABPS has been reviewed and approved by the U.S. Department of Veterans Affairs. Yet they stated to us that it does not mean they have to accept it. The VA reimburses for ABPS board certification but will not recognize it for hiring or promotion.

The Administration also stated to us that board certification is not a requirement, that it is left to the discretion of the local VA. However, this has not been the case. According to USAJOBS, there are over 1,000 open physician positions. Most blatantly discriminate by requiring ABMS/AOA only, limiting the ability to fill much-needed positions.

Only a few hospitals recognize ABPS and have hired them to fill their staffing needs. The Kansas City VA is a good example of this, providing a higher level of care. Some also have hired ABPS physicians, but ABMS continuously creates a hostile work environment and openly discriminates against them. Many of those physicians are not here today because they feared retribution or loss of their jobs.

ABPA wishes to contribute to solutions to ensure that veterans receive the highest quality of care. A directive from the Office of the Secretary of the VA needs to be in place that creates anti-discrimination policy, that clearly defines board certification and goes beyond just the acceptance of ABMS/AOA. Job listings should no longer allow for one specific board over another.

We also ask that a quarterly reporting structure be developed. Whereas VA healthcare institutions report on applications received, the denial and hiring of physicians and all applicant boards be identified, having identified individuals accountable for this oversight—all done in a similar manner as corporations are required to identify and ensure minority hiring. This will allow for a transparent credentialing process, and local VA medical centers will be held accountable.

Thank you again for this opportunity. The ABPS looks forward to working with you to improve hiring practices and end the discrimination. Most importantly, our veterans' health, safety, and care must be placed before physician politics and the egos of a few. It is what they deserve.

[THE PREPARED STATEMENT OF MR. JEFF MORRIS APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Mr. Morris.

Ms. DaSilva, you are up next.

STATEMENT OF RUBINA DaSILVA, PA–C

Ms. DASILVA. Chairman Benishek, Ranking Member Brownley, and other members of the Health Veterans' Affairs Subcommittee, on behalf of the entire Veterans Affairs Physician Assistant Association, we really appreciate the invitation to provide this testimony before you today.

The PA profession has a very special and unique relationship with veterans. The PA profession came into existence in the 1960s due to the shortage of primary-care physicians in the United States. The first graduates of the Duke University program in 1967 were former Navy hospital corpsmen.

The VA was the first employer of the PAs and, to this day, is still the single largest employer of PAs in the country. Currently, there are 2,020 PAs working in the VA system. These PAs provide cost-effective, high-quality healthcare, working in hundreds of VA medical centers and outpatient clinics. In the VA system, about a quarter of all primary-care patients are treated and seen by a PA. Approximately 32 percent of those PAs are veterans, including myself. I am a former Navy hospital corpsman.

The OIG report of January 2015 conducted a determination of the VA occupations with the largest staffing shortages, as required by the Veterans Choice Act. OIG determined that PAs were the third critical occupation on the list compared to all others.

According to the National Workforce Succession Planning of 2015, next year, in 2016, 37 percent of PAs are eligible to retire. This workforce loss will result in approximately a loss of 1.15 million veteran eligible patient care appointments. In 2014, PAs had the highest total loss rate of 10 percent, more than any of the other top 10 occupations deemed difficult to recruit and retain.

Utilizing the VA provisions of the Veterans Choice Act of 2015, the VA reports no current plans for recruiting for new PA positions and for retaining an optimal PA workforce. They are setting goals to hire only physicians and nurses, as they interpret the law, and so not including the PA workforce.

Some facilities are not posting for PAs at all under the Veterans Choice Act. Of the total postings nationally for PAs, there are only 83. This method effectively eliminates 50 percent of eligible applicants. And when medical centers or CBOCs do not post for PAs, the centers send a message that PAs and PA veterans should not and cannot apply, even though military PAs often have higher levels of experience from frontline battlefield care.

The discrepancy in salary, benefits, and education debt-reduction programs between the civilian sector and the VA continues to be a recruiting and retention barrier.

There are three types of providers within the VA that provide direct patient care: physicians, physician assistants, and nurse practitioners. Physicians are mandated a yearly market pay survey. Nurse practitioners, by virtue of being a nurse, are mandated under the yearly R.N. locality pay scale. PAs fall under a special salary rate. However, this is not mandated yearly. Some facilities have not performed a special salary survey for 11 years.

Reporting in the results of the VISN 2014 Workforce Succession Plan, 88 VA main facilities report the reason that their VISN can-

not hire PAs is because they cannot compete with the private-sector pay.

The Secretary can convert physician assistants to covered positions and pay them pursuant to current public law. However, the VA has refused to pursue these steps to solve their current retention problems for PAs. The recommendation is Congress should legislate a mandate that the VA Under Secretary for Health include PAs in the nurse locality pay system under title 38.

For the education debt-reduction program, VAPA is also concerned that the use of recruitment incentives within the VA is at the discretion of the hiring facility and is not standardized across the VA system. During 2013, only 44 physician assistants have received $319,000 in scholarships, compared to 705 registered nurses seeking to become nurse practitioners receiving scholarship awards totaling over $11 million in support of NPs and NP programs.

The recommendation is that VAs must advertise in all PA vacancy announcements so prospective applicants are aware of the education debt reduction—loan forgiveness. Move the program application process for accountability nationally since this is not a facility-funded but a VA-funded program.

Next is the Independent Care Technician, the ICT, Program, also known as the Grow Your Own program. To assist returning OIF/OEF returning veterans, to include targeted scholarships, Grow Your Own mandates the VA shall appoint a PA ICT program director to coordinate the educational assistance necessary to be a liaison with PA university programs so these corpsmen and medics can follow the footsteps and become PAs.

For recruitment, move all direct patient care positions to the National Recruiter/Workforce Office.

In conclusion, Chairman Benishek, Ranking Member Brownley, and other members, as you strive to assure that veterans receive timely access to quality healthcare and demand more accountability into the VA healthcare system, we strongly urge the full committee to review the report and critical role of the PA profession and ensure the VA take immediate steps to address the current problems on a national level and not leave it to the VISN and local facilities to address the problem, as the OIG report shows the PA profession continuously moving up the list on critical occupations. The PA profession was borne from the military, and we need to continue that special relationship.

On behalf of the entire membership of the Veterans Affairs Physician Assistant Association, I really appreciate this opportunity to testify here before you today and ask for your help in supporting the Nation's veterans.

[THE STATEMENT OF MS. RUBINA DASILVA APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Ms. DaSilva.

Ms. DASILVA. Yes, sir.

Dr. BENISHEK. Dr. Salvo, you are up.

STATEMENT OF NICHOL L. SALVO, DPM

Dr. SALVO. Chairman Benishek, Ranking Member Brownley, and members of the subcommittee, I welcome and appreciate the oppor-

tunity to testify on behalf of the American Podiatric Medical Association.

I commend this subcommittee for its focus to assist and direct the Veterans Administration to effectively and efficiently recruit and retain qualified medical professionals and improve access to quality healthcare in the VA.

I am Dr. Nichol Salvo, member and director of young physicians at APMA. I am also a practicing podiatrist, maintaining a without-compensation VA appointment. I am before you today representing APMA and the podiatric medical profession. While I do not represent VA, I do bring with me firsthand experience and knowledge of hiring practices within VA and knowledge of the widespread disparity between podiatric physicians and other VA physicians.

Mr. Chairman, when the VA's qualification standards for podiatry were adopted in 1976, I was not yet born. Podiatry starkly contrasted with that of physician providers of the time and is a far cry from podiatric medicine as it is today.

Unlike 39 years ago, current podiatric medical school curriculum is vastly expanded in medicine, surgery, and patient encounters. Back then, residencies were few and were not required. Today, there are mandated standardized comprehensive 3-year medicine and surgery residencies to satisfy all of our graduates, with 77 positions housed within the VA, each requiring completion of a broad curriculum equitable to medical and osteopathic residency training.

Today's podiatrists are appointed as medical staff at the vast majority of hospitals, and many serve in leadership roles within those institutions. Many of my colleagues have full admitting privileges and are responsible for emergency and trauma calls.

The competency, skill, and scope of today's podiatric physicians has certainly grown from the podiatrists that practiced before I was born. Because of this, CMS recognizes today's podiatrists as physicians, and TRICARE recognizes us as licensed independent practitioners. That is today's podiatrist.

We must also understand today's veteran. Veteran patients, often plagued by socioeconomic and psychosocial issues, are ailing, have more comorbid disease, and are of disproportionately poor health status compared to their nonveteran counterparts. These patients increase the burden of diabetic foot ulcers and amputations, and, as documented in my written testimony, almost 2 million veterans are at risk of amputation with underlying diabetes, sensory neuropathy, and nonhealing foot ulcers.

This is my patient population. The veteran population is far more complex to treat than patients in the private sector as a whole. One of our major missions is amputation prevention and limb salvage, which provides a cost savings to VA and an integral role of the veteran quality of life.

As part of the interdisciplinary team, podiatrists independently manage patients within our respective State scope of practice, and we assume the same clinical, surgical, and administrative responsibilities as any other unsupervised medical and surgical specialty.

Despite this equality in work responsibility, there exists a marked disparity in pay and recognition of podiatrists as physicians in the VA. The majority of new podiatric hires have minimal

experience and lack board certification. The majority of these new hires will separate from the VA within 5 years.

I am speaking to you from personal experience, as I am one of the majority. I entered the VA without board certification, with less than 5 years of experience. I gained my experience, earned my board certification, and then separated from the VA to take a leadership position with my parent organization.

While I will forever remain loyal to the veterans, which is why I still voluntarily treat patients in my local facility without compensation, I testify to the profound disparity.

Legislative proposals to amend title 38 to include podiatric physicians and surgeons in the physician and dentist pay band have been submitted by the director of podiatry services annually for the last 10 years, and these proposals have been denied every single year, as were several requests for an internal fix, despite written letters of support from the former Under Secretary of Health Robert Petzel, M.D.

Five years ago, APMA leadership made this issue a top priority. Since then, we have alerted the VA to our knowledge of this issue, and, in response, former Under Secretary Petzel created a working group with whom we have participated in several meetings and from whom we recently received acknowledgment of the need of a legislative solution to address this issue.

In closing, I would like to state that oftentimes we find that the simplest solution is the best. I come before this committee today to respectfully request that Congress help the VA and its patients by passing legislation to recognize podiatric physicians and surgeons in the physician and dentist pay band.

We believe that simply changing the law to recognize podiatry both for the advancements that we have made to our profession and for the contributions that we make in the delivery of lower-extremity care for our veteran population will resolve recruitment and retention problems for the VA and our veterans.

Mr. Chairman and members of the subcommittee, thank you again for this opportunity. This concludes my testimony, and I am available for questions.

[THE STATEMENT OF DR. NICHOL SALVO APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Dr. Salvo. I appreciate it.

I will yield myself 5 minutes for questions.

Boy, there are a lot of questions I would like to get answered here today from many of you. I think I will start with Ms. Clifford, though, because I think you brought up something that is pertinent here.

How long does the average hiring process take? How long is that time? And talk a bit more about the difficulty in getting people because they take a job somewhere else while the process is ongoing.

Ms. CLIFFORD. Right. So it is pretty variable, and it can go anywhere from 2 to 6 months or maybe more in some places.

It is a very complex process. First, at most places, it will have to go through a resource committee for approval, which usually is the quickest part of the process. It then has to get posted on USAJOBS, so it has to be put in the proper format to be posted on that. And then we wait and get the certification of who has ap-

plied for that position. And then they have to go through all of these other processes we have, such as e-QIP, which is the background check. We have the——

Dr. BENISHEK. In other words, like, 2 to 6 months——

Ms. CLIFFORD. Yes.

Dr. BENISHEK [continuing]. In order to get hired. And so, like, the least amount of time is, like, 2 months.

Ms. CLIFFORD. I think 2 months would be considered a good hire—a quick hire.

Dr. BENISHEK. Because I know that in the private sector it doesn't take—if you apply for a job, it doesn't take 2 months. They get hired in the private sector at the local hospital—I mean, in my experience. Do you have any experience with numbers in the private sector?

Ms. CLIFFORD. That is correct. I don't have any numbers, but I do know that that is what we hear from some of our candidates. And it will come to the point where they will say, I have another job offer, you know, how quickly can you tell me whether or not I can have it. Because they probably haven't even given notice to their other job, so it is another month after we even make the job offer to get them in the door.

Dr. BENISHEK. Dr. Spagnolo, can you comment on the same question as far as the physician side of things? I know that, there is a lot of trouble with the qualifications or making sure that the person's background is right and on getting that right. But how does that process work in the VA, from your experience?

Dr. SPAGNOLO. I would echo what you just heard. It takes sometimes up to a year to recruit a physician. I have heard them taking even longer.

I also run the respiratory care department, and it is usually a year before we can hire a therapist, to get through all the processes and finally get them in. Working with H.R. is near impossible.

Dr. BENISHEK. So this is all done through the H.R. department then? I mean, the physician hires, as well?

Dr. SPAGNOLO. Well, you know, there is more than just the H.R. You have to get it approved by different committees and chairmen and hospital directors, and then it goes back and forth. It just takes forever.

Dr. BENISHEK. Now, Dr. Salvo, you mentioned the podiatrist problem in the VA. At the VA that I worked at, the podiatrist was one of the busiest providers in the surgery clinic. I mean, they had a hard time keeping the podiatrists there long enough to do all the work you had to do.

What is the difference in the payment? Are they not paid as physicians then? Can you explain that to me a little bit more?

Dr. SALVO. Podiatry is on a different pay scale. Unofficially, I am aware that the pay scale ranges anywhere from $60,000 to a $100,000 less from other VA medical and surgical specialties, depending on what the specialty is.

Dr. BENISHEK. Well, that would sort of explain why it is difficult to recruit.

Ms. DaSilva, do you have anything to add on that, on that recruitment and difficulty-in-hiring question?

Ms. DASILVA. I would agree with—it does take a long time. It takes about 6 weeks in the private sector, max, whereas in the VA system it can take up to 6 months.

Dr. BENISHEK. Dr. Spagnolo, could you expand a little bit about my concern when I worked the VA was the fact that, the doctors weren't involved with making the decisions in departments that actually involved how the patient care is delivered. They were sort of told what to do by the administration and then left to do that.

Can you expand on that thought? Do you agree with my thinking there? And what should be done about it?

Dr. SPAGNOLO. Well, yes, we need to empower the physicians in the facilities. I think if you took people, in every VA facility, you took a dozen people in the facility who knew really what was going on, you could find out very quickly what was working and what wasn't working. You need to empower some of the nurses, you need to empower the physicians, get some real input on how to become more efficient and how to provide better care. I think that could be done very quickly.

Dr. BENISHEK. Thank you.

I am out of time, and I will yield to Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman.

I know that the Secretary of the VA is really trying to make transformation at the VA. And I have heard him and others from the VA testify that we need to shift the VA from a rule-based organization to a principle-based organization.

And it sounds to me, based on the longevity of hiring people within the VA, it is the rules that are—because there are so many, is what slows the whole process down, that we would be better off following the practices of private industry in terms of hiring.

Is that a fair assessment for nurses?

Ms. CLIFFORD. I would say so. There is a lot—it is very complex, lots of steps in the process from the human resource side, and that is what causes a lot of the delay.

Ms. BROWNLEY. So, for the nurses, unlike the physicians, the problems are predominantly within the human resources department and their rules. Hiring doctors, you go through human resources but have to go outside of human resources, as well?

Yes, yes, yes, and yes?

Ms. CLIFFORD. I am not sure I understand the question about going outside.

Ms. BROWNLEY. So Dr. Spagnolo testified for longevity, in terms of hiring physicians, that it is within the human resources department but they also have to go outside of the human resources and, I presume, be interviewed by other physicians or other departments. And I am just wondering, for nurses, is the whole hiring process within the human resources department?

Ms. CLIFFORD. Well, the nurse managers or the supervisors make the decision of who they want to hire, and then the technical parts are all done by human resources.

Ms. BROWNLEY. And the same for physicians?

Dr. SPAGNOLO. I can't tell you how many human resource officers I have seen go by in 40 years. But every new director that came to our facility in the last 40 years has said, "My number-one priority is to fix H.R." It has never been fixed.

Ms. BROWNLEY. Mr. Spagnolo, your testimony was shocking, when you said sometimes veterans have medical appointments for care and leave not knowing that they did not see a physician or medical expert of any kind. That is pretty shocking testimony to me.

And then when I hear some of the obstacles around physician assistants and the shortage there, I am not sure what to say, except we have a lot of improvements to make.

But, I mean, do you think that that is a common occurrence, where a veteran comes for an appointment for medical services and never sees a physician?

Dr. SPAGNOLO. Was the question do I think it is common?

Ms. BROWNLEY. Yes.

Dr. SPAGNOLO. Yes, I think it is quite common.

Ms. BROWNLEY. And how do you think—you also said in your testimony that physicians are doing nonphysician care, like typing and filing and followup calls and helping patients change their clothes and patient reception, et cetera.

How did that happen? How did those responsibilities become the responsibilities of the physician? Is it just because of the shortage of people in the operation, or are these specific responsibilities of a physician?

Dr. SPAGNOLO. I don't know specifically how that has occurred over the years, but I can tell you that when I was a chief of staff a number of years ago, I used to say to our hospital director when he would come in and yell at me and say our docs aren't seeing enough patients—and I keep telling him that the reason they can't see patients is there is nobody in the clinic to assist them to see the patient.

They have one examining room. They have to go get the patient. They have to help get the patient undressed. They have to see the patient. Then they have to write a note, usually on the computer nowadays. And they have to help the patient get dressed, and then they have to escort the patient out of the room.

How many times in a day can you do that when you have no other help? You have nobody to help input data into the computer. You have no one to help you request drugs for patients into the computer. You are basically doing the physician, the secretary, the receptionist.

It is very difficult to be efficient—not that the physicians don't want to be efficient. They would love to be efficient, but the system doesn't permit it. And when you talk to the administrators, they just glaze over. It gets the physicians extraordinarily frustrated. They would love to see more patients. Everybody would love to see more patients.

Ms. BROWNLEY. Thank you, Doctor.

My time is up, and I yield back.

Dr. BENISHEK. Dr. Roe, you are recognized for 5 minutes.

Dr. ROE. Thank you, Mr. Chairman.

And, Dr. Salvo, you really threw me off when I realized I have been a doctor longer than you have been alive.

Dr. Spagnolo, I suspect you had the same sort of angst as I did.

A couple of things I just want to go over very quickly. I have to run to the airport and catch an airplane. But, number one, I think

you very clearly pointed out the loss of professionalism that is occurring.

In my practice, I had an assistant, I had a nurse with me, I had three examining rooms. I could really see a lot of patients very efficiently and very well. You cannot see patients efficiently in that circumstance. It is impossible. You can't make you more productive when you have six jobs. And I think that very loss of professionalism has occurred.

I think another thing that has occurred in the VA is that we have fewer M.D. providers as hospital administrators. If you have been in the trenches working, you understand exactly how that clinic works. I understand exactly how your clinic works or doesn't work. So I think that is one of the issues we have to deal with.

And I think another question I have right quickly is, what is the retention problem? When you hire people, there is this huge turnover, both in nursing and on the medical side. What do you all see as that? Why is that? Is it the working conditions? The pay? I mean, there are a lot of things you have gone over, but why is that?

Dr. SPAGNOLO. I will take a stab, and then it is yours.

Ms. CLIFFORD. Okay.

Dr. SPAGNOLO. They come to work with great enthusiasm. Good people, they get put into these situations where, after 6 months or a year, they just are frustrated, depressed, tired, nobody listens, and they leave. So your turnover rates, I don't know what they are nationally, but I know that in primary care some places have turnover rates of 100 percent every year.

It is frustration. Primarily frustration, I would say.

Dr. ROE. And—excuse me. Go ahead, Ms. Clifford.

Ms. CLIFFORD. So I would say it is, again, dependent on different facilities. To your point that people all come in with the best of intentions, but if you happen to be in an area that has a difficult time recruiting, then they are kind of always behind the eight ball. They are required to do a lot of overtime, or they are having lots of shift changes, and so people get frustrated and burnt out and leave. But in facilities that are able to maintain that, people stay because they stay for the mission of the VA.

Dr. ROE. Two other quick questions.

One is, from Mr. Morris' standpoint, is there a barrier? If you have a different—I am certified by the American Board, but are there barriers out there for other board certifications that you see that help reduce staffing? Is that a real issue that he brought up or not?

And I guess, Dr. Spagnolo, you can answer it, or Mr. Morris can answer it, either one.

And the second——

Dr. SPAGNOLO. I think within certain——

Dr. ROE. Let me throw the second one out so you can just answer it.

You know, the Veterans Choice Act, which we spent a lot of time on and getting passed, provided $5 billion to increase staffing for the VA. Is that happening? Is that money being used that way?

Those are my two questions.

Dr. SPAGNOLO. If your question is, on the Veterans Choice Act, whether they are utilizing it, is that——

Dr. ROE. Yes, sir.

Dr. SPAGNOLO. I don't know how much they are utilizing it, to be honest with you. I don't know if the—I know that we have tried to have a few people go somewhere else. One had an artificial heart. And it was like a nightmare to get that done, because the facility that they were to go to had no experience with that.

I can't tell you how it is across the VA. From what I hear, it is not very efficient. So if it is going to work, it has to be efficient.

I would like to see within the VA more efficiencies and getting these procedures done more quickly. I mean, some physicians have no—their access to the operating room is 1 or 2 days a week.

Dr. ROE. Okay.

That second—you know, with staffing less physicians, as Mr. Morris pointed out, is being boarded by somebody other than what I am boarded by, is that a barrier to hiring people?

Dr. SPAGNOLO. Yes, I think it is a barrier.

Dr. ROE. Is it a legitimate barrier, or is it——

Dr. SPAGNOLO. I think it is a legitimate barrier in some situations.

Dr. ROE. Okay.

Any other comments on that? Have any of you—Dr. Salvo, have you seen that?

Dr. SALVO. I am not—in my capacity as a WOC (Without Compensation) appointment within the VA, I have had to deal almost nothing with the Veterans Choice Act personally. That is purely administrative by other departments.

Dr. ROE. Yes.

Ms. DaSilva.

Ms. DASILVA. Sir, I do want to say with the Veterans Choice Act, it has been interpreted to not include physician assistants by some facilities. So if you wanted to talk about increasing recruitment, if the jobs aren't even posted and physician assistants aren't even able to apply for those jobs, that is not going to increase access for care for veterans.

Dr. ROE. Well, Just as I head out the door, it isn't really hard to figure out your needs when you just call the people scheduling appointments and find out you have a 6-month wait. It isn't rocket science. Look, I have been doing it for four decades, and you find out, and all of you there know, if you have a long waiting list for patients to come in, you need to hire people to take care of those waiting lists or make your shop more efficient. It is not complicated. I mean, I did it for years.

And, I mean, the way I learned out if I needed anybody is I would go to church and somebody would say, I can't get an appointment with you for 6 months. I would figure, hey, maybe we better hire another practitioner, and we did. And that is what I see there.

So my time has expired, Mr. Chairman. Thank you for indulging me.

Dr. BENISHEK. Thank you, Mr. Roe.

Mr. O'ROURKE. You are recognized for 5 minutes.

Mr. O'ROURKE. Thank you, Mr. Chairman.

I want to thank everyone on the panel for being here. And your commitment to improving the VA and serving our veterans gives me an opportunity to remember and thank those who serve the veterans in El Paso, Texas. That is the district I have the honor of serving.

And, Dr. Salvo, your story of continuing to treat veterans without compensation reminds me of people that I have met at the VA who are providers there who could be working in the private sector at much greater pay and probably much less frustration and yet choose to work at the VA because they want to serve veterans, and they do a wonderful job.

And I hear that from the veterans that they treat and serve directly, you know, that it is really hard to get in, and there is a lot of frustration with the bureaucracy, but once you are seen by a provider, typically, the experience is excellent. And I think that is something that I have heard my colleagues on the committee share, as well.

Two things stick out to me, in terms of the larger picture. One is—we heard the Deputy Secretary say this day before yesterday, Sloan Gibson—that there are 28,000 unfilled positions at the VA today. Just the hiring challenge there is just monumental, staggering. I don't know how you get over it. And it hasn't improved in a year.

And the other is that wait times also have not improved in a year. You know, $15 billion or $16 billion authorized and appropriated this summer; program went live in November. Dr. Spagnolo, you said you are not sure if you have seen any significant change in access or treatment as a result of that. We know from a hearing earlier this week that we thought that $10 billion of that were going to be obligated sometime in the early part of fiscal year 2016, which could take you to maybe December or January, you know, in the next 6 months, and only $500 million has been obligated.

So you all have each offered important suggestions to improve the delivery of care and the hiring and the speed at which we bring people on board. And I am really glad that Dr. Lynch is here to listen to all this, and I know that he is taking note of this and will incorporate these, I hope, into the operations at the VA. But I am also looking for some kind of big breakthrough in what we are doing.

I don't know that, with these 28,000 outstanding hires, with wait times that haven't improved despite the notoriety around the crisis in Phoenix and all the attention that we have spent and the new legislation that we thought was going to fix it, I don't know that this model works, nor should we expect it to work.

And, you know, one of you said it is not going to be a matter of resources. We can't throw more money at this and just expect it—we can hire people more quickly. You know, I heard these same stories. We had a psychologist who was hired from Georgia, recruited by the VA in El Paso. And he said, you know, sure, I would like to do this job, sign me up, and it took 3 months to bring him on. They recruited him, and it took 3 months. And in that time he said, you know, there were several other offers, and I thought about taking them, but I wanted to serve in an underserved area.

So I realize I have chewed up most of the time I had, but I want to offer the last minute and a half to anyone who might have a big breakthrough idea on how we change what is obviously a system that just doesn't work.

Ms. Clifford, it looks like you might have one.

Ms. CLIFFORD. Well, I don't know if it is a breakthrough idea, but if we don't address the human resource piece of it—and from that, I just want to go on record as saying it is not the staff that are doing the work there. They are killing themselves trying to help us get these people in. But the task ahead of them is just so overwhelming that—I don't know what their retention rates are, but I would think they are not very good because they turn over very quickly. Because it takes a lot of time to get them trained, and so they don't stay long enough to get trained. And they go to other jobs, either in other parts of the government or out of human resources altogether.

So if we kind of don't address that area—because they are our bread and butter of getting people in.

Mr. O'ROURKE. And that is an open question from me to each of you. And I am sure my colleagues on the committee would all be interested in hearing your answer. So we are not going to have time to get that from each of you today, but know that I think, you know, speak for myself, very interested in a different way forward.

I think more of the same we have seen from the last year, despite, you know, what I think is tremendous leadership on the part of the VA and the new Secretary, it is just not working. And the people who are delivering that care on the front lines are suffering, and what is even more important, the people that they serve are suffering. And we have to have a big, bold path forward to fix this.

So, with that, I yield back to the chair.

Dr. BENISHEK. Thank you, Mr. O'Rourke.

Mr. Coffman, you are recognized for 5 minutes.

Mr. COFFMAN. Thank you, Mr. Chairman.

We get scope-of-practice questions here in the Congress relative to the Veterans Administration. I think a lot of these issues have been resolved down at the State level before State legislatures. And I have been on both sides of it as a State legislator, where I think they are better qualified at the State level to make those decisions. They can have hearings; you know, they know that the docs, the providers within their communities.

And so I guess my question to you is, clearly, you know, people that—well, my question to you is, what do you think about devolving the scope-of-practice issues down to reflect whatever the standards are within the given States that these VA facilities are in, number one?

And, obviously, we are going to make sure that the providers are properly credentialed or trained to be able to perform those duties within the scope of practice. So devolve it down to the State level, reflect State regulations wherever these VA facilities are, as opposed to us relitigating these issues at the Federal level.

Would anybody like to comment on that?

Ms. CLIFFORD. Well, I can speak to it from the advanced practice realm. And the issue becomes—we care for patients across States, and so different States have different nurse practice acts which

allow the nurse practitioners to do different things at different levels and how much independent practice they can have.

So, in VA Boston, for example, we are a referral center, so we are patients from Maine and New Hampshire, and yet the nurse practitioners in some States are able to do things and are not able to in other States. So it makes it—it is hard for us to give equitable care across all of our veterans when we have different practices across.

Mr. COFFMAN. Anybody else?

Dr. SPAGNOLO. I am not sure I could respond to that because I have never really thought of that as an answer, but probably have to probably look at that a little bit more and see where that would take us. But it may be a possibility; I don't know. But I would like to get back to you on that.

Mr. COFFMAN. As an example, the issue between anesthesiologists and nurse anesthetists has been settled across this country in different States. And now both sides want us to relitigate it here at the Federal level where I would just as soon to defer to those State legislatures who have made those decisions. So that would be an example.

Dr. SPAGNOLO. I would have to look at that across State lines. I don't have a good answer for you on that whole issue. But I will get back to you on that.

Mr. COFFMAN. Okay.

Thank you, Mr. Chairman. I yield back.

Dr. BENISHEK. Thank you, Mr. Coffman.

Mr. Takano is next.

Mr. TAKANO. Thank you, Mr. Chairman. Thank you.

Ms. Clifford, thank you for your testimony today about the vital that role nurses play in the VA and how we can better attract and retain nurses to care for our veterans.

You mentioned something about streamlining the hiring process and improving education resources for nurses, but I am wondering about your thoughts about giving nurses improved rights to raise grievances about staffing levels and how that can improve the workplace, empower nurses, and encourage them to continue serving our veterans.

In a statement submitted for the record, the AFGE mentions that through a loophole nurses and other VA healthcare providers are denied full collective bargaining rights that other Federal employees have. The AFGE supports a bill that I have introduced, H.R. 2193, the VA Employee Fairness Act, to expand providers' ability to negotiate to improve staffing levels and in turn the care our veterans receive.

Mr. TAKANO. Do you think we need to pay attention to the work environment to attract and retain skilled nurses?

Ms. CLIFFORD. Yes, sir. And in VA nursing we actually use an expert panel for staffing methodology model, in which case we use front-line staff to participate in what those staffing levels and numbers should be for those individual units. That is the model that we use. So we do involve front-line staff in that, and they look at the demographics of their unit, the turbulence of their unit, the things that are going on in their unit, and the acuity levels to determine what should be the appropriate staffing mix and level. And

those recommendations are then put forward through the nurse executive to the resource committees at those.

Mr. TAKANO. Dr. Spagnolo, the similar question regarding the ability to collectively bargain, to set staffing levels. Do you think that expanding the collective bargaining rights and physicians' ability to negotiate would play a role in ensuring physicians' voices are heard, you are paid attention to by the folks that are making decisions?

Dr. SPAGNOLO. Frankly, I am not sure I have an answer to that question. We currently have union representation in the hospital that gets involved in a lot. I think some of these issues, it seems to me many times it makes it more complicated. I think if we could empower more people within the hospital we could probably eliminate a lot of these problems that have to do with working conditions.

Mr. TAKANO. How do you empower them without having collective organization? How are you going to be heard and listened to? How are you going to get people to listen to you unless there is some leverage?

Dr. SPAGNOLO. Well, I am not quite sure I understand that question. But if you are talking about pay or are you talking about working conditions?

Mr. TAKANO. Well, working conditions are also part of what are collectively bargained.

Dr. SPAGNOLO. I am not sure, the issues that we have been discussing here, I don't know if you need that kind of collective bargaining agreement. I think if we can all sit down around the table, we could solve these problems.

Mr. TAKANO. Okay. Thank you.

Mr. Spagnolo, I want to briefly ask you this question. Isn't there a tremendous physician shortage in the country? Does that not play into why it might be difficult for the VA to recruit physicians?

Dr. SPAGNOLO. There is a physician shortage in some areas, I agree with you on that.

Mr. TAKANO. Primary care?

Dr. SPAGNOLO. I think in primary care. But, again, I keep coming back to the same issue, it is a revolving door, if you don't make things a little better. I think the salaries in the last 10 years have come up significantly.

Mr. TAKANO. Okay. On the physician's assistant side, I am just wondering about whether or not there might be some education inflation. I was interested to hear that the military was the beginning of the whole idea of PAs. There are community college programs that will take, up until now, PA people who had up to 5 years of experience, say, in the military, and with a community college program of 2 years they can become PAs, but I understand that the accreditation has moved had a to a master's degree minimum.

Ms. DASILVA. Yes, sir.

Mr. TAKANO. Is that something you agree with, Ms. DaSilva?

Ms. DASILVA. I went to a community college and applied to an accredited physician assistant program. So it is at a master's level now. The Grow Your Own, the ICT is a great program and a great pathway to let returning corpsmen and medics coming back who

are OIF/OEF to have a pathway to go and become physician assistants. So, yes, it is a master's program now and it has to be accredited.

Mr. TAKANO. But is the loss of that pathway through the community college to your program, is that a problem? I mean, is that kind of added burden necessary?

Ms. DASILVA. Sir, when I applied to PA school, and to my knowledge there is not a pathway that you can go to a community college and become a physician assistant, it at a minimum was a bachelor's program even when I applied in 1999. I did not know of any community college that was offering the physician assistant program at that time. There were very few even at that time that were offering a bachelor's, they had all turned to a master's program and now even offering doctorate's.

Mr. TAKANO. Thank you. I yield my time back.

Dr. BENISHEK. Thank you.

Dr. Wenstrup.

Dr. WENSTRUP. Thank you, Mr. Chairman. And I want to thank you and the ranking member for putting this panel together and for all of you being here today. I think it is very insightful and it provides us with a lot of opportunity to make things better in the VA by hearing what you have to say today.

When I first got here 2 years ago, and this is before Phoenix broke and everything else, coming from private practice I was concerned, I remember asking Dr. Petzel if anybody on the administrative staff have ever been in private practice where they had to be in the black to keep their doors open and none of them had. And I found that very significant and a key part, especially when you talk about physician directors today being involved. It would be even more helpful if they had some private practice experience and prove efficiency.

I also asked the question at the time, I said: Do you think the VA, if you took all their expenditures like a private practice has to do, their physical plant, their nurses, their assistants, their supplies, their insurance, and all the bills that they had to pay, I said if the VA looked at themselves that way and took fee-for-service at Medicare rates, would you be in the black. And he said yes. And I about fell out of my chair, because I know how tough it is to be in the black seeing three times as many patients as the VA was doing.

And I greatly appreciate what you are talking about today, where you have physicians doing things that in a private practice you have someone else do, so that you can care for more people. And that really is the bottom line. So I really appreciate what you are saying today.

Look, on this committee alone we have five physicians. If we can't make things better sitting here, then we are in trouble. This is an opportunity that should not be wasted, and I hope that we proceed in that direction. So thank you all for advocating on the things that I think we all believe in.

I do have one question, and it has to do with retention and recruitment and the length of time it takes to fill a spot. I think we have touched on some of the reasons why it is tough, but I am curious how long it takes to fill a spot. Because I have had young doc-

tors, podiatrists, M.D.s, come to me and say: I looked into it, but I didn't see a bright future here. And especially when you talked about the podiatry pay issue.

So if you could both weigh in on length of time it takes to actually fill a slot on average and the challenges, I would appreciate it.

Dr. SPAGNOLO. I don't know what else to tell you other than the processes are so complicated and it has got to go through so many levels and then it has to get approved and reapproved and on a resource committee meeting and then off of committee, and sometimes the committee doesn't meet for 2 months, and then it goes to HR, and then back to the resource committee. That just takes forever.

Dr. WENSTRUP. Well, that is what I want to hear. And I am hoping working with you we can come up with a plan that streamlines that and makes it a whole lot more efficient.

Dr. SPAGNOLO. I would be delighted to help you work on that plan.

Mr. Chairman, I have a clinic at 1 o'clock, which we have 40 people waiting on me. May I be excused?

Dr. BENISHEK. Yes, I suppose so.

Dr. WENSTRUP. Well, Dr. Salvo, I would like you to weigh in as well, if you can.

Dr. SALVO. Thank you. I am in complete agreement with Dr. Spagnolo, and he indicated earlier in his testimony an approximate wait time in terms of getting credentialed and privileged and starting in the VA approximately 1 year. And if I were to consider the average, that is probably true.

When I left my post in the Cleveland system, it was 14 months before that was filled. I have had two WOC (Without Compensation) positions since have I started my current position with APMA. One took me 11 months. The other one, surprisingly, took me 5. It is an excessive, burdensome process when you factor in VetPro and you factor in the application process along with all of the forms and the various HR levels and committees that everything has to be completed. So it is extremely, excessively burdensome.

Dr. WENSTRUP. Thank you very much for your testimony.

I yield back.

Dr. BENISHEK. Thank you, Doctor.

Ms. Kuster.

Ms. KUSTER. Thank you very much to our chair and the vice chair for holding this hearing.

And I apologize to all of you that we have flights that we have to catch, but I appreciate you being here and look forward perhaps another time that we could bring Dr. Lynch back so that more of us could hear.

I just want to focus in. I had the opportunity just recently to visit the White River Junction, Vermont, hospital, which is the VA hospital that serves many of the folks in my district. And I think they are very focused on veteran-centric care. They have actually had some very good results from the Choice Act in hiring just recently. In fact, they were focused on getting nurse practitioners into our CBOC so that in the rural communities they would have the pre-

scribing ability to stay on top of medications and prescribe without people having to go down to the VA hospital.

But I want to focus in on the question of the PAs, and just generally I am pretty familiar with the private sector and the fact that this is a national trend, we are pushing down our medical care to the right person, at the right time, for the right task. So it doesn't surprise me that somebody would come in and not see a physician. I don't typically see a physician when I get care in the private sector. If I can see a PA or see a nurse practitioner, I get terrific care. So I don't want to mislead anyone about what is expected.

My concern about the PAs is this chronic loss rate, 12 to 14 percent loss rate, and particularly comparing it to a very favorable practice with the nurse practitioners in their residency program, 100 percent retention of employed nurses after 1-year of employment, as compared to over a loss rate of over 10 percent in other practices.

I am wondering, and this is for Ms. DaSilva, have you see anywhere, whether it is in the VA or outside, it could be a best practice that we could bring in, a residency-type program where we could be more focused on our PAs, give them the support that they need to be able to stay on the job, because my understanding is it takes at least 6 months to replace a PA. That is expensive. It is expensive to the system. And, as I say, I am just focused on veteran-centric care. Can we get them the care that they need?

Ms. DASILVA. Thank you for that great question.

The issue when you were talking about the residency program, we don't have a particular, like, Grow Your Own residency program. When I had given my verbal testimony, I talked about the scholarships that are just not available. So if you have a medical technician or somebody in the VA system who says they want to go on and become a physician assistant, there aren't really funds that are nationally set aside for it. It is up to each local facility if they do that. There isn't a definite program that you can apply to and have a pathway to become a physician assistant.

So if you wanted to do that, you would have to take out loans or leave the VA system or come into the VA system, spend a short amount of time, and then leave. That is why we were talking about the Grow Your Own. So if you do have corpsmen medics who are in the VA system or returning, can come and work at the VA, get their PA school paid for, and then continue to work within the system.

That would be the ideal pathway to do and to set aside. There are education debt-reduction programs to have PAs come and work in the system. However, the funding is at a local level, so it is not nationally mandated. So if you ask at the local level, they may say that the funds are not available.

Ms. KUSTER. So I would be very interested in looking into bipartisan legislation to bring the PAs in line with both the debt reduction and the scholarship programming too. And I love the idea of our returning vets. I know we have talked a lot on this committee about aligning their abilities and making sure that they have a path to successful employment in the private sector.

And then just briefly, my time is almost up, but I did want to just mention I am also interested in the mandated surveys, to in-

clude our PAs in the mandated salary surveys in the community so that we better align the compensation for PAs. But I think we should do what we can to make sure that doctors are working at their highest and best use and that they have the support to see more patients. I am a big fan of bringing in nurse practitioners and nurses obviously for what they can do for it. And I really want to be supportive of getting PAs up to speed and well compensated so that they will be able to participate as well.

So thank you very much.

And I yield back. Thank you.

Dr. BENISHEK. Thank you, Ms. Kuster.

Dr. Abraham, you are recognized.

Dr. ABRAHAM. I first want to give Dr. Spagnolo who has left accolades for having the patience of Job, if he is able to work 40 years in the system that requires him to enter data. I know as a practicing physician when my triage nurse would call in, or my scribe when we used the electronic health records would call in sick, I would see two-thirds, if not 75 percent less patients that day when I actually had to do the work. So the hard work is actually done by those nurses and good triage people that make us look better than we probably really are.

Saying that, I have worked also with PAs and NPs all my career, and the service and the level of care that you provide is outstanding.

Dr. Salvo, on the podiatry front, I have referred patients all my career to podiatrists for anything from Charcot foot to diabetic cultures, and again could not ask for a better level of care from your profession. So kudos to you guys.

I find it odd that in programs such as Choice or anything that is non-VA related that the VA doesn't mind that our good veterans are being seen outside the VA clinic by board certification other than ABMS. They allow the AOA, I think that is the osteopathic board, and the ABPS, the profession that you represent, Mr. Morris, they allow them to see them and don't seem to have a problem with that, but they evidently have a problem hiring those same types of board certifications in the VA hospitals themselves.

Again, going back to my little world of a practicing physician before this job, I used physicians of every specialty certification, for hospitalists, for referral. And across the board there was no difference in care. They all, whether it be the ABMS, your profession that you represent, the AOA, all provided, again, outstanding level of care, either outpatient or in the hospital, for my patients.

So I guess the question is, how many physicians do you think have been denied positions at the VA because of their different board certification?

Mr. MORRIS. We couldn't get an accurate—I mean, there is a lot of our membership, which is why we have been pushing this issue. Most of them are even veterans themselves. We have tried to reach out to get those counts, to get those numbers, but unfortunately in the politics of medicine some of the physicians are even afraid to even come forward to say things because there are blacklists or names that get out to where if they do get an opportunity to get a job, they have been denied these instances.

The politics of medicine regarding board certification has been something that I was shocked to see when I first came in. If you are having great physicians denied opportunities or even great physicians working within the VA system denied levels of promotion, denied movement along in their career solely because they chose the smaller board. And we are here today and we have been here continuously having you meet our physicians to really show them that it should be looked at the physician as a whole of their education, training, and experience, not what choice they made in their board certification.

Dr. ABRAHAM. Thank you.

Mr. Chairman, I yield back.

Dr. BENISHEK. Thank you.

Well, I think everyone has had an opportunity. So if there are any further questions, otherwise we will excuse the panel.

Well, you all are excused then. Thank you very much for your testimony. We really appreciate you coming in here.

Dr. BENISHEK. I will now welcome our second panel to the witness table. Joining us in the second panel is Dr. Thomas Lynch, the VA Assistant Deputy Under Secretary for Health for Clinical Operations. Dr. Lynch is accompanied by Elias Hernandez, the Deputy Chief Officer for Workforce Management and Consulting, and Dr. Gage, the Chief Officer of Nursing.

Thank you all for being here.

Once you get settled, Dr. Lynch, you are welcome to begin your testimony.

STATEMENT OF THOMAS LYNCH, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR CLINICAL OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY ELIAS HERNANDEZ, DEPUTY CHIEF OFFICER FOR WORKFORCE MANAGEMENT AND CONSULTING, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, AND DONNA GAGE, PH.D., RN, NE-BC, CHIEF OFFICER OF NURSING, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

OPENING STATEMENT OF THOMAS LYNCH M.D.

Dr. LYNCH. Thank you, Mr. Chairman. I think I got the short chair here, but I will try to make the best of it.

I would like to go off script for just a minute after acknowledging you, Mr. Chairman, Ranking Member Brownley, and the members, and thanking you for the opportunity to discuss VA's ability to recruit onboard and retain qualified medical professionals.

I want to acknowledge the panel that preceded us. I want to acknowledge the opportunities that they afforded us I want to hear. I wanted to echo Secretary McDonald's statement of the other day that we really need to engage and empower our employees. We need to listen and we need to learn because they will help us provide better care to veterans.

With that said, I would also like to acknowledge today that I am accompanied by Mr. Elias Hernandez, Dr. Donna Gage. Mr. Hernandez was recently appointed Chief Officer for VHA's Office of

Workforce Management and Consulting and is responsible for providing human resource support services and training. Dr. Gage, who recently joined VA from the private sector, serves as VHA's Chief Nursing Officer and advises on all matters related to nursing and the delivery the patient care services.

Establishing and realizing staffing requirements for VA's healthcare system is a very complex task. The VA operates over 1,000 points of care across the country and provides a full range of primary and specialty care services for patients ranging in age from our youngest, recently discharged servicemembers to our most senior veterans. Rural populations, unique health conditions resulting from combat experiences, and an increasing number of women veterans require a commensurate array of professionals to address their unique and individual requirements.

Adding to the challenge is the fact that there are many approaches to medical professional and support staff modeling across large healthcare systems. There is no one-size-fits-all model and no single set of staffing management tools from the private sector or elsewhere that we can borrow. These are indeed challenges, but they are no means an insurmountable barrier to achieving the goal of timely access to care for veterans.

VA is leveraging our national recruitment program, dedicated recruiters partnering with facilities and identifying hard-to-fill positions, marketing, and hiring qualified medical professionals. We are promoting scholarships and loan repayment programs, such as the Education Debt Reduction Program and employee incentive scholarship programs, as expanded by VACA. We have increased the physician and dentist compensation pay tables in order to attract and retain qualified healthcare providers. We are improving the credentialing process for VA and DoD healthcare providers, which involves sharing credentials to speed up the process.

In the last 12 months, VA has hired more than 37,000 new employees, with a net increase of over 11,000 medical professionals and staff. This includes about 1,000 physicians and 3,000 nurses.

In addition, we are leveraging new technology to expand the reach of healthcare providers. From 2010 to 2014, there was a 114 percent increase in the use of all healthcare technology among unique veterans. At the end of 2014, 12.7 percent of all veterans enrolled in VA care received telehealth-based care. This includes over 2 million telehealth visits, touching 700,000 veterans.

To address the increase in the rural veteran population, the VA's Office of Academic Affiliations, in partnership with the Office of Rural Health, is sponsoring a 3-year Rural Health Training Initiative. The project is designed to fulfill VA's mission to serve veterans living in rural areas. Funding under this request allows VA facilities to expand health professions training to rural VA locations. Additional trainee positions awarded as part of this initiative become part of each facility's permanent base location.

As you can see, we have made significant progress, but we realize we still face many challenges with wait times, the provision of rural healthcare, and the commitment to women's health issues. By increasing staff, clinical space, community care, and the hours of care available we believe our recent progress has resulted in some increases in the number of unique patient visits and large in-

creases in the number of appointments for veterans already enrolled. We have completed 2.5 million more appointments inside VA this past year.

We also believe that in many specific locations, with the longest wait times, the more access we offer, the more veterans will seek VHA care services. It is also a challenge to recruit healthcare professionals at some of these locations. These are all contributing factors as to why wait times are stagnant in some areas and why we must focus our efforts.

In conclusion, Mr. Chairman, we have the best clients in the field of healthcare. We are grateful for Congress' support, and we look forward to your continued assistance in getting the best doctors and nurses to serve veterans. The challenges remain formidable, but our commitment to timely, accessible care and a positive patient experience is unwavering.

Mr. Chairman, this concludes my opening remarks. My colleagues and I are prepared to answer any questions you and the members of the committee may have.

[THE PREPARED STATEMENT OF DR. LYNCH APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Dr. Lynch. And I will yield myself 5 minutes for questions.

It is great that you come and you tell us how well you are doing and how much improved and you cite these statistics and stuff, but it is really frustrating to me. You heard the testimony from the previous panel and that there seems to be just way too many orders from above about how things get done within the VA and that there is not enough, what Dr. Spagnolo talked about, is that the people on the ground who are actually taking care of the patients get to make some decisions that affect how the process works.

Now, the VA provides hospitals, and this bureaucratic mess does not occur at the same level in private hospitals. So not every single private hospital has 2,000 clinics, but they seem to do a better job of hiring and firing and having processes work efficiently than the VA. And I think a lot of it is because the people on the ground have more power to actually change things.

Now, I will give you a great example of this, is I just went to a CBOC in my district, and one of the complaints that I had was that everybody who went and saw the patient had to sign in and out on the computer. There was a computer in the examine room, the nurse goes in, she has to sign into the computer, she has to sign out when she is done. The doctor comes in, he has got to sign in and sign out to write anything down about the patient. They can't take their laptop with them and stay signed in. They have to wait 5 minutes signing in every time they see a different patient. And it was like the cumulative time of signing in and signing out of the computer was, a huge waste.

So the people in the clinic are telling me that this is a big time killer in their clinic and yet nobody could get that changed, because the way they were doing it was from above. Those are the kind of processes, Dr. Lynch, that need to be solved at the local level because every single little clinic or hospital is going to have an issue like that that has to be done.

And I have been here for years now listening to what you guys have been doing as far as physician staffing, for example, eight times in the last 30 years the inspector general has told the VA that they need a central plan for hiring physicians and eight times the VA has agreed with the inspector general that they need that. But they haven't gotten a central plan for hiring physicians over the last 30 years.

So what has changed, Dr. Lynch? How can we get this moving? How can we jump-start this? I mean, it is the same answers I hear. It is not working.

Dr. LYNCH. So let me start by agreeing with you on one point. I think the aggravation of dealing with our computer system is exceedingly frustrating. I think the other side of that, fortunately, is that it provides a very accurate medical record.

I would disagree in that I think the solution is probably central and we need to look for ways to make computer access more efficient across our system. I don't think it is a local problem. I think it is larger.

Dr. BENISHEK. Well, I could tell you that at the hospital I worked at I had a laptop of my own that I used. I signed in once, I kept it with me, and I went and saw a bunch of different patients. I didn't have to sign in and sign out. That was not a centrally planned decision, that was a locally planned decision, and it was a lot better for everybody. The nurse had her computer at the nursing station. She just went back and forth and didn't have to sign in and sign out, lose your spot, all that baloney.

And somehow you can't solve that simple problem? But your answer is it has to be solved centrally. That is the wrong answer, Dr. Lynch. That is what I am trying to tell you.

Dr. LYNCH. I understand your position, but I am going to disagree. And we end up facing obstacles from Homeland Security, and the risk of access to national computers limits——

Dr. BENISHEK. Everybody has a problem with the security of health computers, so don't tell me it is special to you, okay, because everybody is concerned about the patients' privacy on healthcare. So these are answers that don't make any sense, Dr. Lynch, and I am very disappointed to hear this kind of stuff. I want your solution to these problems, and I think it goes down to not having enough control locally.

Mr. Hernandez, let me ask you a quick question before I am out of time about Ms. Clifford's HR question and statement that it is so unwieldy. What can you do about? Quick.

Mr. HERNANDEZ. Thank you, Mr. Chairman.

I will tell you, Mr. Chairman, and to acknowledge to the subcommittee that we do have a complex HR system which is comprised of two different personnel——

Dr. BENISHEK. What have you done in the last year to change that?

Mr. HERNANDEZ. We have trained the HR professionals, the credentialers, the leaders of the organization, and the hiring managers at the local level to understand the hiring process and the roles and responsibilities during that process.

Dr. BENISHEK. Have they changed that process in the last year to make it simpler?

Mr. HERNANDEZ. Sir, we are looking. Mr. Sherman——

Dr. BENISHEK. You have not then, that is a no, you have not changed the process in the last year to make it simpler.

Mr. HERNANDEZ. We have, Mr. Chairman.

Dr. BENISHEK. What have you done?

Mr. HERNANDEZ. We have visited the——

Dr. BENISHEK. What have you changed in the process of hiring people in the last year that made it simpler, one thing?

Mr. HERNANDEZ. We have educated the H.R. community——

Dr. BENISHEK. No, no, no, not educate the person. What about the process have you changed in the last year to make the hiring easier?

Mr. HERNANDEZ. That is what I am trying to convey, Mr. Chairman, that the hiring authority that we have given to us by Choice, as well as the flexibilities that we have of hiring Title 38 and Title 38 hybrid occupation is being fully utilized systemwide.

Dr. BENISHEK. Okay. I am out of time. I am sorry.

Ms. BROWNLEY. Thank you, Mr. Chairman.

Well just to follow up on that line of questioning, I think Mr. O'Rourke asked the first panel, what is a big, major thing? That is what he was looking for, something big and a big change. And Ms. Clifford answered by saying it is human resources. And I think, and I think this is what the chairman was getting after as well, is that there are so many rules that you have to follow that that really slows the process down.

So to me it is the rules, and we probably need more human beings and human resources to carry out the task and the mission of the amount of people that we need to hire within the VA, which many would say is insurmountable. It is a huge number that we need to hire.

So can you address, is there anything underway to evaluate rules that might have been made two decades ago that can be changed, rules that can be changed, and what we can do to hire more in human resources to get this engine running at a higher speed to hire new professionals within the organization?

Mr. HERNANDEZ. Yes. Ranking Member Brownley, there have been numerous engagements at the local level by subject matter experts from the national level to provide support in terms of the processes that we currently have.

And I would like to state this, because it is very important, and perhaps it may look like a simple issue. But we have integrated the requirements identification at the local level with the responsibilities of the human resources professionals, as well as the hiring managers, the people that are responsible for space and equipment, and the individuals responsible for the credentialing process. Where at one time those processes used to be independent and used to operate in silos, we have integrated those particular processes so we don't have the delays that the other panel mentioned to the subcommittee earlier. And we have proven that in Phoenix, we have proven that, the process has worked in St. Louis.

Ms. BROWNLEY. Okay, so you have gotten rid of silos and there is a more integrated process, where in certain areas in the country we are speeding up the process. Have you had any directive from above to say we need to really review the rules within human re-

sources and adding additional personnel? And is anything like that underway?

Mr. HERNANDEZ. Yes, ma'am. I will tell you that last year the Leading Access and Scheduling Initiative looked at the processes and the barriers that we had in the local level in terms of HR and as well as the national level, and we were able to change a lot of the VHA policies that were identified as barriers.

In terms of the human resources situation that we currently have, we are looking at that particular process in terms of bringing up that particular issue to the national level committee so that we can address that particular situation.

Ms. BROWNLEY. But have you had a specific directive to hire additional people and continue to make changes within the rural process to streamline the whole hiring process? You have had directives?

Mr. HERNANDEZ. We have had guidance issued to the field, yes, ma'am.

Ms. BROWNLEY. So, Dr. Lynch, in terms of the testimony from the American Podiatry Association, is there something that we need to do legislatively to fix what they testified in? And if there is not a need for a legislative fix, is there something the Department can do to recognize their growing mission? And I think they also testified vis-&-vis their salaries, et cetera. So how do we get more podiatrists within the VA? Do we need to fix that legislatively or can that by fixed internally?

Dr. LYNCH. So let me first acknowledge the work that podiatrists do. As a vascular surgeon, I have worked closely with podiatrists throughout my career and I appreciate the value of their product.

There have been several suggestions that have been provided. One was suggested this morning that VA be given the authority to recognize podiatrists as physicians, as CMS does. Other changes are to our handbooks. But it appears that one of the more significant opportunities may be legislation, and we are more than happy to work with the committee to provide the clinical input to the development of any legislation that may bring that forward.

Ms. BROWNLEY. Thank you. I will yield back.

Dr. Benishek. Dr. Wenstrup.

Dr. WENSTRUP. Thank you, Mr. Chairman.

Dr. Lynch, you said something that really struck, and it is not on you, but what you said is there are homeland security issues. And I think what a shame it is that the veteran going to the doctor becomes a homeland security issue. And that tells me that we have become way too connected in everything that we do with the core of the Federal Government that when you go to the doctor you have to have these issues.

Because I can tell you from many years in my practice, may be changed since we have had to use EMR forced on us by the government and connect with all these people and people's medical records are now going everywhere rather than staying within your office, but I can tell you, for years any individual, veteran or otherwise, that came to me for care wasn't worried about Russia, China, North Korea, or Iran.

We need to have a solution to that problem, and you are in the middle of it, and I would love to hear some solutions, because that

should not be a concern of veteran, that it is a homeland security issue for them to go to the doctor.

Dr. LYNCH. Congressman, I don't disagree with you, and I am as frustrated as you are.

Dr. WENSTRUP. I am sure you are.

Dr. LYNCH. And I have lived it, okay, and I don't know what the solutions are, but I agree entirely that we need to figure out a way that we can streamline the medical care system that now has the opportunity to use virtual technologies and not let it get tied up in security issues that actually create more work rather than less work.

Dr. WENSTRUP. But I agree with Dr. Benishek, and it is the same on DoD side from personal experience. You are putting your CAC card in a million times a day rather than seeing patients and you are going back and forth. I mean, the difference, in my practice if somebody comes, they tell a medical assistant there is someone up front, what is wrong with them, how they injured themselves. They turned their ankle, we go get an x-ray. Haven't seen the doctor yet. Now they see the doctor, the x-ray is there. I hadn't had to plug in three times to make that happen and do that from patient to patient.

Let us help you help fix this problem by coming up with solutions that we can insist that the VA make changes. And I know as a practicing physician, if you have had to experience that or know the difference, help us come up with the solutions and demand that we get it done.

Dr. LYNCH. Yes, sir.

Dr. WENSTRUP. Thank you. I yield back.

Mr. TAKANO. Thank you, Mr. Chairman.

Dr. Lynch, in your testimony you mentioned that as a result of the Choice Act the VA has already hired 2,500 medical professionals and support staff. Did I get that right?

Dr. LYNCH. Twenty-six hundred actually, yes.

Mr. TAKANO. Twenty-six hundred. Were all of those new positions or were some of those staff hired to fill existing vacancies?

Dr. LYNCH. To my knowledge those were new positions.

Mr. HERNANDEZ. New positions.

Dr. LYNCH. New positions.

Mr. TAKANO. Okay. Well, with the resources the Choice Act provided will the VA be able to shorten the long wait time it takes to fill the vacancies at the VA?

Dr. LYNCH. I am confident they are. I think Mr. Hernandez implied earlier that human resources has begun looking at their process. It has in the past been a serial process. It needs to be a parallel process. It can be complex, but it can be simplified. It requires proactively assessing our needs. In certain cases it requires staffing to organizational charts. We know somebody is going to leave, we know that position is approved, let's replace it. It involves communication, it involves preparation.

I think, to the chairman's point, this is where the clinical staff does need to get involved with the leadership and with human resources to further the efficiency of the process that we currently have. It is not efficient, it takes too long. I think we know how to

change it. I think we have begun to implement changes. We need to go further.

Mr. TAKANO. Another vital provision of the Choice Act was the increase of 1,500 GME slots. I understand that the first round of residencies have already been awarded.

Dr. LYNCH. Yes, sir.

Mr. TAKANO. And that the VA is moving forward with the second round.

Dr. LYNCH. Yes, sir.

Mr. TAKANO. Will expanding the number of residencies improve the pool of candidates for the vacancies at the VA?

Dr. LYNCH. Absolutely. Two standpoints. Number one, I think VA has a unique advantage over the private sector. Currently, we have over 40,000 residents and medical students that rotate through our VA. We have nurses as well. These are all potential employees. We have first chance at evaluating those individuals. We just need to be able to efficiently move to hire them.

What the Choice Act did was to give us more positions in primary care and mental health in rural areas and in areas where there is not access to care. The goal will be to train people in communities where they may go back to practice. VA once again has the opportunity to say: Let's try to look for the best and let's hire them for the VA, but let's do it efficiently.

Mr. TAKANO. You know what, I did get a call from a gastroenterologist, a young one, working at the USC medical facility in Los Angeles, and expressed extreme frustration at not being communicated with. This person has applied for a vacancy at gastroenterology at the LA VA hospital. And so I am beginning to understand what made on Hawaii this frustration. What do we need to do to bring through this inefficiency? I mean, do you have a plan? Have you pinpointed where the bottlenecks are?

Dr. LYNCH. The bottlenecks, Congressman, are the fact that we don't move fast enough and that we don't give people commitment soon enough. I was talking to Mr. Hernandez before the subcommittee hearing, and we have mechanisms in place now where we can offer a job a year in advance of the completion of their program. That means we can identify the people we want, we can offer them the job. The only condition is that they have to complete their training. But otherwise, we have an opportunity to take advantage of these educational training programs that we have. And we haven't been doing it, but we need to.

Elias, do you want to comment briefly on how we can begin to recruit and get these people sooner?

Mr. HERNANDEZ. Yes. Thank you, Dr. Lynch.

Going back to my original point is taking advantage of the flexibilities we have on the Title 38 and Title 38 hybrids appointing authority. We can engage in early conversations with the residents so we can get their commitments with the condition that once they complete their training program we will be able to convert them into permanent employees for the organization.

Mr. TAKANO. What about people who already are trained and certified and are applying for vacancies?

Mr. HERNANDEZ. Congressman, I will tell you that we have a very aggressive national recruitment program, and I, personally

speaking, would like to know a little bit more about that particular individual because gastroenterology is one of the most critical occupations we have in the organization. And our national recruiters are dedicated staff that deal directly with those individuals to engage with them early on in the process and walk them through the entire onboarding process.

Mr. TAKANO. I will be happy to furnish the names to you.

Mr. HERNANDEZ. I would love to have it, Congressman.

Dr. BENISHEK. Thank you. Thank you.

Well, it is just funny that they are solving the problem, but your guy can't get a job after a year.

Dr. Abraham.

Dr. ABRAHAM. I will add my frustration to Dr. Benishek's and to Dr. Wenstrup and evidently the panel's about having to log in every time that patient goes from room to room. Homeland security was one issue that you brought up, Dr. Lynch, but certainly on the civilian side we as physicians have to worry about HIPAA compliance if we let a record escape. The fines are very hefty. So we are under the gun, so to speak, as much the VA is and we understand.

But if we have a computer system in the VA facility that the record can't move from computer to computer, then we do have a problem. And I am sure that they can, but the reason that they don't is I guess a question I do have, is like Dr. Benishek said, why can't that computer travel with the patient or just travel from room to room as the patient travels, just boot that record to another facility? The first question.

And the second question, I only have two, you heard Mr. Morris' testimony, he was representing, I think, the American Board of Physician Specialties, as far as not being able to receive jobs in I guess the ratio that the ABMS was able to with their certification. Is there a disparity between those two specialties and even the AOA, the osteopathic physicians, and if so, why?

Dr. LYNCH. Congressman, I will be honest, this is the first I have heard of the concern today. I take it seriously because it is the potential opportunity to find more healthcare providers for the VA and for veterans. I will take it for the record to go back and find out a little more information about that and what has happened in the past.

Dr. ABRAHAM. I would appreciate if you would send that to me or just a followup. I would appreciate that.

Dr. LYNCH. Absolutely.

Dr. ABRAHAM. Okay. And the first question, what is the issue with the computers?

Dr. LYNCH. I share your frustration.

Dr. ABRAHAM. I know you do.

Dr. LYNCH. I have been there.

Dr. ABRAHAM. We are past Alexander Graham Bell and we actually have got some pretty good computers these days.

Dr. LYNCH. I grew up in an era when the phones were still dial and actually in an era when you had party lines, which was always kind of interesting.

Dr. ABRAHAM. I was also there.

Dr. LYNCH. I can carry a phone in my pocket now. We need to figure out a way how we can harness computers to work for us and not necessarily create obstacles for us.

Mr. ABRAHAM. And I appreciate that. And again, my request is that you please look into that, because it shouldn't be that hard with the computer systems we have now.

Mr. Chairman, I yield back.

Dr. BENISHEK. Thank you.

Anyone have any other questions?

Go ahead.

Ms. BROWNLEY. I just wanted to make one final comment before we close here. And I just want to say I know that the employees within the VA, particularly in human services, and you, Mr. Hernandez, are working very, very hard every day. Ms. Clifford testified that you are working really hard every single day, and I believe that and I thank you for your service.

I just believe that we need to do more, that you need more assistance, you need a larger team, and we have to streamline the rules that are made, and we have got to put on our commonsense thinking hats, if you will, and streamline this process.

So I didn't want to close without you thinking that, because I believe that you are working very, very hard and the people who are working for you are working very, very hard. I just believe you need more people and we need to improve upon the rules.

Mr. HERNANDEZ. Thank you, ma'am, and we appreciate your support.

Dr. BENISHEK. Thank you all once again for being here today. I think we have touched on several issues that are very important for our veterans, and I really appreciate the work that you do.

The subcommittee may be submitting additional questions for the record. I would appreciate your assistance in ensuring an expedient response to those inquiries.

Dr. BENISHEK. And if there are no further questions, the panel is excused. Thank you very much.

Dr. BENISHEK. I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material. Without objection, so ordered.

Dr. BENISHEK. I would like to once again thank all of our witnesses and the audience members for joining us here this morning and this afternoon. And the hearing is now adjourned.

[Whereupon, at 1:02 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF JOAN CLIFFORD, MSM, RN, FACHE

Overcoming Barriers to More Efficient and Effective VA Staffing

Chairman Benishek, Ranking Member Brownley and members of the Subcommittee, on behalf of the nearly 3,000 members of the Nurses Organization of Veterans Affairs (NOVA), I would like to thank you for the opportunity to testify on today's important and timely subject—VA Staffing.

As the Department of Veterans' Affairs undergoes a system-wide reorganization to include the many challenges of implementing The Veterans Access, Choice and Accountability Act, staffing must be at the forefront of its evaluation. I am Joan Clifford, Deputy Nurse Executive at the VA Boston Health Care System and am here today as the immediate Past President of NOVA. NOVA is a professional organization for registered nurses employed by the VA.

NOVA respects and appreciates what our labor organizations do for VA nurses. NOVA's focus is on professional issues not working conditions which are the purview of the union.

NOVA is uniquely qualified to share its views on the ability of VA to effectively and efficiently recruit, on-board and retain qualified health care professionals to treat our veteran patients. As VA nurses, we are in the medical centers, community-based outpatient clinics and at the bedside every day. With this in mind, we have identified retention and recruitment of health care professionals as a critically important issue in providing the best care anywhere for our veterans and would like to offer the following observations.

NOVA believes that the underlying issues reside in the lack of a strong infrastructure for Human Resources, insufficient nursing education opportunities, as well as the complex application system—USA Jobs—that the VHA utilizes for hiring staff.

VHA is facing a shortage of both corporate experience, and a lack of sufficient HR staffing to support the multiple priorities required for hiring health care professionals.

USA Jobs is a complex hiring process. The system is very slow to review applications online, adding days, even weeks to the time it takes to create a complete qualification review. Upcoming enhancements in HR such as Web HR and HR Smart have to be able to interface with USA Jobs. Some candidates have had to wait five months while HR processed their applications. This results in candidates accepting non-VA jobs, and puts VA back in the hunt for another qualified candidate.

HR employees often have limited knowledge of direct hiring process for Registered Nurses, resulting in unnecessary recruitment delays. HR has also been faced with multiple initiatives, policies and Human Resources Management letters with unclear instructions and guidance. Additionally, current VA process and policies for obtaining recruitment and retention incentives can also cause significant delays in hiring personnel.

All levels of support personnel, as well as RN's, are impacted by the current inflexibilities in pay structure and years of flat lined and non-existent pay increases. Reclassification and downgrades of some occupations such as Surgical Technicians who were brought in at the GS7 level, and have recently been downgraded to GS5 are making it impossible to competitively recruit and retain. Additionally, the increased availability of private sector jobs due to retirements and program expansions within the Affordable Care Act has created other hurdles for VA.

Locality pay challenges, which directly influences RN pay, have once again been brought up by Medical Center leadership. Due to the lack of corporate knowledge among staff within HR on how to maximize the law inconsistent application of the Pay Law remains an obstacle of hiring. NOVA asks that the ceiling on nurse pay be increased to prevent compression between the grades in order to remain competitive.

Ensuring an infrastructure of knowledgeable education leaders within VHA is also critical to support programs that produce nursing graduates who honor and respect Veterans Programs. These programs are often key to hiring opportunities at the Post Baccalaureate Nurse residency and the Nurse Practitioner residency level within VA.

Nursing residents from these programs are embedded in the VA and have the opportunity to demonstrate clinical competency as well as apply for available positions. An increase to the nursing education infrastructure budget is needed to provide for more senior nursing leaders who initiate and manage these programs.

Tuition reimbursement and loan forgiveness monies should also be enhanced in order to help new nurses defray the cost of their education if they work for VHA. The Office of Academic Affairs has supported a wonderful RN Residency Program

across some VA's, but funds are limited thus potentially impacting the recruitment of future RN hires who flock to these programs. Programs that already exist, such as the Health Professional Scholarship Programs, which allow the VA to recruit nurses by paying their tuition in exchange for a service commitment after licensure, need to be considered an important part of funding methodology.

Funding is also needed to support VA Nursing Academic partnerships which enables VA and School of Nursing faculty to develop and implement Post Baccalaureate Nurse Residency (PBNR) and Nurse Practitioner Residency programs (NPRP). The PBNR has had an impressive impact on nursing recruitment and retention. The PBNR had 100% retention of employed nurses after one year of employment as compared to the overall loss rate of 10% in other practices. The nurse practitioner residency program has found that residents overwhelming wish to work in the VA. The NPRP program is currently a pilot and will require sustained funding to pay for resident stipends and education infrastructure for the educational programs and infrastructure for VA Nursing. NOVA believes it is a good investment as hiring NP's will increase access and enable additional services to veterans needing care nationwide.

Another area of concern is the use of Advanced Practice Nurses (APRNs), which at this time, are subject to the state laws in which the facility is located. If a state has a physician supervisory or collaborative relationship in their regulations, then APRNs are not allowed to practice autonomously to the full scope of their abilities. Currently there are 20 states and the District of Columbia that have Full Practice Authority laws in place; in those states and the district, VA APRNs are allowed to practice to the full extent of their scope. However, in the other remaining states this is not permissible.

VHA is advocating for "Full Practice Authority" which would result in APRNs employed by the VA to function to the full extent of their education, licensure, and training, regardless of what state they live and work. Legislation has been introduced, H.R. 1247, the "Improving Veterans Access to Care Act of 2015," which is the model already practiced by the Department of Defense, Indian Health Service and the Public Health Service systems. NOVA, together with the American Nurses Association, American Association of Colleges of Nursing, American Association of Nurse Practitioners, American Association of Nurse Anesthetists, National Association of Clinical Nurse Specialists and the American College of Nurse-Midwives are calling on Congress to support this legislation which would begin to address critical needs within VA facilities by improving wait times and access to care for all veterans.

In closing, NOVA would like to add that the past year's negative publicity surrounding the scheduling and access crisis within VA has also had an impact on recruiting potential applicants. VA employs over 90,000 nurses, which is about one third of its health care workforce. NOVA believes that there is no greater time to have representatives from the Office of Nursing Services at the table as VA reorganizes the way it provides care and services to America's heroes

Improvements and careful review of the process of downgrades across VA, increased training and utilization of Locality Pay law, revising the cap on the RN Pay schedule to eliminate compression, as well as establishing a more user friendly application process and supporting HR offices across the U.S. will go a long way towards correcting the challenges VHA faces with staffing.

NOVA once again thanks you for this opportunity to testify and I would be pleased to answer any questions from the committee.

Statement on Receipt of Grants or Contract Funds: Neither Ms. Joan Clifford, nor the organization she represents, the Nurses Organization of Veterans Affairs, has received federal grant or contract funds relevant to the subject matter of this testimony during the current or past two fiscal years.

NATIONAL ASSOCIATION OF VETERANS AFFAIRS PHYSICIANS AND DENTISTS

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STATEMENT FOR THE RECORD

SAMUEL V. SPAGNOLO, M.D. PRESIDENT

NATIONAL ASSOCIATION OF VETERANS AFFAIRS PHYSICIANS AND DENTISTS (NAVAPD)

BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HEALTH

CONCERNING RECRUITING, ON-BOARDING, AND RETAINING MEDICAL STAFF TO TREAT VETERANS

FRIDAY, MAY 15, 2015
334 CANNON HOUSE OFFICE BUILDING
9:45 A.M.

Mr. Chairman and Distinguished Members of the Subcommittee:

Thank you for the opportunity to address your Sub-committee this morning.

I am here as a practicing physician who has spent 45 years with the VA and as the President of the National Association of Veteran Administration Physicians and Dentists usually referred to as NAVAPD.

I might add that I too am a veteran, having served for two years on active duty in the US Public Health Service.

NAVAPD is the official national organization of VA physicians and dentists who proudly serve our nation's veterans. Our 501(c)(6) nonprofit organization is dedicated to improving the quality of patient care in the VA health care system and ensuring the doctor-patient relationship is maintained and strengthened. In fact, our bylaws state that "NAVAPD has as its highest priority the preservation and strengthening of the VA Health Care Delivery System so that it is able at all times to give veterans quality medical care equal to or better than can be obtained elsewhere in our society." I appear today in pursuit of that purpose. This year NAVAPD celebrates its 40th year.

NAVAPD believes that a key means of enhancing the care of the Veterans is by employing the best physicians and dentists. To that end, we work to ensure that physicians and dentists are enabled to positively influence care; that the professional working conditions encourage VA physicians and dentists to increase access to high-quality health care for our veterans; and that incentives assure that the best physicians and dentists are attracted to the VA health care system. NAVAPD believes it is essential for health care providers to be involved in decisions regarding delivery and quality of care.

Although I began my involvement with the VA during the Vietnam War era as a resident in internal medicine in Boston, it wasn't long before I arrived in DC and began my long tenure at both the DC VA Medical Center and George Washington University and over these many years I have held various titles and positions.*

During these years, I have also witnessed firsthand many changes in the VA, some good and some not so good. I have had the opportunity to meet nearly all the Secretaries of the VA over the last 35 years, get to know several of them, and a few I have seen as patients. I believe all of these individuals have been good people and all had the best of intensions. I am sure Secretary McDonald, whom I have also met with, also has good intentions.

*1981-	Professor of Medicine George Washington University School of Medicine
1975–1976	Acting Chief, Medical Service, VA Medical Center, Washington, DC
1978-1993	Director, Division of Pulmonary Diseases George Washington University Medical Center
1976-1994	Chief, Pulmonary Diseases Section, VA Medical Center, Washington, DC
1998-1999	Chief of Staff, VA Medical Center, Washington, DC
2000-	Senior Attending in Pulmonary Diseases and Medical Director Respiratory Care

Notwithstanding the good intentions of these good people, however, the role of the physician within the VA system as the leader of medical care has greatly diminished over this same period.

Diminishing the role of physicians and dentists in the VA's decisions regarding delivery and quality of care is a primary cause of – if not ***the*** primary cause of: difficulty in recruiting physicians and dentists, VA physician and dentist retention problems and drop in veteran confidence in their care.

Currently, in the VA, the single greatest impediment to recruiting and retaining physicians and dentists is the disenfranchisement and marginalization that many of the current physicians and dentists experience daily. Today, most VA physicians and dentists feel like their opinions are neither helpful nor requested. At many centers, physicians and dentists are no longer even considered professionals but referred to as simply the "workers". These observations come from our members, VA docs and dentists. Men and women who want to help improve "the system."

In the late 1960s and 1970s nearly all of the VA Medical Centers were led by Directors who were physicians. Today, very few medical centers have physician directors. The position now called the VA Undersecretary for Health was known as the Chief Medical director. At that time there was a direct line from the Chief of Staff at the medical centers to the Chief Medical Director. Issues of delivery and quality of medical care were raised and addressed by medical professionals. Today the Chiefs of Staff report to a Clinical Specialist in the Veterans Integrated Service Networks (VISN). All too frequently it appears that the Clinical Specialist has different priorities and has little care or interest in what the Chief of Staff has to say. In more recent times there has been a strong movement to eliminate the need even to have a physician in the role of Undersecretary for Health. Would it be wise, or even possible to run the Defense Department without Generals and Admirals in leadership positions?

The single greatest possible source of knowledge to improve care, enhance access, and advance improved outcomes is the VHA's physicians and dentists and it's Medical Staff. Some of the best health care systems in the country are managed by physicians: Mayo Clinic, Massachusetts General Hospital, Cleveland Clinic, if not actually by physicians in the

corporate offices, at least through incorporation in decision making and strategic planning.

The VA touts its superb physicians and dentists when they speak of VA's many accomplishments in clinical care and research while at the same time physicians and dentists are generally being ignored, isolated, and disrespected. An organization that strives for medical excellence should be encouraging its professionals to maintain and enhance their skills and education. However, the VA's budget allotment for physicians' continuing medical education (CME) continues to decline and burdensome forms and approvals keep increasing. A further, biased and manipulative productivity assessment of physicians continues within some specialty departments.

We are not saying that there is no role for non-physicians in the administration of hospitals or medical care. We are saying, however, that medical judgments should be based on years of education and patient care. Professional health care judgments should be made and evaluated by physicians and dentists, not MBAs. Yet at the VA a variety of non-physicians have been elevated to the role of "overseers" of physicians and dentists. In recent years VA non-physicians have taken on roles traditionally reserved for physicians. In the name of cost-savings and efficiency, nurses have been granted authority over physicians and judge and evaluate competency of physicians and dentists.

Physicians are being loaded with additional duties more appropriate for non-physicians, such as typing letters, filing, follow-up calls, patient reception, and preparation. Similarly, it is not a cost saving nor is it efficient to have physicians routinely escort patients from waiting rooms to exam rooms. These near-sighted, inappropriate duty reassignments greatly reduce physician efficiency resulting in fewer patients being seen on any given day. Merely increasing the VA budget has not and will not solve the problem; more money alone will not provide more timely access to physicians. The problem is the many practices that decrease efficient use of physician time.

There is a growing trend to add non-physicians and there is a growing concern that a veteran may never be seen or treated by a physician while a patient in the VA system. Veterans are seen by non-MD doctors without ever realizing they have not seen a medical doctor. We believe this is dangerous for patients and their families and may raise ethical issues.

The VA is currently considering a change in its Nursing Handbook. Under the proposed Handbook, there will no longer be any physician oversight for the process of sedation and providing operating room anesthesia by Certified Registered Nurse Anesthetists (CRNAs). The proposed change provides no guarantee that this will provide safer patient care. Additionally, LPNs with little or no psychiatric experience are taking the place of psychiatrists doing intake counseling and assessments in some psychiatric departments. Psychologists instead of M.D. psychiatrists are doing Veterans' Compensation & Pension (C&P) Examinations.

Congress has provided additional funds to add physicians and clinical staff to meet the needs of Veterans. Unfortunately, the additional funds are all too frequently misapplied. For instance in some facilities it is reported that newly hired junior physicians are being paid as much as $40,000 more than senior attending physicians and the additional funds were applied only to new physicians. If continued, this will clearly cause the loss of experienced VA physicians.

2014 was a crisis year for the VA where confidence in the entire system was badly shaken. New leadership was put into place and all are still hopeful for better things to come. The VA has even published their Blueprint for Excellence, a rather lengthy 50-page document full of wonderful pronouncements about the future of VA care. But taking care of patients and providing excellent care has a lot to do with providing the basics and using a lot of common sense.

For example, when patients are asked what is important to them you will hear simple straight forward common sense questions such as:

- Will I be admitted quickly?
- Is the room clean?
- Is there a bathroom in the room?
- Does the call button work and does someone answer and arrive quickly if I need them?
- Does everyone speak so that I can understand them?
- If I need help to eat will someone be there to help me?
- Do my doctors and nurses spend time explaining things so that I can understand what is happening?

Patient surveys indicate that none of the above questions are being answered very well in the VA.

Although the crisis last year in the VA did focus on access to care, this is but one small piece of the total package. Getting timely initial access is of little value if it still takes months to get a hip replaced or have a lung cancer removed or a colonoscopy screening because there may not be sufficient physicians or adequate access to operating room time. Timely access must be assured throughout the course of care, not just on initial visits.

VHA is referred to as a health care system. At best, it is a collective of hospitals and other medical facilities operating under a common umbrella identity. The operation and standards of every facility are different. The hiring process is different, the process for scheduling patients is different, and the way Performance Pay and Travel Pay are processed and approved is different. As one Congressman commented to the then-Acting Secretary in a House Veterans Affairs Committee meeting last June, "During my visit to the medical center I was told that there is "our" way and the VA way, and here we do it our way."

In reality there is no unified "VA way." The common chatter throughout the organization is "If you have seen one VA, you have seen one VA." There may be increased efforts to align the processes across the organization, but from the frontline perspective, it is not apparent. The facilities operate as individual fiefdoms with little interference from the VISNs or the Central Office. In that same House VA Committee meeting in June, 2014, health care experts from Humana and the Studer Group noted that operating in such non-aligned, inconsistent ways is a major challenge to efficiency and consistent outcomes. The process of hiring, terminating, promoting, or evaluating an individual should not vary building-to-building.

There must be a unification and simplification of processes across the organization to achieve any order of efficiency and common outcomes. An employee should not have to guess or learn totally different processes when shifting from one building to another.

Within the VA there remains a lack of a valid staffing or productivity system. For over 34 years, the VA has been under a Congressional mandate to develop and implement such a plan. So far to our knowledge no such

comprehensive plan has been put forth for review. We believe there exists in some facilities a striking imbalance in physician ratios between specialty sections and services. This imbalance also exists within nursing services when compared to the private sector. We have heard that one VA medical center has more than 50 nurse managers for a facility with only 150 in-patient beds. In addition, in some facilities the physicians and dentists' productivity is severely reduced because they can utilize only one exam room. In a southern VA medical center requests to hire additional dentists are denied because only 8% of veterans access dental care, despite more than 500 restorative appointments being booked more than 90 days out.

A customer service program implemented a few years ago called "I CARE" has been resurrected. Initially, this was only through circulation of a document reintroducing the program. Fortunately, after complaints from Veterans Service Organizations (VSOs) and various groups including NAVAPD, a few in-person sessions were added. However, most employees are only required to do an online review and self-certify that they are committed to the program. Changing a culture is difficult but not impossible. Simply reviewing a few slides periodically will not do the trick. The "I CARE Quick Reference" spells out the desired core values of the VA: Integrity, Commitment, Advocacy, Respect and Excellence. After a year of focused attention many agency employees and veterans are questioning the "I CARE" program as a cosmetic effort that has done little to improve services. Many feel that management's approach has made a mockery of the program.

In reality, according to VA employees from around the Nation, announced programs and changes to date have not resulted in improvements in their facilities. Employees are no more empowered than before and feel less trusted and less respected.

Despite recent additional funding from Congress, employees report that acquiring critically needed patient care staff is harder than before. However, staffing has increased for additional non-patient care and for management. Impediments to improved care and operations have not been removed.

No operational or structural changes that would increase the efficiency of physicians and dentists have been implemented. Changes announced by the current Secretary are not being consistently implemented in local

facilities, perhaps because the facility leaders have not understood that these changes are mandatory.

In summary, as physicians and dentists in the VA Health Care System our goal above all others is to provide world-class care to our nation's veterans.

Above and beyond the Hippocratic Oath, our duty is to care for and provide the very best treatment to those who put their own lives at risk for our freedom. When roadblocks or unethical practices prevent us from doing so, it is our duty and responsibility to speak up.

Hearings like this are important and helpful and NAVAPD appreciates the opportunity to be heard. I believe that Congress and the Nation WANT to "fix" the medical care "problem" at the VA. The unfortunate truth however, is that it is far easier to "throw money" at the problem than it is to fix it. We at NAVAPD ask that as new efforts and strategies are explored to improve delivery and quality of care to our Nation's veterans, that the physicians and dentists who treat them are included in the process and the solution.

Testimony

Jeff L. Morris, J.D.
Director of Communications & External Affairs
American Board of Physician Specialties

Chairman Benishek, Ranking Minority Member Brownley, and distinguished Members of the Health Subcommittee, on behalf of the American Board of Physician Specialties (ABPS) and its physician Diplomates across the United States, I thank you and your colleagues for examining the issue of overcoming barriers to more efficient and effective V.A. staffing.

Introduction

Veterans should never be short-changed in their medical care. With the return of so many of our soldiers from military actions abroad, the current number of patients throughout V.A. hospitals will only continue to increase. Unfortunately, with the physician shortages reaching epidemic proportions, so will their ability to receive quality care from experienced and highly qualified physicians.

Recruiting qualified and highly skilled physicians to work within the V.A. Health System is needed now more than ever.

What many do not know are the reasons behind the difficult recruitment process, making it ever more challenging and difficult for the V.A. to recruit and retain top medical care.

Due to physician politics and the monopolization of V.A. VISNs by the largest physician certifying body, the American Board of Medical Specialties (ABMS), many physicians, including highly qualified and skilled ABPS Board Certified physicians, are being denied or not even being considered for employment at V.A Healthcare institutions throughout the country. What is indefensible and inexcusable is that these physicians are not being denied because of their training, education, or experience. These highly skilled physicians are being denied employment opportunities solely because of their choice in Board Certification.

Doctor Robert M. Weinacker, who some of you have had the pleasure of previously meeting late last year, is a prime example of this very discrimination going on within the Administration.

Dr. Weinacker, a Veteran himself, with a long history of service as a Green Beret and former member of Special Forces, who was handpicked as the Battalion Surgeon to lead the medical treatment of 400 Special Forces (Green Beret) soldiers, wanted to work for the V.H.A. administration. He applied for up to 7 different positions and was never even called back for an interview. Was it is his education and professional experience? Sadly, it was not. Dr. Weinacker, a graduate of the University of Alabama Medical School is residency-trained in his specialty and was even awarded an honorary fellowship by the American Academy of Radiology. In addition to his profession in the field of medicine, Dr. Weinacker has earned 3 doctoral degrees and is a health law attorney specializing in hospital administration, Stark Laws, Anti-Kickback regulations, certificates of need, Fraud & Abuse, medical malpractice, and more.

The only barrier that prevented Dr. Weinacker from being interviewed by the V.A. institutions he applied to was his choice of board certification, for each position required the certification by ABMS' American Board of Radiology (ABR) only. What is even more reprehensible is that under the G.I. Bill, Dr. Weinacker could be reimbursed for his ABPS Board Certification, yet within V.A. healthcare institutions they all too often choose to not accept that.

Dr. Weinacker, who could have been board certified by the larger certifying body (ABR) leading the discriminatory practices, chose to be board certified by ABPS. Due to that choice, he, a Veteran himself, has been denied the opportunity to take care of the individuals he wished to treat most – his fellow Veterans.

We are here to request that the V.A. cease to enable the domination of the largest certifying body and end the ongoing discrimination of ABPS physicians and other highly qualified physicians such as Dr. Weinacker. Dr. Weinacker is just one example of many highly skilled physicians and medical specialists being denied due to the growth and control of one leading organization.

What is Board Certification?

Much behind the growth of this ongoing monopoly is the fact that most people do not have a true understanding of what Board Certification even is. Board certification is more than just an exam given by one organization.

Board Certification is a voluntary process and is an indicator that a practitioner has mastered the core body of knowledge and skills in his/her chosen specialty at a specific time by demonstrating their knowledge and passing a comprehensive, rigorous exam.

Throughout the United States, there are numerous certifying bodies – many of which that do not meet the rigorous standards required to be recognized.

In the current standard of physician board certification, there are three recognized multispecialty-certifying bodies. They are the American Board of Medical Specialties (ABMS),

the American Osteopathic Association (AOA), and the American Board of Physician Specialties (ABPS).

The ABMS, which is by far the largest, is made up of 24 individual specialty bodies – making many believe they are all different certifying bodies. This confusion and set up has hidden the monopoly that the ABMS has been establishing within the certification and healthcare industries – always communicating under the guise of being the "Gold" standard. This being the very gold standard that has lowered the quality of care of our Veterans, which has been documented in the press throughout the country.

The ABMS has been able to use this confusion and their size to make many believe that they are the only certifying body, but what one must realize is that even though ABPS is smaller, they are equally qualified and should be equally recognized. Size does not measure the quality of an organization.

Certification Standards

To ensure the validity and credibility of a physician board of certification, the organization must meet certain standards in certification. First, they must ensure that the medical board exam is developed and administered with the goal of accurately reflecting a physician's mastery of the knowledge base and skill set in his or her selected specialty. Second, all of the exams must be reviewed by an independent psychometrician and have been documented as valid, reliable, and psychometrically sound, as well as be consistent with testing standards of the American Educational Research Association (AERA) and the American Psychological Association (APA), and be a 501 (c)(3) organization.

To that end, the Member Boards of the ABPS employ all of the above rigorous standards for the development of content within their written, simulation, and oral examinations.

In fact, the ABPS is the only one of the three recognized multispecialty certifying bodies to conduct a self-audit of their testing and processes and have received an independent affirmation of the high standards of its exam development process and content through an exhaustive practice analysis study performed by Castle Worldwide.

This well-respected testing agency concluded that the ABPS certification programs "meet or exceed the equivalent standards of any other certifying organization." What this means is that physicians who achieve certification through the ABPS can be sure that their core body of specialty knowledge has been thoroughly and fairly tested, and that the result will be an accurate demonstration of their abilities and knowledge, ensuring that all Veterans will be receiving the highest level of care.

Furthermore, all physicians that are eligible for the exam are required to complete an accredited residency program and demonstrate substantial and identifiable training in the specialty for which they wish to be certified in.

Finally, many of the ABPS Member Boards are constituted or governed by Diplomates who are at the same time dually certified by the larger boards, ABMS/AOA, whom work in consort furthering the monopoly.

History with the Department of Veterans Affairs

Since 1994, the ABPS has approached the Department of Veteran Affairs on the very issues that have prevented skilled physicians from caring for our Veterans, further creating barriers to physician recruitment and fueling the growth of the monopoly within its healthcare institutions. The lack of recognition of the ABPS Boards of Certification has created discrimination for many physicians.

Each time we approached the Department of Veterans Affairs, the Administration would continue to protect the monopoly of the larger certifying organizations and respond that they had no plans to recognize any additional certifying bodies at this time.

In 2011, ABPS went back to the administration, hoping to stop the discrimination and to further explain that ABPS was part of the current standard of certification. Unfortunately, they again refused to see that there was an issue regarding board certification and the hiring practices within the V.H.A.

All of the discussions were led and controlled by the former Undersecretaries of Health, Drs. Petzel and Jesse, as well as the Deputy Chief of Academic Affiliations, Dr. Karen Sanders. All are board certified by ABMS boards, the very same organization keeping ABPS and other highly skilled physicians and medical specialists out.

What is most confusing is that ABPS Boards of Certification have been reviewed and approved by the U.S. Department of Veterans Affairs, under the G. I. Bill, as an acceptable certification for reimbursement of qualified physicians. Nevertheless, the V.A. has continued to state there is no need for additional changes to V.A. Policy. In fact, ABPS was told by the V.A. directly, even though one side of the administration has accepted ABPS, it does not mean that this will give you automatic acceptance within the V.H.A.

After being unable to make headway within the Administration, ABPS has been working directly with the House V.A. Subcommittee on Health to bring awareness to this issue, which has negatively impacted our Veterans' health safety and care. Over the past 3 years, ABPS has worked to educate the committee members on the issues and has demonstrated the discrimination is ongoing within the V.A. in its hiring practices.

We have all seen the results of the lack of physicians in V.A. healthcare institutions in the press around the country. This monopolistic and discriminatory practice is a large causation of the wait times our Veterans face throughout the nation.

The Issue

The V.H.A. in their own comments to ABPS have stated that board certification is not a requirement for appointment as a physician in the V.A. and that any board certification to a local V.A. medical center is a discretionary. However, this has not been the case.

What ABPS has worked to continuously explain to the administration over the years is that these local V.A. medical centers are making board certification a requirement, and that they are openly discriminating against hiring a physician solely based on their choice in board certification.

Currently, according to USA jobs, there are over 1000 open physician positions throughout the V.A. Of those open positions, many of them are blatantly discriminating against ABPS and other physicians. In these listings, the local V.A. medical centers have placed as a requirement for employment, that the physician be board certified by an ABMS/AOA member board only. Many of them will place these requirements in the description or under the preferred experience section.

Furthermore, many of the listings will just state board certified/board eligible and when a physician goes to apply, they are then told their ABPS certification is not recognized and that they only accept the board of the larger certifying organizations.

This lack of acceptance and recognition of ABPS, as well as other credible and widely accepted certifying boards, contributes to the current discriminatory practices existing within the V.A. and leans towards a monopolization by certifying boards. This discriminatory practice limits the ability of the V. A. to provide higher levels of quality care and patient safety.

Not every local V.A. medical center is doing this. A few regional V.A. institutions recognize ABPS physicians and have hired them to fill their need in each facility, some of which are proven to provide higher levels of care.

Unfortunately, the discrimination does not just end at the hiring level. There are also some that have hired an ABPS physician but then have created a work environment that is hostile and openly discriminates against their board certification.

The majority of ABPS physicians working for the V.A. were even afraid to provide written testimony for today because of the fear of retribution and potential of losing their jobs.

A uniform policy system-wide acceptance by the V.A. would greatly contribute in ensuring a streamlined process for verification of qualified ABPS board certified physicians – avoiding any further discriminatory practices.

The Ask & Conclusion

The ABPS wishes to contribute to solutions within the V.A. and work with the Administration so that Veterans receive the highest quality of care they deserve.

Albeit the V.A. should not be called upon to be involved in the comparative evaluation of all certifying boards, there needs to be a change in how this system is set up today and the discriminatory actions in hiring practices need to cease.

We believe a Directive from the office of the Secretary of Veterans Affairs and his Undersecretary of Health needs to be in place that creates an anti-discrimination policy that clearly defines board certification and goes beyond just the acceptance of ABMS/AOA - which is advancing the creation of a monopoly. Job listings should no longer allow for one specific board over another.

In addition, we ask that a quarterly reporting structure be developed. Whereas V.A. healthcare institutions report on applications received, the denial and hiring of physicians and all of the applicant boards be identified – all done in a similar manner as how corporations are required to report, identify and ensure minority hiring.

Further, the policy will create a reporting structure that will allow the administration to track the certifications of all physicians being hired. This will allow for transparency in the credentialing process, and local V.A. medical centers will be held accountable if they are still openly discriminating against physicians.

Within this policy, local V.A. Medical Centers will begin to end the monopolistic and discriminatory practices and learn how to credential all board-certified physicians, regardless of which organization they chose.

Taking such action will ensure that all medical staff credentialing and privileging will be uniformly based upon the physicians' and medical specialists' competence, qualifications, experience and education, ceasing the current discriminatory practices taking place today.

Thank you again for this opportunity. The ABPS looks forward to working with you and this committee to improve hiring practices within V.A. staffing and to finally end the discrimination ABPS and other physicians and medical professionals face on a daily basis. Our Veterans' health safety and care must be placed before physician politics and the egos of the few. The ongoing bullying and discrimination must cease. Our Veterans care must be placed first. The V.A. continuously struggles to recruit top physicians, these little known roadblocks have played a key role in keeping good doctors away. More highly qualified and skilled physicians along with

medical professionals should be able to care for the few in our country that sacrifice so much for us. It is what they deserve and what has driven ABPS and other organizations to fight for the betterment of our Veterans care.

Veterans Affairs Physician Assistant Association

HOUSE COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON

HEALTH

May 15, 2015

President VAPAA

Rubina DaSilva PA-C

Chairman Benishek, Ranking Member Brownley, and other members of the House Veterans Affairs Subcommittee on Health, on behalf of the entire membership of the Veterans Affairs Physician Assistant Association (VAPAA) we appreciate the invitation to provide this testimony before you today.

The Physician Assistant (PA) profession has a special unique relationship with veterans. The very first classes of physician assistants to graduate from PA educational programs were all former Navy corpsmen and Army medics who served in the Vietnam War and wanted to apply their knowledge and experience in a civilian role. Today, there are 196 accredited PA educational university programs across the United States and approximately 2,020 PAs are employed by the Department of Veterans Affairs (VA), making the VA the largest single federal employer of PAs. These PAs provide high quality, cost effective quality healthcare working in hundreds of VA medical centers and outpatient clinics, providing medical care to thousands of veterans each year in their clinics. Physician Assistants work in both ambulatory care clinics, emergency medicine, CBOC's in rural health, and in wide variety of other medical and surgical subspecialties.[1,2] In the VA system about a quarter of all primary care patients treated are seen by a PA[3]. Approximately 32% of PAs today employed by VHA are veterans, retired military, or currently serving in the National Guard and Reserves.

The Veterans Affairs Physician Assistant Association (VAPAA) maintains that Physician Assistants are a critical component of improving VA healthcare delivery, and have consistently recommended that VHA include them in all healthcare national strategy staffing policy plans. Since January 1993 when VA added the Title 38 GS-13, Chief Grade more than 22 years ago, little else has been done for this critical workforce.

Growth of the Physician Assistant Profession

Forbes, US News & World Report, and New York Times articles all again named physician assistant occupation the single best master's degree for the third year in a row, citing the profession's favorable outlook for salary and long-term employment. The PA field was listed as one of the 50 best careers in 2014 due to increasing demand for healthcare services, the impending retirement of baby boomers, and broader efforts to limit healthcare costs. [2] According to the US Bureau of Labor Statistics the PA profession is expected to grow by 38% from 2012-2022.

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[1] William Fenn, PhD, PA, Vice President, American Academy of Physician Assistants, Testimony before the United States Senate Committee on Veterans Affairs, *Hearing on S. 1155, a bill to elevate the VA's PA Advisor to a full-time director of PA services in VA central office,* (October 21, 2009)

[2] Physician Assistant Education Association, Letter to Senate Majority Leader Harry Reid and Speaker of the House Nancy Pelosi (January 15, 2010) http://www.paeaonline.org/index.php?ht=a/GetDocumentAction/i/99520

[3] American Academy of Physician Assistants, Press Release (March 5, 2011) http://www.aapa.org/news_and_publications/pa_pro_now/item.aspx?id=1917

[2] US News and World Report, Best Careers 2011: Physician Assistant (December 6, 2010) http://money.usnews.com/money/careers/articles/2010/12/06/best-careers-2011-physician-assistant

The National Commission on Certification of Physician Assistants (NCCPA) reports unprecedented levels of demand for PAs upon graduation, with 78 percent of recent graduates receiving multiple job offers and 52 percent entertaining three or more.[4] The AAPA's annual census reports of the PA profession showed that nearly 22 percent of the total profession was employed by the federal government in 1991, and has since documented a steady and significant decline, with the percentage dropping to nine percent in 2008, where it has remained. New graduate census respondents were even less likely to be employed by the government (17 percent in 1991, down to 5 percent in 2008).[5]

VHA Recruitment and Retention Problems Continue to rise

Although Physician Assistants provide health care access for millions of veterans each year, VHA has not developed strategic national plans to address the chronic 12% to 14% total loss rate, which is the highest of any profession in the VA and VHA - top ten hard to recruit occupations. With the existing reported disparity in pay between PAs employed by the VA and the private sector market this problem continues to grow. For several years, *The Independent Budget* veterans service organizations (IBVSOs) along with American Academy Physician Assistants (AAPA), and Veterans Affairs Physician Assistant Association (VAPAA), have all recommended that Congress and VHA ensure the retention and recruitment problems for PAs be immediately rectified with new national targeted policy and programs for this critical occupation.

The recent VA Office of Inspector General (OIG) Report #15-00430-103, January 30, 2015; conducted a determination of Veterans Health Administration (VHA) occupations with the largest staffing shortages as required by Section 301 of the Veterans Access, Choice, and Accountability Act of 2014. VAOIG determined Physician Assistants were 3rd compared to all other VHA occupations with the largest staffing shortages,[6]
We stress that in addition to the VAOIG report the National Workforce Succession Planning 2015 - the data demonstrates the scope of the problems if something is not done to correct the barriers to keeping PAs integrated in VA systems of care.

According to the 2015 National Workforce Succession Planning 2015

- In 2016 37% of VHA PAs are eligible to retire. That is an approximate loss of 600 Physician Assistants. This workforce loss will result in a loss of approximately 1.150 million veteran eligible patient care appointments
- By 2021 48% of VHA PAs are eligible to retire.
- 2014 - PAs have the highest *Total Loss Rate* of 10%; more than any of the other top ten occupations deemed difficult to recruit and retain.

[4] https://www.aapa.org/twocolumn.aspx AAPA News October 6, 2014
[5] www.AAPA.Org Annual Census Reports 2009-2010
[6] VAOIG Report #15-00430-103, January 30, 2015 VA Health Care Critical Occupations Staffing

- 2014 - 14.28 % VHA PAs left the VA due to compensation (salary and benefits), second only to retirement at 28.6%
- 2014 Only 2.7% Physician Assistants chose the VA because of pay/compensation
- *2014 Merritt-Hawkins, Review of physician and advanced practitioners recruiting incentives*: For PAs in private sector, cite relocation allowance: average $6,904 with a high of $10,000. Sign on bonus: average $8,000 with a high of $20,000
- 2014 Merritt-Hawkins, 2013/14 PA private sector education loan forgiveness: average $40,000 with a high of $60,000. Loan forgiveness in the private sector is paid up front with a service commitment.

Civilian Sector Competition

The PA workforce has grown far less than other physician extender positions within the VHA; therefore, a signal of retention and recruiting problems. The discrepancy in salary, benefits and education debt reduction programs between the civilian sector and the VHA continue to be a recruiting and retention barrier. Currently Physician Assistants remain in an antiquated pay system with no competitive market survey resulting in a large pay disparity with the civilian sector. For certain professions the VA utilizes the Nurse Locality pay system surveys (LPS) allowing for market salary surveys aligning these professions within the VA with the private sector market. Inclusion of Physician Assistants into the Nurse LPS will allow for salary adjustments so that the VHA can be competitive with the local market. Since a salary survey is not mandated it is not widely supported at many VAMC's or at VISN levels. The Secretary of the VA may sign occupations into the Nurse LPS with the power given in Public Law 101-366-August 15, 1990, subchapter IV-Pay for nurses and other health care personnel.

VAPAA is also concerned that the use of recruitment incentives within the VA is at the discretion of the hiring facility and is not standardized across the VA system. During 2012-2013 only 44 Physician Assistants have received $319,074 in funding to further their education in comparison to Seven hundred five registered nurses seeking to become Nurse Practitioners receiving scholarship awards totaling over $11,842,919 in support of NPs and NP programs. VA should implement recruitment and retention tools targeting Employee Incentive Scholarship Program and Employee Debt Reduction Program funding to include PAs and that these programs are made consistently available to all advertised PA vacancy announcements. VISN and VA medical center directors must be held accountable for the failure to utilize these recruiting tools. EDRP cannot be issued unless it is advised in the initial vacancy announcement in USA Jobs.

VA must make certain that employees gain opportunities for required PA professional development and continuing education and training. Physician Assistants provide high quality, cost effective medical care as they are held to the same standards of healthcare delivery as their MD/DO VA colleagues who are afforded a yearly stipend for continuing educations. PAs must maintain 100 hours of CME every two years; 50 hours must be Category 1 and 50 hours of Category II. Physician Assistants mush recertify by examination every 10 years. In order to be

competitive with the civilian sector, the VA must make certain that employees gain opportunities for required PA professional development and continuing education and training in support in maintaining a high level of professional competence.

Delays in Hiring Health Care PA Employees

VAPAA has found that whenever a PA employee leaves the VA, the VA acknowledges that six months to a year are required to fill one vacant position—assuming a viable pool of candidates is interested and available. When VA seeks to replace healthcare professionals, VA cannot compete with nimble private health care systems. The lengthy process VA requires for candidates to receive employment commitments and boarding continues to hinder the VA ability to recruit and officially appoint new employees.

Privatehealth care systems can easily fill PA vacancies in a matter of days or weeks. While PA applicants may have noble intentions of working for VA and serving veterans, many will forgo what could be a 4 to 6 month long waiting period and pursue timely employment opportunities elsewhere. For these reasons, we ask Congress to carefully review VA appointment authorities, internal credentialing processes, and common human-resources practices to identify ways to streamline the hiring process. If the VA takes months to fill its healthcare vacancies with top talent, VA will continue to fail the delivery of timely, quality care to our nation's veterans.

Members of HVAC sent bipartisan letters of inquiry to the Secretary of the VA last October, requesting specific plans for utilizing VHA provisions (Titles III and VIII of the newly enacted Veterans Access, Choice, and Accountability Act of 2014) to include the specific national VHA plans for expanding recruiting for new FTEE PA positions and for retaining an optimal PA workforce. The responses detailed outdated ineffective programs leaving VISN directors and local facilities to address the problems.

Department of Veterans Affairs "Independent Care Technician" (ICT) Program, One Solution to Support Transitioning Medics and Corpsmen OIF OEF OND into "Grow Our Own" to Physician Assistant Occupation

VAPAA points to another solution for meeting the healthcare workforce challenges in a recent pilot program. On October 26, 2011, the Administration announced its commitment to providing support to unemployed Post 9/11 combat veterans and it highlighted the PA profession as a prominent targeted career path for new returning veterans who had served as medics and corpsmen with combat medical skills similar to the history of returning Vietnam War veterans with these skills within the ICT pilot VA program at 19 VA sites. Under this initiative, the Administration promoted incentives to create training, education, and certifications of these veterans needing in transition to a civilian application of their military medical skills, being hired to work inside VA emergency departments, and has expanded into primary care, mental health, and surgery clinic positions. Then the ICT's should be encouraged to enter into college healthcare education, such as entering the PA profession.

The VA has an excellent opportunity to facilitate and coordinate "Grow Our Own" combat medics, Corpsmen, or Air Force paramedics to transition to the physician assistant occupation. Existing legislation though needs to be amended to include specifically making the ICT permanent (ICT's) a Grow Our Own VHA program and language directing VHA to support candidates, assisting them in obtaining their necessary educational eligibility requirements for prerequisites for admission to accredited PA university Masters programs, and then continue to provide employment training throughout their PA education with targeted scholarships for PA Education.

- Initial temporary appointment of selected veteran Medics and Corpsmen as Independent Care Technicians ICT's (0640 Health Aid and Technician Series – GS-7)

- Convert the appointment as a Physician Assistant (Master's) upon graduation from accredited PA university program and National Commission on Certification Physician Assistants (NCCPA) to Title 38 PA employee.

The VAPAA and AAPA were encouraged by this pilot ICT program started in 2010, but are still very concerned that the lack of use of recruitment incentives within VHA is left at the discretion of the hiring facility and is not standardized across the VA system with VA scholarships rarely utilized for entering into the critical PA occupation shortages. The recent track record is an "early warning sign" of the problems that continue today. The Office of VA Healthcare Retention and Recruitment and the VAMC's participating in the pilot ICT program have no dedicated support to transition them into PAs in the Employee Incentive Scholarship Program (EISP) or EDRP. To effectively address the barriers to PA recruitment and retention, VA must ensure that employee incentive programs, such as the EISP and the VA Employee Debt Reduction Program are made consistently available to all advertised PA vacancy announcements and utilized in ICT the program. VISN and VA medical center directors they must be held accountable for the failure to utilize these recruiting tools.

Critical Workforce Occupation:

VA's mission statement for human resources is to recruit, develop, and retain a competent, committed, and diverse workforce that provides high quality service to veterans and their families. VA identifies specific occupations as "critical occupations" based on the degree of need and the difficulty in recruitment and retention.

Summation:

There are 3 types of providers within the VA that provide direct patient care - Physicians, Physician Assistants and Nurse Practitioners. Physicians have *mandated* yearly market pay survey. Nurse Practitioners, by virtue of being a nurse, are under the *mandated* yearly RN LPS. PAs fall under *Special Salary Rates*, however, this is NOT *mandated yearly*. Some facilities have not performed a special salary survey for 11 years, resulting in the reporting in the VISN 2014-15 Workforce Succession Plan - 12 out of the 21 VISNs (88 VA main facilities) reported the reason that their VISN cannot hire PAs is because they cannot compete with the private sector

pay. Pub. L. 102–40, title III, § 301(a),May 7, 1991, 105 Stat. 208 specifically states that the Secretary can convert Physician Assistants to 'covered positions' and pay them pursuant to section 7451 of such title, as re-designated by section 401(c)." However VA has refused to pursue these steps to solve the current retention problems for PAs.

> **Recommendation 1**: Congress should legislatively mandate that the VHA Under Secretary for Health include PAs in the Nurse Locality Pay System under 38 U.S. Code § 7451 - Nurses and other healthcare personnel: competitive pay (2) The health-care personnel positions referred to in paragraph (1) (hereinafter in this section referred to as "covered positions" are the following: (A.) Registered nurse adding: *Physician Assistant. Such positions referred to in paragraphs (1) and (3) of section 7401 of this title (other than the positions of (physician, dentist, registered nurse, and physician assistant) as the Secretary may determine upon the recommendation of the Under Secretary for Health. The USH shall set PA grade levels I, II, III, IV for salary grades corresponding to RN grade levels.*

PUBLIC LAW 101-366—AUG. 15, 1990 104 STAT. 431. Authorizes the USH to recommend to the VA Secretary to include other occupations into the LPS.

> **Recommendation 2: VHA shall** establish and adopt standards for the 3R's for PAs to compete with the private sector with national strategic plan for retention and recruitment. VHA must hold medical center directors accountable for failure to utilize incentives known to improve recruitment and retention of PAs and set requirements for posted vacant positions.
>
> **Recommendation 3:** Establish new standards for EDRP. Model the program after the private sector with upfront education loan relief. VAMC's must advertise in all PA vacancy announcements so prospective applicants are aware of EDRP loan forgiveness. Move the program application process nationally for accountability since this not facility funds but a VA funded program.
>
> **Recommendation 4:** Establish standards to create a robust EISP/VANEEP program to encourage VA employees to apply and use national funding to go to PA school. Move the program under the local Designated Learning Officer (DLO). Hold medical center directors accountable for failure to utilize and advertise EISP/VANEEP to advance VA employees in their education as PAs.
>
> **Recommendation 5**: Include targeted scholarships for the ICT program OIF OEF Grow Our Own returning veterans, and mandate VHA shall appoint PA ICT program director to coordinate the educational assistance necessary and be liaison with PA university programs.
>
> **Recommendation 6:** Move all direct patient care positions to the National Healthcare Recruiter, Workforce Management & Consulting VHA Healthcare Recruitment & Marketing Office. This Office can compete with the private sector in a way that the local Human Resource Officer (HRO) often will not. The VA National Healthcare Recruiter has

a proven track record of finding qualified candidates in a matter of days not months. VHA must incorporate a PA consultant into this National Healthcare Workforce program office.

Recommendations 7: Congress needs to carefully review VA appointment authorities, internal credentialing processes and common human-resources practices to identify ways to streamline the hiring process.

Conclusion:

Chairman Benishek and Ranking Member Brownley and other members as you strive to ensure that all veterans receive timely access to quality healthcare and as you build increased capacity for delivery of accessible high quality health care, and demand more accountability into the VA health care system, I strongly urge the full Committee to review the important critical role of the PA profession and ensure VHA takes immediate steps to address the current problems. On behalf of the 2,020 PAs employed in the VA system, I appreciate this opportunity to testify here today and ask for your help in supporting our nation's veterans. I will gladly now answer any questions that you might have regarding this testimony.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

Veterans Affairs Physician Assistant Association

The Veterans Affairs Physician Assistant Association (VAPAA) does not currently receive any money from a federal contract or grants. During the past six years, VAPAA has not entered into any federal contracts or grants for any federal services or governmental programs.

VAPAA is a 501c (3) nonprofit membership organization.

VAPAA Witness Biography

Rubina DaSilva, PA-C

Rubina DaSilva served four years on active duty as a Navy Hospital Corpsman from 1992-1996. In 1996, she married an active duty Navy Seabee. Upon completion of her active duty contract, she attended community college to pursue her goal of becoming a Physician Assistant (PA) while working part time. She obtained an Associate of Arts degree in 1998 from Okaloosa-Walton Community College in Florida and served as an active Reservist from 1996-1999. She left the reserves when she moved to Philadelphia to attend MCP Hahnemann University. She graduated with a Bachelor's of Science degree in Physician Assistant Studies in 2001. Her first employment was in a small town, population of 2000, in Spencer, West Virginia. She wanted to work in a remote and rural setting. Post 9/11, she and her husband enlisted back in the active Navy Reserves. In December of 2002, her husband deployed for 8 months in support of OIF/OEF, upon his return, he was accepted into West Virginia University, they moved to

Fairmont, WV. The clinic was recognized as a Federally Quality Health Center (FQHC). Her position was the sole provider in a satellite clinic about 15 miles away from the main clinic. It was a great experience both professionally and personally, especially working with coal miners and their families. Rubina applied and was granted the National Health Service Corps loan repayment where she had a service obligation of 2 years. She practiced medicine for 5 years in West Virginia until she found the opportunity to go home to Texas and find employment with the VA.

Rubina has been employed by the Michael E. DeBakey Houston VA Medical Center since 2007. Her first position was in a Community Based Outpatient Clinic (CBOC) as a primary care provider and was the OIF/OEF champion for the clinic and provided coverage in the emergency room two weekends a month. She has since 2010 been working at the main hospital in the Occupational Health Clinic. She is a board member of the National VA Occupational Health Advisory Board. She is also a member of the National VHA Physician Assistant Field Advisory Committee.

She has been a member of Veteran Affairs Physician Assistant Association since 2008 and became president of the organization in June of 2014. She will obtain her Masters Business Administration in Health Care Management (MBA-HC) degree this fall of 2015.

On a personal note, she has been married for 19 years and has two daughters ages 10 and 9. She is able to speak four languages. She enjoys running and completed her first marathon; the Marine Corps Marathon in Oct 2014.

PREPARED STATEMENT OF DR. NICHOL L. SALVO

Chairman Benishek, Ranking Member Brownley and members of the Subcommittee, I welcome and appreciate the opportunity to testify before you today on behalf of the American Podiatric Medical Association (APMA). I commend this Subcommittee for its focus to assist and direct the Veterans Administration (VA) to effectively and efficiently recruit and retain qualified medical professionals to treat veteran patients and improve access to quality health care in the VA system by addressing the lengthy and burdensome credentialing and privileging process.

I am Dr. Nichol Salvo, member and Director of Young Physicians' at the American Podiatric Medical Association (APMA). I am also a practicing VA physician, maintaining a Without Compensation (WOC) appointment status. I am before you today representing APMA and the podiatric medical profession, and specifically our members currently employed, and those seeking to be employed, by VA. While I do not represent VA in my capacity today, I do bring with me first-hand experience and knowledge of hiring practices within VA, as well as knowledge of the widespread disparity between podiatric physicians and other VA physicians.

APMA is the premier professional organization representing America's Doctors of Podiatric Medicine who provide the majority of lower extremity care, both to the public and veteran patient populations. APMA's mission is to advocate for the profession of podiatric medicine and surgery for the benefit of its members and the patients they serve.

Mr. Chairman, when the Veterans Health Administration (VHA) qualification standards for podiatry were written and adopted in 1976, I was not yet born. Podiatric education, training and practices in 1976 starkly contrasted with that of other physician providers of the time, and with podiatric medicine as it is today. Unlike thirty-nine years ago, the current podiatric medical school curriculum is vastly expanded in medicine, surgery and patient experiences and encounters, including whole body history and physical examinations. In 1976, residency training was not required by state scope of practice laws. Today, every state in the nation, with the exception of four, requires post-graduate residency training for podiatric physicians and surgeons. In 1976, podiatric residency programs were available for less than 40 percent of graduates. Today there are 597 standardized, comprehensive, three-year medicine and surgery residency positions to satisfy the number of our graduates, with 77 positions (or 13 percent) housed within the VA. In contrast to 1976, today's residency programs mandate completion of a broad curriculum with a variety of experiences and offer a direct pathway to board certification with both the American Board of Podiatric Medicine (ABPM) and the American Board of Foot and Ankle Surgery (ABFAS). These certifying bodies are the only certifying organizations to be recognized by the Council on Podiatric Medical Education (CPME) and VA. These bodies not only issue time-limited certificates, but they participate in the Centers for Medicare and Medicaid Services (CMS) Maintenance of Certification (MOC) reimbursement incentive program. Unlike the residency curricula in 1976 (which were not standardized, nor comprehensive), today's residency curriculum is equitable to MD and DO residency training and includes general medicine, medical specialties such as rheumatology, dermatology and infectious disease, general surgery and surgical specialties such as orthopedic surgery, vascular surgery and plastic surgery. CPME-approved fellowship programs did not exist in 1976, but since their creation in 2000, they offer our graduates opportunities for additional training and sub-specialization. Today, podiatric physicians are appointed as medical staff at the vast majority of hospitals in the United States, and many serve in leadership roles within those institutions, including but not limited to chief of staff, chief of surgery, and state medical boards. Many of my colleagues have full admitting privileges and are responsible for emergency room call as trauma and emergency medicine are now also incorporated into post-graduate training. The competency, skill and scope of today's podiatric physicians are vastly expanded and truly differ from the podiatrist that practiced before I was born. Because of this, CMS recognizes today's podiatrists as physicians, and Tricare recognizes us as licensed, independent practitioners.

The total number of VA enrollees has increased from 6.8 million in2002 to 8.9 million in 2013 (1). While we are slowly losing our Vietnam veteran population, we are gaining a solid base of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) patients, returning from war with their unique lower extremity issues. The projected patient population of Gulf War Era veterans is expected to increase from 30 percent in 2013 to approximately 55 percent in 2043 (1). The number of service-connected disabled veterans has increased from approximately 2.2 million in 1986 to 3.7 million in 2013 (1). Over 90 percent of disabled veterans were enrolled in VHA in 2012 (1). The likelihood of service-connected disabled veterans

seeking VA health care generally increases with the veteran's disability rating (1). The majority of male veterans who are currently seeking care from VA served during the Vietnam era (1).

As a matter of fact, veteran patients are ailing and have more comorbid disease processes than do age-matched Americans (2, 3, 4, 5, 6). This includes major amputation, where age-specific rates are greater in the VHA compared to the US rates of major amputation (7). Elderly enrolled veterans have substantial disease burden with disproportionately poor health status compared to the same age enrolled in Medicare (8). The prevalence of diabetes is substantially greater among veteran patients compared to the general population, and unfortunately, the prevalence is trending up (6). While diabetes affects 8 percent of the US population, 20 percent of veteran patients carry this diagnosis (9).The aging veteran population combined with these increased rates of diabetes has increased the burden of diabetic foot ulcers and amputations (10). Veteran patients with one or more chronic diseases account for 96.5 percent of total VHA health care (9). In addition to diabetes, some of the most common chronic conditions documented in our veteran patients manifest in the lower extremity such as hyperlipidemia, coronary artery disease, chronic obstructive pulmonary disease, and heart failure.(9).

Socioeconomic and psychosocial issues often plague our veterans and further complicate disease management. Veteran patients statistically have lower household incomes than non-veteran patients (1). Sadly, many of our veterans are homeless and suffer from comorbid conditions such as diabetic foot ulcers, sometimes with a level of amputation, so management of this patient population can be extremely challenging. Health care expenses combined with disability and compensation coverage account for the majority of VA utilization and have demonstrated significant growth since 2005 (1).

This is my patient population, Mr. Chairman. I serve patients who are statistically comorbid with psychosocial and socioeconomic issues, all of which play a role in my delivery of care and final outcome. I know first-hand, with private practice experience and VA experience, that the veteran population is far more complex to treat than patients in the private sector, as a whole. Greater than 90% of the veteran podiatric patient population is 44 years and older, with the majority of our patients of the Vietnam era, who are plagued by the long-term effects of Agent Orange. Because of this and because of the increasing number of OEF, OIF, and Operation New Dawn (OND) veterans with lower extremity conditions, one of our major missions as providers of lower extremity care is amputation prevention and limb salvage. The value of podiatric care is recognized in at-risk patient populations. Podiatric medical care as part of the interdisciplinary team approach reduces the disease and economic burdens of diabetes. In a study of 316,527 patients with commercial insurance (64 years of age and younger) and 157,529 patients with Medicare and an employer sponsored secondary insurance, there was noted a savings of $19,686 per patient with commercial insurance and a savings of $4,271 per Medicare-insured patient, when the patients had at least one visit to a podiatric physician in the year preceding their ulceration (11). Nearly 45,000 veterans with major limb loss use VA services each year. Another 1.8 million veterans within the VA Healthcare Network are at-risk of amputation. These at-risk veterans include 1.5 million with diabetes, 400,000 with sensory neuropathy, and 70,000 with non-healing foot ulcers (12). Despite having a large at-risk patient population from the Vietnam era, VA podiatric physicians are seeing increasing numbers of OEF, OIF and OND patients who are at-risk for amputation. From FY 2001 to 2014, the number of foot ulcers increased in the OEF, OIF, and OND populations from 17 documented cases to 612 (12). Despite our statistics of at-risk patients, lower extremity amputation rates among all veteran patients decreased from approximately 11,600 to 4,300 between fiscal year 2000 and 2014 (12). Given the magnitude of amputation reductions, podiatric physicians not only provide a cost-savings to VA, but we also play an integral role in the veteran quality of life (12).

While limb salvage is a critical mission of the podiatry service in the VA, the care delivered by the podiatric physician is of much broader scope. As the specialist of the lower extremity, we diagnose and treat problems ranging from dermatological issues to falls prevention to orthopedic surgery. As one of the top five busiest services in VA, we provide a significant amount of care to our veteran patients and the bulk of foot and ankle care specifically. In fiscal year 2014, the foot and ankle surgical procedures rendered by the podiatry services totaled 4,794, while foot and ankle surgical procedures performed by the orthopedic surgery service was a sum total of 72.

The mission of VA health providers is to maintain patient independence and keep the patient mobile by managing disease processes and reducing amputation rates. Podiatric physicians employed by VA assume essentially the same clinical, surgical,

and administrative responsibilities as any other unsupervised medical and surgical specialty. Podiatrists independently manage patients medically and surgically within our respective state scope of practice, including examination, diagnosis, treatment plan and follow-up. In addition to their VA practice, many VA podiatrists assume uncompensated leadership positions such as residency director, committee positions, clinical manager, etc. Examples include:

- Steve Goldman, DPM, Site Director for Surgical Service, Department of Veterans Affairs - New York Harbor Health Care System;
- William Chagares, DPM, Research Institutional Review Board Co-Chair, Chair of Research Safety Committee and Research Integrity Officer and Chair of Medical Records Committee at the James A. Lovell Federal Heath Care Center;
- Aksone Nouvong, DPM, Research Institutional Review Board Co-Chair at the West Los Angeles VA;
- Lester Jones, DPM the former Associate Chief of Staff for Quality at the VA Greater Los Angeles Health Care System for eight years, and podiatric medical community representative while serving on the VA Special Medical Advisory Group; and
- Eugene Goldman, DPM formerly the Associate Chief of Staff for Education at Lebanon VA;

Despite this equality in work responsibility and expectations, there exists a marked disparity in recognition and pay of podiatrists as physicians in the VA. These discrepancies have directly resulted in a severe recruitment issue of experienced podiatrists into the VA, and unfortunately have also been the direct cause of retention issues. The majority of new podiatrists hired within the VA have stories just like mine. They have less than ten years of experience and they are not board certified. As a result of the disparity the VA is attracting less experienced podiatric physicians. After hiring, the majority of these new podiatrists that hire into the VA separate within the first 5 years. I am speaking from personal experience, Mr. Chairman. As stated earlier, I am one of the majority. I entered the VA with less than five years of experience and was not board certified at the time. I gained my experience, earned my board certification, and separated from the VA to take a leadership position with my parent organization. I will forever remain loyal to VA, which is why I still voluntarily treat patients at my local facility, without compensation. Having worked inside and outside the VA, I can truly attest to the disparity that exists.

Compounding the recruitment and retention issues, there exists lengthy employment vacancies when a podiatrist leaves a station. The gap between a staff departure to the time of filling the position is in excess of one year. I am personally aware that my position was assumed by a podiatric physician 14 months after my separation. Because of employment gaps as a consequence of the inherent and chronic recruitment and retention challenges, wait times within the VA for lower extremity care are unacceptably long. Since October 2014, 22,601 of the 191,501 (11.8 percent) established patients suffered a wait time of greater than 15 days, with some greater than 120 days. During this same time period, 23,543 of the 25,245 (93 percent) new patients suffered a wait time of the same magnitude. The prolonged vacancy exists partly because the VA is not capable of attracting experienced candidates, but also because the credentialing process is ineffectively burdensome. My credentialing process for my recent two without compensation (WOC) appointments was 11 months and 5 months, respectively. Those are 16 months of missed opportunity to treat patients, but instead, I was needlessly waiting, as were the patients

It is precisely because of the aforementioned issues that legislative proposals to amend Title 38 to include podiatric physicians and surgeons in the Physician and Dentist pay band, have been submitted by the Director of Podiatry Services annually for the last ten years. These proposals have been denied every single year. Additionally, several requests for an internal fix have been denied, despite written letters of support for this movement from the former Under Secretary of Health, Robert Petzel, MD.

Five years ago the APMA's House of Delegates passed a resolution making this issue a top priority. Since then we have alerted the VA to our knowledge of this issue. In response, former Under Secretary Petzel created a working group composed of Dr. Rajiv Jain, now Assistant Deputy Under Secretary for Health for Patient Care Services, Dr. Margaret Hammond, Acting Chief Officer for Patient Care Services, and Dr. Jeffrey Robbins, Chief of Podiatry Service. We have participated in several meetings with members of the working group and, most recently, we have received written support of Patient Care Services and Podiatry Service for a legislative solution to address this issue.

Occam's razor is a problem solving principle whereby the simplest solution is often the best. I come before this committee today to respectfully request that Congress help the VA and its patients by passing legislation to recognize podiatric physicians and surgeons as physicians in the physician and dentist pay band. We believe that simply changing the law to recognize podiatry, both for the advancements we have made to our profession and for the contributions we make in the delivery of lower extremity care for the veteran population, will resolve recruitment and retention problems for VA and for veterans. Mr. Chairman and members of the Subcommittee, thank you again for this opportunity. This concludes my testimony and I am available to answer your questions.

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12. Preventing Amputation in Veterans Everywhere (PAVE) Program

STATEMENT OF
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FOR CLINICAL OPERATIONS
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON VETERANS' AFFAIRS

May 15, 2015

Chairman Benishek, Ranking Member Brownley, and Distinguished Members of the House Committee on Veterans' Affairs Subcommittee on Health, thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) ability to recruit, on-board, and retain qualified medical professionals to treat Veteran patients. I am accompanied today by Mr. Elias Hernandez, Chief Officer for Workforce Management and Consulting, and Dr. Donna Gage, Chief Officer of Nursing.

Introduction

Today's discussion on Veterans Health Administration (VHA) staffing will initially focus on clinical productivity and modeling as determinants of staffing requirements. From there, we will transition to workforce composition and recruitment, followed by on-boarding medical professionals and subsequent retention. We will also discuss health care staffing in certain focus areas such as women Veterans and rural health.

Establishing, recruiting, filling and projecting staffing requirements for the VA's health care system is a very complex task. VHA operates 144 hospitals and 749 community based outpatient clinics across the United States and countries and territories around the world. VHA provides a full range of primary and specialty care health services for patients ranging in age from our youngest recently discharged Servicemembers to our most senior Veterans. There is substantial geographic and age variation among the Veteran population, most notably in rural areas – where more than five million Veterans reside. Veterans also present with health conditions as a result of their experiences and exposures in combat, and require an array of professionals to

address these unique needs. Ensuring the health of women Veterans requires a spectrum of care delivery specific to their needs.

Although a challenge, VHA has undertaken steps in recent years to improve clinical staffing management of medical professionals and support staff. This includes leveraging both external and internal best practices, notably in the area of team-based, patient centered care. VHA's *Blueprint for Excellence* establishes specific actions to achieve improvement of Veteran access to clinical care; and to improve the overall Veteran experience. VHA has in place a work force planning process specific to each medical center. And, VHA is aligning clinical staffing methods and models for greater effectiveness at forecasting requirements for care delivery.

To achieve the Secretary's goal for Veterans to receive timely access to care will require further integration of existing staffing, modeling, data, technology, and budgeting capabilities - and the development of new ones. In that way, we will proactively evolve positive health care outcomes for our Nation's Veterans.

Staffing Models

VHA has a work force of 23,000 employed physicians practicing across more than 30 sub-specialties. The largest component of this work force is Internal Medicine (largely primary care) and Mental Health (psychiatrists), representing nearly half of the physician work force. The majority of VHA's physicians are salaried, with approximately 10 percent of the physician work force under a contractual-type arrangement.

A sound staffing model should consider the needs of the population served, the performance (quality and access) and the productivity of the provider. Physician staffing is defined as adequate when ready patient access to high quality care/outcomes is achieved and provider productivity is within an acceptable range. When performance goals are not met, facilities need to determine whether this imbalance is related to an inadequate: supply of providers for the Veteran population served, provider productivity, systems to support high productivity such as support staff, and capital infrastructure.

VHA began development and implementation of the Patient Aligned Care Team (PACT) model in 2009, and it has since evolved into the central model for Veterans'

primary care across the country. Being team-based and panel-centric, PACTs are not evaluated as a function of productivity units per se, but rather assessed as a function of patient population served.

The diverse requirements of care delivery for mental health and women's health require a blend of staffing planning that incorporates elements of both team-based and productivity modeling.

To that end, clinical modeling, both for VHA and for other health care systems, is not a static, point-in-time function. Rather, clinical modeling is a constantly evolving activity, where emerging best practices are identified from continuous review of data and processes. Data sources and information technology themselves likewise evolve, further refining the ability of models to project requirements.

VHA has made noteworthy progress in some aspects of clinical staffing models and methods, with much work remaining to be done. Central to this effort is a determination of how to further evolve the application of productivity standards to clinical resource management. As noted previously, VHA has completed the definition of productivity standards for specialty physician practice areas, and is now moving forward on establishing the appropriate alignment of standards with assessments of staffing operations. Productivity measures (to include relative value units or RVUs) are by no means the sole determinant of efficiency of care delivery, but will serve as one of a number of relevant data points to evaluate overall clinical staffing practices.

For primary care, our providers are responsible for following a panel of patients, and in specialty care, we assess provider productivity consistent with industry standards using RVUs. Productivity expectations (panel size/provider or RVU/provider) are in place and monitoring is underway. Productivity data coupled with access measures provides a framework for determining the adequacy of VA specialty physician staffing levels. A web-based tool called the Specialty Productivity – Access Report Quadrant (SPARQ) tool is fully operational in VA and provides comprehensive practice management information for local managers and an algorithm to right size our provider work force toward the ultimate goal of ready access to quality care including, if necessary, purchasing this care in the community.

Veterans Access, Choice, and Accountability Act

The 2014 Veterans Access, Choice, and Accountability Act (Choice Act) appropriated funds to recruit and hire additional medical professionals and support staff to improve timely access to care. VHA's current baseline of 200,000 medical professionals and clinical support staff will be augmented by more than 10,000 additional staff by the end of Fiscal Year (FY) 2016. To date, VHA has recruited more than 2,500 additional medical professionals and support staff leveraging the Choice Act resources, approximately 25 percent of the overall target.

The requirements for additional medical professionals and support staff above VHA's existing baseline of clinicians and support were initially established by the Leading Access and Scheduling Initiative (LASI), launched on June 12, 2014. The objective of LASI was to define, analyze and propose solutions for the factors that inhibited care delivery for each medical facility in the Department. The review began with a centralized analysis of the latest access data from the field, along with clinical staffing models and managerial cost accounting to produce an initial estimate of the additional medical professionals and support staff required to improve Veterans' access to care.

Following this analysis, VHA conducted a series of reviews with the field medical facilities, to refine the estimates, based upon local conditions. This activity was incorporated into the Choice Act Spending Plan presented to Congress in accordance with Section 801 on December 3, 2014.

VHA then refined the spending plan into facility-specific hiring targets and refined the cost estimate per professional. The hiring plans were completed on January 14, 2015. This analysis produced a count of 10,682 Full-Time Equivalent (FTE) providers and staff, leveraging $2.2 billion in Choice Act funding, as identified in the Spending Plan, to be executed by the end of FY 2016. These revised estimates were transmitted to Congress in the Funding Plan for Section 801 of the Veterans Access, Choice and Accountability Act of 2014 as required by Section 301 on December 3, 2014.

It should be noted that these numbers are point-in-time estimates of the projected FTEs required to enable timely access to care for Veterans. Veterans Integrated Service Network (VISN) Directors and Medical Center Directors continuously

evaluate and realign human resources between medical facilities and clinical practice areas as circumstances change over time. The location, quantity and specific skills of the medical professionals and support staff will be adjusted accordingly.

Recruitment Initiatives

VHA's National Recruitment Program, also known as the NRP, utilizes a multi-pronged approach to ensure we obtain the best health care workers in the country to treat America's Veterans. The NRP includes a dedicated national recruitment team that provides programs, services, and tools that enhance recruitment and retention of clinicians, allied health, and support staff. Recruiters, VISN Directors, Medical Center Directors, clinical leadership, and local human resources departments all work together in the development of comprehensive, client-centered recruitment strategies that address both current and future critical needs. VHA facilities also have in-house human resources departments, as well as physician and nurse recruiters, who conduct open houses and outreach within their local markets to identify, recruit and coordinate with potential applicants.

As noted above, marketing to medical professionals is another key element of the recruiting process. VHA's marketing plan is an aggressive multi-faceted, sustained, national outreach campaign to include targeted recruitment to areas which we have identified as challenged recruitment areas (rural and highly rural markets, psychiatry, gastroenterology, etc.).

VHA has been authorized to hire marriage and family therapists and licensed professional mental health counselors since 2010 and continues to hire individuals into these professions to expand the mental health workforce.

VHA initiated *Take a Closer Look at VA*, a national campaign to attract VHA health professions trainees to permanent positions. The campaign uses consistent centrally-coordinated marketing on a regular basis to reach out to VHA trainees, including information on how to directly contact a national recruiter about future permanent employment with VHA.

VHA also conducts additional recruitment activities with professional health care associations, including state medical boards and national conferences such as the

American Organization of Nurse Executives, the National Medical Hispanic Association and the American Psychological Association.

Unique Veteran Needs

We recognize that there are unique populations of Veterans that need to be taken into consideration,such as women Veterans and those living in rural areas.

Of the 22 million Veterans in the United States, 5.3 million (24 percent) live in rural areas of the country, and 3.2 million (60 percent) of those rural Veterans rely on the VA for at least some of their health care. Seventy-seven percent of rural communities in the United States currently have shortages in primary care providers, which impacts the health care of everyone in those communities, including rural Veterans, many of who use both VA and community providers for their health care. There are also shortages in specialty providers, for example, there are only 16 psychologists per 100,000 rural residents. Compounding this issue are rural residents' long drive times to care facilities, limited options for integrated health care options, lack of public transportation, limited broadband access and socioeconomic challenges. Combined, these factors can impede the wellness of local individuals, and ultimately the community.

The VA Office of Rural Health, in collaboration with other VA partners and non-VA Federal partners is exploring opportunities to:

- Determine where and what types of providers are in short supply at rural health care facilities providing care for rural Veterans;
- Develop and/or expand and support clinical training opportunities for rural health care practitioners providing care for rural Veterans to help retain them in rural areas;
- Promote and support rural health educational and rural clinical training experiences for residents, nursing and other health professions' students to help recruit future health care providers to rural practice; and
- Expand opportunities for training rural primary care providers in specialty areas that address the unique medical needs of rural Veteran demographic groups.

The increase in the rural Veteran population calls for a strong recruitment, marketing and advertising campaign that directs qualified applicants to VA facilities serving rural Veterans. The VA's rural relocation marketing campaign targets urban physicians in transit during their daily commutes with a compelling recruitment, marketing and advertising campaign to persuade them to explore options for relocation to the nearest VA medical center in a rural setting. This campaign targets geographic regions and specialties with highest need, and is published online and in a wide range of professional health care publications.

The number of women Veterans enrolling in VA health care is increasing, placing new demands on a VA health care system that historically treated mostly men. There are more than 2 million women Veterans in the United States accounting for more than 400,000 users of VA health care services in FY 2014. To address the growing number of women Veterans who are eligible for health care, VA is strategically enhancing services and access for women Veterans.

VA recognizes that the availability of on-site gynecologists plays a critical role in providing comprehensive care to women Veterans. However, gynecology specialty providers are not available on-site at all VA health care centers. Therefore, VA intends to address the hiring of gynecologists and improved access by expanding on-site gynecologic services and support as we implement the Choice Act. VHA is already enhancing gynecology care to women in rural areas through innovative technologies such as e-consults, tele-gynecology, and tele-maternity services. Expansion of these innovative technologies is being explored as a mechanism to ensure access to gynecology care in parts of the country where recruitment of gynecologists is a challenge.

Monetary Incentives

Recruitment, relocation, and retention incentives, also known as the "3Rs", may be used when there is a need to help recruit and retain highly qualified employees in difficult to fill positions. A recruitment incentive may be used to attract a new employee to a position that is likely to be difficult to fill without an incentive. A relocation incentive may be used to encourage a current employee to accept a position in a different

geographic area that is likely to be difficult to fill without an incentive. Retention incentives may be used to retain employees with high or unique qualifications or whose services are essential to special VA needs and would otherwise be likely to leave Federal service. All 3Rs incentives have specific criteria that must be addressed and documented in order to justify approval.

The Education Debt Reduction Program (EDRP) provides education loan repayment to certain health care professionals for hard to recruit or retain clinical occupations. In FY 2014, a Congressionally authorized enhancement to EDRP from the Choice Act increased the maximum allowable benefit from $60,000 to $120,000 for eligible applicants to this program. Considering the national scarcity of specialized health care providers and the significant debt associated with clinical training, this enhancement improves VA's recruitment and retention capabilities.

The Employee Incentive Scholarship Program (EISP) authorizes VA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. The National Nursing Education Initiative (NNEI) and the VA National Education for Employees Program (VANEEP) are policy-derived programs that stem from the legislative authority of EISP. EISP awards cover tuition and related expenses such as registration, fees, and books. The NNEI program funds registered nurses pursuing associate, baccalaureate, and advanced nursing degrees. And VANEEP provides replacement salary dollars and allows participants to accelerate their degree completion by attending school full-time. Each of these scholarship programs addresses critical recruitment and succession planning needs by obligating participants to complete a service obligation following completion of their academic program.

Special salary rates is another recruitment tool that allows VA to remain competitive with local labor markets by establishing higher salaries when needed for particular occupations. Competitive salaries are essential in the recruitment of candidates for critical hard to fill vacancies.

Credentialing and Privileging

Many of our most critical specialties require credentialing and privileging as part of the on-boarding of each medical professional. VA must take great care to hire qualified health care providers. Credentialing is the systematic process of screening and evaluating the provider's qualifications including education, training, licensure, certification, experience and competency. It is one of several steps in the entire process of hiring medical professionals. Privileging is the process by which a provider, licensed for independent practice, is permitted by law and the facility to practice independently and provide medical or other patient care services within the scope of their privileges. These requirements are driven by statute, regulation, policy, and accreditation standards. VHA is striving toward a streamlined credentialing and privileging process to address critical shortages of clinical staff for all medical facilities.

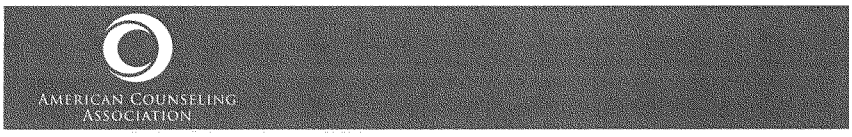
The credentialing process is supported by a national software program, called VetPro, that allows for credentials, once completed, to be shared across all VA medical centers. National recruiters, who have been given access to VetPro, were trained in and granted access to the system, to support providers in submitting information in a timely manner after accepting their tentative job offer. Additionally, VA is encouraging concurrent processes such as:

- Completing VetPro which is being linked to the VA Human Resources applications for all health care occupations which will autofill with information entered in VetPro, thereby reducing redundant submission requirements for candidates.
- Encouraging compensation panels to be held promptly after selection and concurrently with initiation of credentialing.
- Ensuring that medical and credentialing office staffing levels are appropriately and properly staffed.
- Continue encouragement of widespread utilization of the expedited medical staff appointment process when candidates are available to report for duty in 60 days or less from the tentative offer.

Conclusion

In conclusion, VHA is aggressively moving on all fronts: outreach, integration, technology and strategic planning through the *Blueprint for Excellence* to ensure we have a properly staffed and well-qualified team of health care professionals serving our Nation's Veterans. The challenges remain formidable, but our commitment to timely, accessible care and a positive patient experience is unwavering.

Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to answer any questions you, or other Members of the Committee, may have.



Counseling — Passion, Profession, Purpose

Testimony of Robert Smith, Ph.D., N.C.C., F.P.P.R., President of the American Counseling Association to the House Committee on Veterans' Affairs Subcommittee on Health

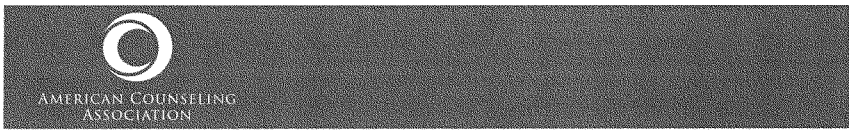
May 15th, 2015

Chairman Benishek, Ranking Member Brownley and Members of the subcommittee, I want to thank you for inviting me to submit testimony to the Committee today. It is an honor and a privilege to speak on behalf of the American Counseling Association and we appreciate the opportunity to contribute to this very important discussion. We share the concerns of this committee regarding the well-being of our veterans. We consider it a national tragedy that on average, one of our veterans commits suicide every 80 minutes. I can think of no more pressing concern for this committee than stopping this terrible toll.

The American Counseling Association is the country's largest and oldest professional association representing the counseling profession, with over 55,000 members across the United States and overseas. Our members have diverse backgrounds and many of them specialize in treating substance abuse disorders, mental health issues, trauma, family issues and depression among others.

There are more than 120,000 licensed professional counselors (LPC's) nationwide, authorized under licensure laws enacted in all 50 states and other U.S. jurisdictions to practice independently. As with the profession of social work, states use slightly differing titles for those licensed as professional mental health counselors, the most commonly used title being "licensed professional counselor." LPCs meet education, training, and examination requirements similar to—and in many states, more stringent than—those of marriage and family therapists and clinical social workers. Licensed professional counselors must have a master's degree in counseling or a related field, pass a national exam (in some cases two exams), and accumulate thousands of hours of post-degree supervised experience. As with other health care professionals, counselors must adhere to a code of ethics, are required to practice within the scope of their expertise, and practice subject to the oversight and approval of their state's licensure board. Counselors provide outpatient psychotherapy independently under private sector health plans nationwide, as authorized by state licensure laws, and form a significant part of the nation's mental health workforce.

I would like to state for the record, that while I am immensely grateful for the opportunity to offer testimony to your committee, I am also very saddened and very frustrated. These emotions stem from the fact that while I was preparing this testimony to you, I reviewed previous testimony that one of my predecessors, Dr. Brad Erford, submitted to some of you just over two years ago. Upon reviewing that testimony, I saw that many of the problems that were occurring then are still occurring now. Most, if not all the barriers that Licensed Professional Counselors face when seeking employment in the VA still exist today. In short, after working with VA for over two years and after legislation was passed over seven years ago, we are no closer to having more mental health clinicians available to our veterans than we were two years ago. With the rate of veterans' suicide and the scandals that have ensued during those years, it is remarkable and quite frankly, an insult to our veterans that nothing has been done.



Counseling — Passion, Profession, Purpose

As of last month, the Office of Personnel Management (OPM) has still not issued an occupational series for Licensed Professional Counselors in the VA. This means that if an LPC was to be hired, their ability to provide the treatment that veterans so desperately need would be in question. We and other organizations have asked the VA and OPM to resolve this issue for over three years, only to be told by the VA that OPM must author the series and then have OPM tell us that VA must make it a priority for OPM to author the series. Either way, we are still no closer to having this problem solved.

Another source of frustration has been that we have been asking the VA to fully incorporate licensed professional counselors into the training program that is run by the Office of Academic Affiliations. The VA's Office of Academic Affiliations each year establishes paid traineeship positions for both psychologists and clinical social workers, which serve as a pathway to service in the VA health care system. After being denied entry to the program for several years, the VA has finally decided that they will at least begin a pilot program for counselors to serve as trainees. However, it is our understanding that the pilot program will require that the VA utilize LPCs as trainers, but only if those LPCs are serving in a supervisory position. With LPCs currently making up less than one percent of the entire VA, we are anxious to see if there are even any LPCs eligible to institute this pilot program. Couple this criterion with the fact that the VA has recently announced that Vet Centers will no longer be eligible to be training facilities, and the possibility of this pilot program succeeding dwindles dramatically.

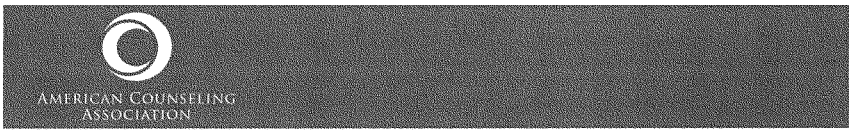
Sadly, our overall experience with the VA has been that the only time that they have been creative or innovative when it comes to delivering mental health care is when they find ways to prohibit the delivery of that care.

As the Chairman and the rest of the committee know, Licensed Professional Counselors can make a valuable contribution to treating the mental health concerns of veterans, and the consequences of psychological and cognitive injuries are the signature wounds of the Iraq and Afghanistan conflicts. Policymakers both inside and outside the Department of Veterans Affairs have repeatedly said that there aren't enough mental health providers available to meet veterans' treatment needs. From our perspective this problem is to a large extent a self-inflicted wound, because despite a past press release to the contrary, the VA has effectively decided not to utilize LPCs as part of its mental health workforce. The VA's rules and policies have kept far too many counselors from operating under either of those two areas at a time when we need them most.

And these rules could be changed by the Administration in a fairly simple and quick manner so that we can begin to deliver the care and treatment that our veterans need right now.

In an effort to reform the delivery of care and begin truly honoring our veterans, the American Counseling Association would ask the committee that they immediately direct the VA to take the following actions:

1. Fully integrate Licensed Professional Counselors (LPC) into VISNs across the country
2. Demand accountability and action at the VA and OPM on finalizing an occupational series for LPCs
3. Reform VA Supervisory Guidelines to accelerate hiring of LPCs
    a. This should be done across the VA and immediately for the LPC training pilot program
    b. There is precedent for this with other professionals and their hiring rates increased dramatically
4. Cross-post mental health care provider job openings to include licensed professional counselors



Counseling — Passion, Profession, Purpose

The members of this committee know what the problems are in regards to overcoming the barriers to more efficient and effective VA staffing. In many cases, the committee has been the leader in calling on the VA to implement solutions to ensure that the VA overcomes those barriers. But it seems that the biggest barrier that stands between the veteran and mental health care is the VA itself. What is needed here is a wholesale change in the culture and approach that the VA takes in developing new ways to treat our veterans. But how we get to that result is the question we must answer and answer urgently.

After the scandals of the past year, the loss of our veterans to suicide, and the lack of access to adequate care, it seems like the VA is still an immovable roadblock. I and my organization are at a loss as to what will ever make them realize that their inaction has in all too many cases been the very thing that has kept veterans from getting the help they deserve.

On a plaque on the VA's headquarters is the VA's motto, a line taken from the second inaugural address of President Abraham Lincoln, which states, "To care for him who shall have borne the battle and for his widow and his orphan". It is of course more than a motto, it is a sacred promise that we make with our nation's veterans. Unfortunately, when it comes to fulfilling that obligation, at least when it comes to mental health, we are all failing. We all fail because we let the problems like the ones I have described perpetuate and we do not hold the VA accountable.

I hope that today, we can begin to fulfill that promise and ensure that we are caring for those who shall have borne the battle and their families. The American Counseling Association is ready, all that we ask is that the Congress and the VA allow us to treat the invisible wounds of war and welcome our veteran's home.

STATEMENT FOR THE RECORD BY
THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO
BEFORE THE HEALTH SUBCOMMITTEE OF THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

OVERSIGHT HEARING ON VA'S ABILITY TO RECRUIT, BOARD AND RETAIN QUALIFIED MEDICAL PROFESIONALS

MAY 15, 2015

The American Federation of Government Employees, AFL-CIO and its National Veterans Affairs Council (AFGE), which represents over 220,000 employees of the Department of Veterans Affairs (VA) thanks the Subcommittee on Health for the opportunity to submit this statement regarding recruitment, boarding and retention of VA medical professionals.

AFGE's representation of health care professionals at the vast majority of VA medical facilities and our participation in national level VA policy setting groups allows us to offer recommendations for national policy changes, and provide reports of issues that need to be addressed at specific facilities (Appendix A).

MONITORING PERSONNEL PRACTICES AT EACH FACILITY

AFGE appreciates the willingness of Members of this Subcommittee and other Committee members to maintain direct lines of communication with AFGE local officials and the front line employees they represent during site visits. Front line employees are reluctant to speak freely about their concerns at town halls and other management sponsored local meetings. **AFGE urges lawmakers to hold separate meetings and conference calls with employees and their representatives;** this is the only way for

lawmakers to gain full information from employees who interface with veterans on a daily basis about what is working and what is not working at each facility.

HIRING AND RECRUITMENT

Hiring of new providers under the Choice Act is slow to nonexistent at many medical centers, despite chronic staffing gaps, particularly in primary care and behavioral health. The perspective of most front line providers is that management continues to address access problems caused by staffing shortages and increased demand for services by requiring current employees to take on more patients without hiring additional clinical staff or support staff, regardless of its impact on work hours, morale, patient care or retention. Space needs are typically handled in an equally short sighted manner, i.e. reassign scarce space already in use for patient care to meet other patient needs, and converting clinic space to office space.

Medical professionals exchange information all the time. Providers contemplating employment with the VA are well aware of the working conditions, work culture and pay problems faced by current employees (discussed in more detail below). They hear about the frequent "bait and switch" that occurs during the hiring process including broken promises of permanent status, pay incentives, assistance with student loans and continuing education, and family friendly schedules. They also hear from colleagues who discovered that they had little or no recourse to require the VA to make good on those promises, even after uprooting their lives to relocate to a rural area. **AFGE urges the Subcommittee to investigate bait and switch hiring practices and increase HR accountability for its hiring commitments**.

VHA's excessive use of temporary and part-time appointments hurts recruitment and retention, deprives providers of civil service protections, job stability and career opportunities, and adversely impacts coordination and continuity of care. AFGE has heard that almost half of physician appointments may currently be temporary. **AFGE urges the Subcommittee to investigate the extent on non-permanent appointments among front line health care personnel.**

When hiring does occur, the VetPro credentialing process is so slow (up to six months) that good applicants are unable to wait any longer and take jobs elsewhere. A credentialing process that includes evening and weekend hours will speed up the process and work better for applicants who are currently employed elsewhere. Human resources personnel have too much paperwork to process and they also need additional training. Many providers question whether VetPro can even be fixed.

Cronyism and nepotism in the hiring process are rampant at most facilities. **AFGE urges the Subcommittee to investigate this widespread violation of merit-based hiring and promotion processes** that is depriving facilities of its best clinicians and hurting morale among the current workforce who are regularly passed over by outsiders with no VA experience for transfers and promotions.

RETENTION

Insufficient workforce data: Today's recruitment success is tomorrow's recruitment problem. Medical professionals continue to leave the VA at alarming rates during the first five years of employment. VHA is not collecting sufficient data to fully understand and address the reasons why VA providers quit or early retire from the VA. Even the limited data that was provided in the *2014 VHA Interim Workforce and*

Succession Strategic Plan reveals that 31.5% of new hires in critical shortage occupations quit in the first five years, and that nearly half of them quit within the first year. The VA physician quit rate was the highest of all the top occupations. This VHA document devoted *one paragraph* to the reasons why physicians leave the VA, and only listed three reasons: advancement, normal retirement and relocation with spouse. All the quits and early retirements due to pay, workload, schedules, lack of professional support, hostile workplace culture, discrimination, and the like can never be fully addressed if VHA data continues to mask the most significant barriers to recruitment and retention. **AFGE urges the Subcommittee to overhaul VA's recruitment/retention data collection in consultation with front line employees and their representatives** who are in the best position to know why their peers choose to come to or leave the VA.

Growing pay disparities**:** Pay disparities are currently one of the largest barriers to VA provider retention. The increased pay ranges for physicians and dentists instituted by Secretary McDonald are still only being used for new hires in most instances, despite promises made at the national and local levels to make equivalent adjustments to the pay of current providers. It is extremely demoralizing to a physician who has devoted 15 or more years to the VA to see job postings and new hire pay offers that are $20,000 higher than his or her own salary. **Market pay panels must be convened promptly at all facilities to fix this tremendous pay inequity. In addition, we urge the Subcommittee to investigate the widespread noncompliance with requirement in the law (5 USC 7431(c)) to convene market pay panels every two years.** Performance pay requirements in 5 USC 7431 are also widely violated and

ignored, which further hurts morale and deprives the VA of a valuable opportunity to reward and incentivize good performance.

Workload and work hours are also significant contributors to retention and morale problems, and most important, the ability of providers to adequately care for veterans. Official panel sizes continue to exceed VA's own limits in policy and too often, the VA's solution is to raise the official limit instead of taking steps to reduce excessive workloads. For example, the VA is currently proposing to increase the 900 panel size for nurse practitioners by 25% without additional compensation, a proposal that AFGE has opposed.

In addition, all our providers are expected to take on unassigned patients and walk-ins on a regular basis including new patients from providers who have left (and they are only given only 30 minute established patients slots instead of new patient full hour slots they actually need); consequently, providers have too little face to face time with their patients and too little time to handle post-appointment duties such as computer alerts, lab reports, medication monitoring, aid and attendance reports, and outside medical records. AFGE field reports indicate that on average, VA physicians spend 60 hours a week doing work remotely at home to handle these additional duties. Our member survey on computer alerts indicated that our providers handle on average over 100 daily computer view alerts, some of which are not critical to patient care. **AFGE recommends (in addition to adequate provider staffing): (1) official allocation of non-appointment time to handle these additional duties; (2) additional support from nursing personnel and administrative staff to handle**

some non-appointment duties; (2) VA Central Office analysis and guidance on ways to manage and reduce computer alerts.

Perhaps the most demoralizing work hour issue for physicians and dentists is management's widespread violation of a new VA policy curbing the widely abused "24/7 rule" that sets a 40-hour work week, requires advance notice of schedule changes and limits 24/7 coverage to on call duty (*October 21, 2014 changes to VA Handbook 5011/27*). After fighting for decades for this commonsense fix, many of our providers have learned that their managers have been advised to disregard the new policy. **The VA should provide clarification and training on the new policy to ensure uniform compliance with this extremely valuable new tool for improving patient care and recruitment/retention.**

UNEQUAL WORKPLACE RIGHTS

Sadly, for a select group of VA providers (physicians, dentists, RNs, PAs, podiatrists, optometrists, and chiropractors), there is virtually no recourse to address *any* VA policy violation through the collective bargaining process. This is a process used every day by other VA employees (over 90,000 Hybrid Title 38s) and Department of Defense (DoD) and Bureau of Prisons (BOP) clinicians to resolve routine labor management disputes such as schedules, assignments and training in a quick, low cost manner. How can a VA psychiatrist have fewer bargaining rights than a VA psychologist or a DOD psychiatrist? How can a VA registered nurse have fewer rights than a VA licensed practical nurse or Bureau of Prisons registered nurse? The answer lies in the Title 38 bargaining rights law, "Section 7422". Health care professionals in other VA positions and in DoD and BOP have full Title 5 bargaining rights that allow them to

efficiently resolve labor management disputes, whereas VA physicians and others covered by Section 7422 are not able to grieve management actions. Managers also use Title 38 bargaining rights to silence providers who report mismanagement, by using Section 7422 to refuse to bargain over retaliatory actions such as the sham peer reviews and trumped up charges of patient neglect and HIPAA violations that have been the subject of testimony at many recent hearings.

VA labor relations has claimed for the past five years that it has fixed this problem with a new "7422" policy but nothing has actually changed since this loophole in the law was first exploited on a massive scale over a decade ago. **Therefore, AFGE urges lawmakers to support H.R. 2193, the VA Employee Fairness Act of 2015, introduced by Rep. Takano (D-CA) to amend Title 38 bargaining rights law and restore an equal voice to VA physicians and other covered providers.**

Recent whistleblower hearings have highlighted the vulnerability of VA health care professionals who question management practices and then risk loss of employment, patient contact and privileges that can destroy their careers. To ensure that current and future VA professionals view the VA as a good professional choice, it is crucial that they receive *more*, *not fewer*, workplace rights. Therefore, **AFGE strongly urges lawmakers to reject H.R. 1994,** a bill that would apply the expedited SES firing procedures to *everyone* in VA, including the housekeeper cleaning the operating room, the ICU nurse, the PTSD treating psychologist and every physician the VA is currently trying to recruit and retain. These front line, non-management employees have no control over mismanagement; rather, like patients, they also pay a heavy price for mismanagement. Passage of the due process cuts in H.R 1994 will devastate VA's

ongoing efforts to recruit and retain a strong front line, non-management health care workforce, and accelerate more cronyism among managers who are already abusing their Title 38 discretion.

The real path to greater VA accountability is ensuring that every VA employee – regardless of whether he or she is permanent or probationary, part time or full time, Title 38 or Title 5 - has equal OSC and MSPB whistleblower protections, as well as equal bargaining rights.

Recent testimony also highlighted the particular vulnerability of the many newly hired veterans in the VA workforce; it is surprising for many to learn that *VA's own health care system* can pass over preference eligibles in the hiring process because the Veterans Employment Opportunities Act (VEA) does not apply to Title 38 appointees. **AFGE urges reintroduction of legislation championed by Rep. Walz (D-MN) to extend full veterans' preference appeal rights to VA Title 38 health care personnel** so it is no longer up to each facility HR office to choose whether to recognize veterans' preference or pass over a veteran applying for a new or different health care position with the VA.

A VA medical center is a community, not just a place to work. Another group that deserves fair treatment are VHA's lowest paid customer service representatives, the VA Canteen Service employees who serve warm meals and coffee to worried families and tired providers every day. A workplace culture that currently tolerates abusive at-will employment of its lowest paid employees is detrimental to the entire workforce. **Therefore AFGE urges lawmakers to enact legislation to amend 38 USC 7802 to**

provide canteen employees with the right to appeal their terminations through the grievance process.

PROFESSIONAL DIGNITY AND RESPECT

VA providers are not treated with the same professionalism and respect that they can expect from many other health care employers. Too often, direct supervisors are nonclinical and lack an understanding of patient care delivery. VA managers with or without medical skills are equally uninterested in the input of front line clinicians. Front line providers have no control over the scheduling of their patients because schedulers also report to nonclinical supervisors.

In addition, provider needs for continuing education are frequently ignored. Only physicians and dentists have a statutory right to a fixed amount of reimbursement for critical outside courses they need to maintains skills and credentials, and that amount has not been increased *for 24 years*! In addition, managers routinely deny requests for time to attend outside courses even when similar courses are not offered within the VA. **AFGE urges the Subcommittee to amend 38 USC 7411 to offer updated, competitive levels of reimbursement and extend this recruitment and retention incentive to other VA health care professionals.**

To address complaints that managers pay lip service at best to the input of front line providers, **AFGE urges the Subcommittee to conduct regular Congressional roundtables to receive reports and recommendations from front line providers and their employee representatives.**

RURAL CHALLENGES

Rural facilities are not consistently offering additional recruitment and retention incentives to attract providers to hard to serve rural areas. Despite new tools for rural recruitment in law and VA policy, in practice, management is reluctant to make these expenditures, despite the adverse impact on rural access to care and the increased cost of diverting and contracting out this care.

AFGE is also very concerned about the growing number of field reports from our members about reduced inpatient services, especially in rural areas, such as the closings of emergency rooms, intensive care units and other inpatient services and beds. Patients are diverted to facilities that are very far away from their rural communities and families. This also harms recruitment and retention by driving away providers who lose the ability to maintain their skills. **AFGE urges the Subcommittee to investigate this dangerous form of backdoor facility closures.**

Thank you for the opportunity to share AFGE's views on these critical VA health care issues.

APPENDIX: SAMPLE REPORTS BY FACILITY

IRON MOUNTAIN: Our Director is closing the ICU and downgrading the ER to urgent care. We will not be able to accept severely ill patients anymore and they will have to be diverted hours away from their communities and families for care. We just hired a new anesthesiologist who will not have any major surgeries to perform. This is devastating to veterans as well as to our medical professionals who will leave because they will not be able to maintain their skills. Even when veterans are diverted from Iron Mountain to Milwaukee or Madison, it is difficult to secure beds for them there so they still have to stay at Iron Mountain regardless of whether we can currently handle their severe conditions. Other retention problems include higher pay for new hires than for very experienced clinicians, and cronyism in the hiring process that has deprived dedicated long term health care personnel of the opportunity to transfer from closed units to active units and promotions; almost every nurse manager was hired from the outside. Hiring practices are too inflexible, barring valuable experienced employees of certain positions. *Recommendation*: If the VA will not allow non-manager RNs to be Nurse IIIs, they should create more Nurse II steps to increase retention. Management at Iron Mountain also discriminates against older employees and those filing EEO claims.

NASHVILLE: HR will not pay retention bonuses or recognize serious staffing shortages. They need to count everyone who leaves the unit as a loss, including retirements, resignation and transfers. Our chief nurse stated that they only look at terminations. We had over 50 vacancies in the inpatient area due to internal transfers. Physicians making less than new hires should have their pay adjusted immediately, not when the next scheduled market pay panel is convened. Physicians with 20 years of VA experience are demoralized by much higher pay offers made to new hires. Managers who make decisions about promotions do not actually understand the work. The primary care panels are being increased to 1,400 patients. The boarding process is flawed and slowed down by VetPro; it takes up to two months to get people hired. HR needs more training and more staff to expedite hiring. Currently, hiring decisions have to go through many layers (committees, resource boards, governing council, VISN). Managers need more training on assembling and conducting the boarding process; we lose a lot of good applicants due to low ball offers.

MOUNTAIN HOME: HR waits until a physician leaves (after a month of advance notice) to being the process of hiring a replacement. That physician's patients are transferred to others already handling large panel sizes (and are only allotted 30 minute established

patient slots); this is especially bad in primary care. The Business Office instructs schedulers to overbook; providers have no say. Managers do not want any front line physician input; it's my way or get out even though together, we could figure out solutions. All the money being spent on new office space should go to staff and beds. Promises to new hires for bonuses, good tours of duty, loads and reasonable schedules are not kept; some new hires leave right away because they see what the truth is on the very first day.

WILMINGTON, DE: We were told indirectly about a hiring freeze here and we cannot fill vacancies but managers will not cancel clinics. HR does not maintain a pool of applicants so they are ready when an opening occurs when people leave. There are no backup staffing plans. They are not internally posting all Title 38 positions.

COLORADO: The hiring process is too slow. Human Resources paperwork slows it down. We keep losing good applicants who sometimes have to wait up to six months and usually at least three months to be boarded.

PALO ALTO:

- Many full time physicians and dentists are hired on a temporary basis with yearly or once every two year renewals (NTE appointments). We have several physicians who have been here 10+ years who are still temporary. The facility uses this to remove physicians who are whistleblowers or folks who disagree with the management way. All part -time physicians are temporary with NTE appointments. The facility states that the law or national regulations do not allow converting part-time employees to be permanent employees.
- Even though we have lost several physicians in this VA, they are not replaced by new VA physician hires. PAVA hires many contractors, fee-basis and university contract to replace VA physicians and commonly uses the reason that there are no available doctors who would work for the VA. If that's the case, how is the University hiring them to provide the contract and how is Kaiser hiring these physicians?
- Physicians and dentists are not appropriately labor-mapped and individual mapping is not readily available. So, it often appears that the services are appropriately covered when in fact there is physician shortage leading to access issues.
- Here are some examples of physicians we have lost in the recent past:

    - Young female physician who found the VA environment very stressful and non-family friendly. [No paid maternity leave, day care on campus has a year or more wait time for infants, non-flexible work hours and no option for telemedicine even part-time when possible]
    - Young male physician, researcher who left the VA because another employer offered him $50k more per year that he needed to buy a home in this expensive area.

- A mid-career female physician left because her opinions to improve patient care were disregarded, and she was subject to sexual harassment from a manager. She was afraid of retaliation and felt that it was just easier to leave than to lodge a complaint.
- We are touted as the "crown-jewel" of the VA, but with this history of fear, retaliation, intimidation etc. NO young person wants to come to the PAVA to practice medicine if they become aware of it.
- As in any other VA, there is a glass ceiling here for women (unless you are willing to acquiesce to management), pay is not transparent, and there is cronyism.

LOS ANGELES:

- Staffing shortages for doctors and mid-level providers are getting worse In primary care; patients are waiting longer some up to 6 months;
- We have vacancies due to providers on maternity leave, retirement and sick leave and vacancies cannot be filled in a timely manner.
- Even with the new pay ceilings approved by the Secretary, facilities are not taking advantage of this for existing employees.

ARIZONA

The Phoenix VA can't recruit and retain enough physicians to meet patient needs. In general employee morale is at an all-time low. Recent pay increases for some physicians has resulted in major pay inequities in the field where a physician that is board certified with 14 years' experience makes the same monetary compensation as a non-board certified new physician in the same field.

STATEMENT FOR THE RECORD OF
THE AMERICAN LEGION
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
VA STAFFING OF MEDICAL PROFESSIONAL

MAY 15, 2015

Chairman Benishek, Ranking Member Brownley and distinguished Members of the Health Subcommittee, on behalf of Commander Helm and the 2.3 million members of The American Legion, The American Legion applauds you and your colleagues for examining the Department of Veterans Affairs (VA) ability to effectively and efficiently recruit, onboard, and retain qualified medical professionals to treat veteran patients.

Background

As far back as 1998, The American Legion began expressing concerns regarding VA physicians and medical specialists staffing shortages within the Veterans Health Administration (VHA). This was accomplished by monitoring the progress in establishing patient centered primary care within each Veterans Integrated Service Network (VISN), including both rural and urban localities as well as ensuring that the model of care features both the quality and efficient combination of medical physicians and other medical specialists that are tailored to the needs of the local veteran's population.[1]

From the inception of The American Legion's System Worth Saving (SWS) Program in 2003, to its transformation to the Veterans Benefit Centers (VBCs) in 2014, The American Legion has tracked and reported staffing shortages at every VA medical facility across the country and submitted those to Congress, VA Central Office (VACO), and to the President of the United States. Through numerous SWS hospital site visits, and now regular VBC visits, The American Legion has dedicated considerable resources to monitoring the Veterans Health Administration (VHA) healthcare system.

Unfortunately, there are no easy solutions for VA when it comes to effectively and efficiently recruiting and retaining medical staff to treat the growing number of veterans that are entering the VA healthcare system. The American Legion believes that access to basic health care services offered by qualified primary care providers should be available locally as often as possible. VHA is still struggling to achieve the appropriate balance of primary care and medical specialists across the country.

[1] Resolution 311: The American Legion Policy on VA Physicians and Medical Specialists Staffing Guidelines

In 2004, The American Legion urged the VA to develop an aggressive strategy to recruit, train, and retain advanced practice nurses (APN's), registered nurses (RN's), licensed practical nurses (LPN's), and nursing assistants (NA's) to meet the inpatient and outpatient health care needs of veterans. The Legion fully supports VA's education-assistance programs for APNs, RNs, LPNs, and NA's. We also urged VA to provide equitable and competitive wages for Advanced Practice Nurses (APNs), Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and nursing assistants.[2]

The American Legion has also studied the problems faced by veterans who reside in rural areas. Rural veterans struggle to find timely and quality VA health care that meets their individual health care needs. VA medical centers in rural areas have concerns regarding recruiting and retaining qualified medical and clinical providers as a result of not having the ability to offer attractive resources for these professionals to live and practice in rural communities. In The American Legion's 2012, SWS Report on Rural Healthcare, The American Legion found that:

> *"[Department of Veteran Affairs Medical Centers (VAMCs)] in rural America, recruitment and retention of primary and specialty care providers has been a constant challenge. Some clinicians prefer to practice in more urban settings with more research opportunities and quality of life that urban settings provide."* [3]

In 2014, The American Legion published a SWS report titled *"Past, Present, and Future of VA Healthcare"*, which noted several challenges VA still faced:

- Several VAMCs continue to struggle to fill critical leadership positions across multiple departments.
- These gaps have caused communication breakdowns between medical center leadership and staff that work within these departments.

During our 2013 site visit to the Huntington VA Medical Center in Huntington, West Virginia, we recommended that, "VHA conducts a rural analysis for hard to recruit areas and look into different options to support VAMCs in getting talent they need to better serve veterans."[4] VHA needs to ensure that veteran health care is consistent across each Veterans Integrated Support Network (VISN).

In December 2014, The American Legion conducted a veteran's town hall and site visit at the Mann-Grandstaff VA Medical Center in Spokane at the request of the Department's of Washington, Idaho, and Oregon. At the town hall meeting, American Legion members and staff met with the medical center's leadership team. Veterans from Washington, Idaho, and Oregon, all of whom use the medical center in Spokane to receive their health care, were provided an

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[2] Resolution No. 237: The American Legion Policy on VA Nurse Recruitment and Retention

[3] The American Legion 2012 System Worth Saving Report on Rural Health Care: http://www.legion.org/sites/legion.org/files/legion/publications/sws-rural-healthcare-report-2012-web.pdf

[4] The American Legion 2013 System Worth Saving Report on Huntington VA Medical Center: http://www.legion.org/sites/legion.org/files/legion/publications/SWS%20Report%202013%20-%20Huntington.pdf

opportunity to participate in a facilitated discussion about the Spokane VA hospital to discuss the decision to reduce their Emergency Room (ER) operating hours.[5]

According to VAMC leadership in Spokane, the ER was being closed because the facility lacked sufficient staff Emergency Room physicians to operate the ER effectively. According to the medical center director, this was due to the recent loss of ER physicians and not a cost factor. The American Legion inquired why it would take so long to hire ER physicians, and was informed by the director that there was a critical shortage of ER doctors in the Spokane area. The American Legion's team visited several neighboring local hospitals in the area. The following information was discovered during the visits:

- *Neither of the hospitals in the Spokane area were experiencing a shortage of ER doctors*
- *Area hospitals that were visited have existing contractual relationships with the Spokane VA to swap services, and would certainly consider revisiting that agreement to help out VA in this instance, yet these agreements had not been acted on in some time*
- *Area hospitals that were visited told us that if VA were to contact them, that they would have doctors who would be willing to moonlight at VA's ER until they were able to hire the necessary staff to fill shortages*
- *One Medical Staff Director told us that she has had no problems whatsoever finding qualified ER doctors, and that she uses several contracting agencies that have never had a problem filling their requests. This particular director went on to say that if the contract company that VA is currently using isn't able to provide qualified ER docs immediately, then VA should find another company immediately.*
- *Both hospitals said that they would be willing to work with VA to help with their staffing needs.*
- *Both hospitals that were visited stated that they would never consider reducing ER hours as a viable option based on the existing business climate*

The American Legion met again with the Mann-Grandstaff VA Medical Center Director and senior leadership. After sharing our findings and research with them, and offering to assist and facilitate introductions or host meetings, the Mann-Grandstaff medical center ignored our suggestions and continues to have an Urgent Care Center, rather than a true Emergency Department. Originally, the center Director told us that she would be able to have the ER fully operational "by spring", however after continued follow up by The American Legion, we now understand that the emergency room will not be opened any time before October 2015. This date is contingent on recruiting quality staff.

On January 30, 2015, the VA's Office of Inspector General (VAOIG) released their determination of the *"Veterans Health Administration's Occupational Staffing Shortages,"* as required by Section 301, of the *"Veterans Access Choice and Accountability Act (VACAA) of 2014"*. With this report, VAOIG determined that the five occupations with the largest staffing shortages were Medical Officers, Nurses, Physician Assistants, Physical Therapists, and Psychologists. The OIG recommended that the *"Interim Under Secretary for Health continue to*

[5] http://www.kxly.com/news/spokane-news/va-shutting-er-down-on-weeknights-weekends/29563416

 1608 K Street N.W. ♦ Washington, D.C. 20006 ♦ www.Legion.org ♦ (202) 861-2700

develop and implement staffing models for critical need occupations."[6] Ultimately, if the VA continues to struggle with retention and recruitment, the trend of closures (or continued closures) for multiple departments within VAMCs nationwide will continue.

With the passage of Public Law 113-146, the "*Veterans Access, Choice, and Accountability Act (VACAA) of 2014*", VA was empowered to hire, and given funding to hire, more than 10,000 medical professional and staff as well as to expand their training programs within the clinical areas to meet the overall health care needs of their enrolled veterans. The Veterans Choice Act also directed VA to increase the number of Graduate Medical Education (GME) residency positions by up to 1,500, and the law extended the VA's existing Health Professionals Educational Assistance Program (HPEAP) from December 31, 2014 to December 31, 2019. The Choice Act also doubled the maximum reimbursement ceiling for the Education Debt Reduction Program (EDRP) from $60,000 to $120,000.

In The American Legion's 2012 SWS "*Quality of Care and Patient Satisfaction*" report, it was recommended that VA Central Office (VACO) should create a VHA Executive Hiring Task Force to assess the numbers of vacancies and positions with acting staff across the country and to swiftly hire these positions as permanent positions. Additionally, a policy should be developed and enforced on succession planning for hiring executive leadership and critical hospital staffing positions. We also recommended that VHA convene a hiring and tracking task force to monitor and speed up the hiring of primary and specialty care positions, as well as establish strategies to expedite the hiring of critical health-care positions such as doctors and nurses. [7]

The American Legion urges Congress to develop a recruitment and retention strategy to incentivize medical providers to practice in rural communities, as well as ensure that each Community-Based Outpatient Clinic (CBOC) has adequate staff and direct communication between the CBOC's and medical center's Rural Health Consultants (RHCs).[8] Furthermore, The American Legion encourages the VA, specifically VHA, to allow military education, training, and experience to be considered towards a license or certification for healthcare and non-healthcare related positions that requires licenses or credentials.[9] And finally, The American Legion urges VA to work more comprehensively with community partners when struggling to fill critical shortages within VA's ranks. VA is FAILING in many of these areas while neighboring hospitals offer to help, yet VA remains undeterred and rebuffs assistance.

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[6] Department of Veterans Affairs, Office of Inspector General, Report No. 15-00430-103: *"OIG Determination of Veterans Health Administration's Occupational Staffing Shortages"*: http://www.va.gov/oig/pubs/VAOIG-15-00430-103.pdf

[7] The American Legion System Worth Saving Quality of Care and patient Satisfaction: http://www.legion.org/sites/legion.org/files/legion/publications/swsreport2012_0.pdf

[8] Resolution No. 37: Department of Veterans Affairs Rural Healthcare Program

[9] Resolution No. 352: Support Licensure and Certification Standards for Veterans Health Administration

Conclusion

In January of this year, a veteran called the emergency room from their parking lot in Seattle Washington because his ankle was broken and he needed assistance getting inside. He was told to call 911.[10]

In 2006 the VA hospital in Spokane shuttered their emergency room and called 911 for a veteran who died on the steps of the emergency room because they were "closed".[11]

The American Legion understands that filling highly skilled vacancies at premiere VA hospitals around the country is challenging. We also expect VA to do whatever legally permissible to ensure that veterans have access to the quality healthcare they have come to expect from VA. VA leadership needs to do more to work with community members and stakeholders.

As always, The American Legion thanks this subcommittee for the opportunity to explain the position of the 2.3 million veteran members of this organization.

For additional information regarding this testimony, please contact Mr. Warren J. Goldstein at The American Legion's Legislative Division at (202) 861-2700 or wgoldstein@legion.org

[10] http://www.seattletimes.com/seattle-news/health/seattle-va-hospital-strands-veteran-outside-er-2/
[11] http://www.spokesman.com/stories/2006/oct/07/hospital-wouldnt-treat-dying-vet/

PARTNERSHIP FOR PUBLIC SERVICE

Statement of Max Stier
President and CEO
Partnership for Public Service

Prepared for
The House Committee on Veterans' Affairs
Subcommittee on Health

Hearing Entitled,
"Overcoming Barriers to More Efficient and Effective VA Staffing"

May 15, 2015

Chairman Benishek, Ranking Member Brownley, Members of the Subcommittee, thank you very much for the opportunity to share the Partnership's views on ways to overcome barriers to more efficient and effective staffing of medical professionals at the Department of Veterans Affairs (VA).

I am Max Stier, President and CEO of the Partnership for Public Service. The Partnership is a nonpartisan, nonprofit organization that works to revitalize our federal government by inspiring a new generation to serve and transforming the way government works. The work of the Department of Veterans Affairs is critical in caring for our nation's veterans, and in order to achieve its mission, the Department must be able to attract and retain the very best talent. In my statement, I will share the Partnership's perspective on the current state of the workforce and provide recommendations for how the agency can more effectively recruit, onboard, and retain qualified medical professionals to meet the agency's needs and deliver vital services to veterans.

I. Trends in Hiring and Employee Engagement at the VA and VHA

The Partnership is devoted to the idea that good government starts with good people. The staff of the Department of Veterans Affairs are among the most mission-oriented civil servants working in government today; however, they have also made it clear that more can be done, from their perspective, to improve hiring, retention, and perhaps most importantly, leadership in the department.

VA Employees Are Committed to the Agency's Mission

While there has been much attention focused on mismanagement and abuse at VA – and problems need to be taken seriously and addressed – it is also important to recognize that, across VA, employees are deeply dedicated to the mission and are achieving great results for the American people.

In the 2014 Office of Personnel Management (OPM) Federal Employee Viewpoint Survey (FEVS), 91.4 percent of all VA employees, and 91.6 percent of Veterans Health Administration (VHA) employees, responded positively to the statement, "The work I do is important". Additionally, more than 90 percent of VA and VHA employees reported that they are constantly looking for ways to do their jobs better.

Not only are VA employees committed to the mission, but they are achieving results. I have had the chance to meet three remarkable individuals from VA, Dr. William Bauman and Dr. Ann Spungen, at the James J. Peters VA Medical Center in the Bronx, New York, and Mr. Ronald Walters, of the National Cemetery Administration, who the Partnership recognized as winners or finalists of the *Samuel J. Heyman Service to America Medals.* The *Service to America Medals*, or *Sammies*, highlight excellence in our federal workforce and inspire other talented and dedicated individuals to enter public service. I would like to share their stories with you because I believe they are powerful examples of the dedication and sense of purpose of the vast majority of VA employees.

Drs. Bauman and Spungen have spent their careers at the VA conducting innovative research on the impact of paralyzing spinal cord injuries on the overall quality of life of veterans. Over the years their research has led to many novel medical advances and drug therapies to improve the lives of both veterans and non-veterans with spinal cord injuries, a disabled population with numerous medically incapacitating conditions that had previously been largely overlooked. In 2001, Drs. Bauman and Spungen established the VA's Rehabilitation Research and Development National Center of Excellence for the Medical Consequences of Spinal Cord Injury, where Dr. Spungen recently tested a new bionic walking assistance system that enables individuals with paralysis to stand, walk and climb stairs.

At the National Cemetery Administration, Ronald Walters, VA's Acting Deputy Under Secretary for Memorial Affairs, has implemented a series of innovative management practices that have contributed to high performance ratings as assessed by next of kin, while simultaneously tackling the growing need for burial space. The cemetery administration received a score of 96 out of 100 in the 2013 American Customer Satisfaction Index – a score 28 points above the federal agency average and nearly 22 points higher than the average private sector score. Improving customer service is vital to repairing VA's reputation and enhancing healthcare quality. Mr. Walters's leadership is a bright spot at VA, and shows that positive and lasting change is achievable.

Employee Satisfaction and Morale at VA is Declining

Many great VA employees like Dr. William Bauman, Dr. Ann Spungen, and Ronald Walters are succeeding despite low morale and decreasing employee engagement. Over the last several years the VA has struggled to achieve high levels of engagement among its employees. This is a critical issue; disengaged employees have lower productivity, higher rates of attrition and provide lower-quality customer service. If VA is to build and maintain a high-quality workforce and develop a reputation as an employer of choice in the highly competitive healthcare field, it will need to devote resources and leadership attention to improving employee engagement.

Each year the Partnership and Deloitte publish the *Best Places to Work in the Federal Government* rankings. The rankings quantify and analyze employee satisfaction levels across government, provide measurable indicators of employee satisfaction and commitment, and offer an important tool by which Congress and the administration can hold agency leaders accountable for the health and performance of their workforces. The Partnership uses data from the FEVS to rank agencies and their subcomponents according to an overall *Best Places to Work* index score. In 2014, VA's index score was 54.6 out of 100, its lowest level since the Partnership began the rankings in 2003, and VA ranked 18 out of 19 large agencies in employee satisfaction.

The Partnership and our partner, the Hay Group, are able to analyze FEVS data to determine the most important factors in an individual agency that contribute to employee satisfaction and engagement – what we call the "key drivers" of employee satisfaction. The key drivers of employee satisfaction at VA in 2014 were effective leadership, pay, strategic

management and employee skills-mission match, in that order. VA ranked near the bottom of the large agency rankings in the category of effective leadership (18 out of 19) and last in satisfaction with pay (19 out of 19). The Department performed significantly better in the category of employee skills-mission match, which measures the extent to which employees feel that their skills and talents are used effectively in the workplace (7 out of 19) and marginally better in the category of strategic management, which measures the extent to which employees believe management ensures they have the necessary skills and abilities to do their jobs and is successful at hiring new employees with the necessary skills to help the organization. VA ranked 12 out of 19 large agencies in this category, but saw its score decline by three points in 2014 to 52.0 out of 100. The fact that agency employees view strategic management as a key driver of their workplace satisfaction indicates that the ability of the agency to recruit and retain the right talent has a significant impact on employee satisfaction.

Diving deeper into VA's FEVS data shows a more troubling picture. Only 34.3 percent of respondents believe their work unit is able to recruit people with the right skills, while slightly fewer than half believe the skill level in their work unit has improved in the past year (49.9 percent). Especially concerning for the Department's ability to retain younger talent is that satisfaction among VA employees under 40 declined by 8.9 points in 2014. The decline was even steeper at the Veterans Health Administration, where satisfaction among employees under 40 fell by 9.9 points from 2013 to 2014. Additionally, according to OPM's FedScope database, the percentage of employees under 40 quitting the VA increased slightly over the last five years, despite decreasing government-wide. These declines are particularly troubling because just four years ago, a report by the Partnership and Deloitte entitled, *Best Places to Launch a Career in the Federal Government*, found that new employees under 30 years old at VA had the highest levels of satisfaction in government among their cohort. Since 2009, VA has experienced a higher rate of employees of all ages leaving the agency through resignation as opposed to retiring, a troubling workforce dynamic that goes against trends at many other federal agencies. Overall, quits and retirements at both VA and VHA have risen every year since 2009. While some departures can be good for the department, presenting an opportunity to bring in new skills and reshape the workforce, the department needs a clear picture of who is leaving and why, and should ensure that top performers are incented to stay.

II. Recommendations

Some of the challenges VA faces are unique to the agency, while others are common across government. Fortunately, there are many things VA can do to improve. The recommendations that follow focus on three primary areas where I believe VA can make positive change: streamlining and re-centralizing certain aspects of the hiring process, standardizing onboarding practices across VA, and increasing retention through a focus on employee engagement.

Reform the Hiring Process

The VA has a number of tools to recruit and retain medical professionals, including education loan repayment programs for employees in scarcity occupations, tuition reimbursements, fellowships and internships, and employee education programs, several of which Congress expanded last year with the passage of the *Veterans Access, Choice, and Accountability Act of 2014*. While these tools are useful, they do not address many of the VA's underlying recruitment and retention challenges. The decentralized nature of VA's hiring means that while the VA recruits and hires a large number of individuals to fill positions, it does not recruit strategically and does not recruit to build the workforce it will need to address future challenges. This is due in part to the considerable workload of HR staff in individual VA facilities, a dearth of training in workforce planning and lack of access to workforce planning resources. Many VA medical centers leave the recruitment of highly-specialized staff such as doctors and psychologists to HR staff who are responsible for filling many other positions – not just medical professionals – and who may not have the training, resources or technology to effectively recruit needed talent. Further, this decentralization means that rigorous and comprehensive workforce planning does not take place, and leads to a focus on local recruiting that prevents VA from addressing specific occupational shortages in the places where they may exist.

- **Take an enterprise-wide approach to hiring –** The decentralized nature of VA hiring means that individual VA medical centers are responsible for conducting their own recruitment and hiring. By creating a centralized resume bank and streamlining the application process to require job seekers to apply to the VA only once to be considered for similar positions across the organization, the agency can reduce frustration for applicants and increase opportunities for qualified individuals to get in the door. The Partnership's and Booz Allen's 2013 report, *The Biggest Bang Theory: How to Get the Most Out of the Competitive Search for STEMM Employees*, highlighted NASA as an agency that uses this strategy to acquire STEMM talent. Applicants for positions at the agency apply just once and can be considered for a position in any NASA facility. NASA's ten centers around the country coordinate with one another in reviewing applications, which has also made it easier for the agency to vet candidates. Applications are considered three times in the course of a year without applicants having to reapply. Such an approach could also increase the availability of qualified candidates to VA facilities in rural areas by expanding the overall applicant pool.
- **Develop agency-wide hiring metrics –** To continue to improve the hiring process, VA must be able to measure and hold itself accountable for improvement. There are three sets of data which the Partnership believes are key to understanding VA's progress: 1) time to hire, disaggregated for internal and external hires, 2) manager satisfaction with the quality of applicants and new hires, and 3) applicant satisfaction with the hiring process. VA should ensure this data, as well as relevant information gathered from entrance and exit surveys, is being collected consistently and used to make improvements to the hiring process to make it not only more applicant-friendly but to make sure the agency is getting the best talent. Per VA Directives 5004 and 5006, employees already have the opportunity to complete entrance and exit surveys to share their reasons for joining or leaving VA. These

surveys offer potential vehicles for collecting data on these key metrics and for better understanding why certain classes of employees, such as medical professionals, are choosing employment at VA or choosing to go elsewhere.

- **Sharing certification lists for mission-critical talent** – Senators Jon Tester and Rob Portman and Representatives Gerry Connolly and Rob Wittman are expected to re-introduce the *Competitive Service Act*, which would streamline the federal hiring process and allow agencies to recruit and hire top talent more easily – a particularly valuable tool for hard-to-fill or mission-critical positions like nurses and medical officers. The bill would allow a federal agency to review and select job candidates from another agency's list of applicants who have already undergone a competitive assessment process and are certified as eligible for selection. Such authority would allow greater flexibility for the VA to hire medical professionals from agencies such as the Department of Defense, the National Institutes of Health, and the Department of Health and Human Services, which also have large numbers of applicants with healthcare backgrounds.
- **Allow federal agencies, including VA, to rehire former employees at any position for which they qualify** – Currently, former federal employees who have left federal service may be non-competitively reinstated in the federal government only to a job at or below the grade level they last held. This means that medical professionals who have left the VA and gained valuable higher-level experience outside of government may not be considered for non-competitive reinstatement to a position above the grade level for which they would otherwise qualify. It is in the interest of the government and the public to allow agencies to have the option to reinstate former federal employees, particularly in mission-critical and shortage occupations, at any level for which they qualify as a way to encourage experienced employees to re-enter federal service.
- **Create a truly market-sensitive pay system for government** – The *Department of Veterans Affairs Health Care Personnel Enhancement Act* was designed to make compensation for VA healthcare providers conform more closely to market salaries for those occupations. However, VA still struggles to compete with private sector compensation for medical professionals, particularly in hard-to-find specialties. While system-wide average VA salaries are largely in line with national averages, this masks huge regional variations that hinder the ability of some medical centers to remain competitive. The Partnership's and Booz Allen's 2014 report, *Building the Enterprise: A New Civil Service Framework*, laid out a new pay-setting process that would compare federal and nonfederal salaries and benefits on an occupation-by-occupation basis, set salaries based on those comparisons and give agencies the flexibility to bring in the talent they need at the appropriate level. While this framework should be enacted government-wide, VA is a great example of an agency that could benefit from a fully market-based approach to pay.
- **Hold VA leaders accountable for identifying workforce needs and helping the agency recruit and hire the very best talent** – Agency leaders should be responsible for ensuring their agency identifies strategic workforce needs and has a plan in place to meet current and future needs. Executives, along with supervisors and managers, should be held accountable in their performance plans for hiring and

developing the next generation of talent. VA also needs to ensure that HR staff and hiring managers are trained in the use of the hiring tools available to them.

Standardize the Onboarding Process

Hiring the right talent is only the first step to building a high-quality workforce. Just as important is ensuring that new employees are onboarded effectively. The Partnership's and Booz Allen's 2008 report, *Getting On Board*, found that government lacks a comprehensive, enterprise-wide onboarding process that goes beyond the transactional aspects of onboarding, such as filling out paperwork, to a strategic view of onboarding that emphasizes the vision and mission of the agency and extends through the employee's first full year on the job. Research by the Partnership and others has shown that effective onboarding can improve employee performance, increase employee engagement and retention and reduce the time it takes for an employee to become fully productive. While the Partnership did not study VA specifically in our report, many of the challenges and solutions we identified were common government-wide. I believe the following recommendations will help VA integrate and acculturate new talent more effectively.

- **Develop a comprehensive VA-wide onboarding strategy –** We recommend creating a robust agency-wide onboarding plan to ensure new employees receive the support they need to be successful. Effective onboarding programs introduce new hires to the agency's mission and connect them to strategic organizational goals. Other key parts of the onboarding program include clearly defining roles and responsibilities, providing points of contact for new employees to answer questions, assigning sponsors and mentors to new employees, involving senior leaders in the onboarding process, and tailoring programs to meet the needs of specific groups and levels of employees. To the extent that these activities are not already part of the agency's onboarding program, integrating them into current VA onboarding activities is a straightforward way to improve employee retention. In addition, VA should measure employee satisfaction with the onboarding process and use the results to make continuous improvements.
- **Strengthen the probationary period for new supervisors –** Many supervisors in government are selected for their technical expertise, rather than their leadership skills, and have little incentive to manage effectively. To fix this, managers at VA should be required to make an affirmative decision to pass a new supervisor through their probationary period – the period during which the individual must demonstrate successful performance as a supervisor – only if he or she has exhibited the necessary management capabilities, in addition to possessing technical qualifications. Managers should also be held accountable in their performance plans for providing feedback to new supervisors throughout the probationary period and for making a decision whether the supervisor should continue on after the probationary period has ended. The Committee has already taken a step in this direction with H.R. 1994: the *VA Accountability Act of 2015* and I thank Chairman Miller and the members of the committee for their leadership on this issue.

- **Provide opportunities for employees to work and collaborate across the organization** – VA should, to the extent possible, provide opportunities for new employees to meet and learn from colleagues in other parts of the organization and in different functional areas. This may include rotational assignments or cross-team projects. Promoting collaboration from within is an effective way to build relationships among employees and can help to address criticisms of the VA as "insular" and "stovepiped". Such opportunities would allow employees to be more effective in their jobs through a better understanding of the roles of different offices and functions within the larger VA organization.
- **Focus on onboarding for senior executives** – Thanks to their knowledge, tenure and experience, senior executives play an outsize role in the success of the VA enterprise. Federal agencies, including VA, should work with Congress to provide onboarding that includes opportunities for new executives to collaborate and build relationships. This onboarding should provide executive mentors so there is a safe space to discuss challenges and problem-solve with experienced, external executives. Content of the onboarding program should be tailored to meet the VA's and executives' needs. The program should also include opportunities for new executives to learn about the various department operations (HR, IT, budget) that will be critical to their success and to participate in action-learning projects to put their collaboration and problem-solving skills into practice to improve the Department's management and operations. New senior executives should solicit feedback from direct reports, peers and supervisors to assist them in continuous improvement (360 degree assessments, for example). Finally, the VA should implement and continuously review results of its onboarding surveys to ensure the program is effective at preparing senior executives to succeed.

Fully Engage to Retain Talent

The best retention strategy for any agency is to keep its workforce engaged. Satisfied and committed employees are an essential ingredient of a high-performing organization and a necessary part of attracting and retaining top talent. High levels of engagement lead to greater discretionary effort from employees and better customer service – two components of quality healthcare. Congress and the Department of Veterans Affairs should work together to implement the following recommendations to improve employee engagement at VA:

- **Hold VA leaders accountable for employee engagement** – Effective leadership is a key driver of employee engagement. The VA, unfortunately, performs poorly in this measure. Change needs to start at the top with Secretary McDonald and his leadership team. Agency leaders and managers must own and drive employee engagement efforts in order to address key issues in the workplace and increase agency performance. Evaluating leaders on their performance, as measured by improvements in a variety of workplace areas, can establish leadership investment in the process and achieve better outcomes. Many high-performing agencies, including the U.S. Patent and Trademark Office, the Department of Transportation,

and the Nuclear Regulatory Commission, have found this to be an effective strategy to improve employee engagement. We are pleased the Committee included language in H.R. 473, the *Increasing the Department of Veterans Affairs Accountability to Veterans Act of 2015,* to hold VA's leaders accountable for taking steps to improve employee engagement. This reinforces recent guidance by the administration on *Strengthening Employee Engagement and Organizational Performance.* I encourage the Committee to codify this requirement and to follow up to ensure that engagement remains a priority for VA's leadership this year and in future years.

- **Require the Office of Personnel Management to report Federal Employee Viewpoint Survey data by occupation** – The 2004 National Defense Authorization Act required federal agencies to conduct annual surveys of employee satisfaction, and over time OPM has assumed this role on behalf of the agencies. The survey results are an excellent oversight and accountability tool for Congress and agency leaders, but there is more that can be done to ensure that survey data is collected in a way enhances decision-making by Congress and agencies. Specifically, Congress should codify current practice and require OPM to conduct the survey on an annual basis, which will lead to greater efficiency and easier comparison of data across agencies. Congress should also require that OPM report data from the survey by occupation to the extent feasible in order to allow VA and Congress to better understand the views of medical professionals. Such information would allow for the tailoring of policy and oversight to this specific, critical segment of the VA workforce.
- **Invest in training and hold supervisors accountable for managing employee performance** – According to data from the Office of Personnel Management's 2014 Federal Employee Viewpoint Survey, just 26.3 percent of employees at VA agree with the statement, "In my work unit, steps are taken to deal with a poor performer who cannot or will not improve". Supervisors are often reluctant to make difficult performance distinctions. Some fear litigation when they hold poor performers accountable. Others are not adequately trained to deal with performance issues. Managers should be required to receive necessary training in how to effectively motivate, manage and reward employees, and how to deal effectively with poor performers. They should also be held accountable in their performance plans for taking action to address poor performance or misconduct.
- **Hold political appointees at VA accountable for their performance** – Career employees undergo an annual performance appraisal process. Political appointees should be similarly required to have annual reviews and be held accountable for their performance and contributions to the goals of the organization.
- **Permit VHA doctors to travel to and attend conferences** – Employees are engaged when they believe their agency values their development. The most evident expression of that appreciation is investment in the training and professional growth of employees through attendance of professional conferences and high quality trainings. This is particularly critical for medical professionals who use conferences as an opportunity to learn from others in their field, share research findings, build reputations in their field, and grow their professional networks – activities which help them to become better healthcare providers and burnish the

reputation of the VA. Congress should ensure that medical professionals do not face undo difficulties in participating in these gatherings, while also providing the oversight to make sure taxpayer funds are used responsibly.

Chairman Benishek, Ranking Member Brownley and Members of the Subcommittee, thank you for this opportunity to share the views of the Partnership on this important issue. I look forward to continuing to work with the Subcommittee on finding ways improve VA's recruitment and retention of qualified medical personnel to serve our veterans.

MERRITT HAWKINS
an AMN Healthcare company

STATEMENT OF RECORD PRESENTED TO

THE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITEE ON HEALTH OVERSIGHT

HEARING ON THE ABILITY OF THE DEPARTMENT OF VETERANS AFFAIRS (VA) TO EFFECTIVELY RECRUIT, ONBOARD AND RETAIN QUALIFIED MEDICAL PROFESSIONALS

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May 15, 2015

Overview:

I would first like to thank Dan Benishek, M.D., Chairman of the Committee of Veterans' Affairs Subcommittee on Health, for the opportunity to submit this statement of record concerning the ability of VA healthcare facilities to effectively recruit and retain qualified physicians and other medical professionals.

Merritt Hawkins is the largest physician search and consulting firm in the United States, carrying out over 3,100 physician and advanced practitioner search assignments annually for healthcare facilities located in all 50 states. Established in 1987, Merritt Hawkins is a company of AMN Healthcare (NYSE: AHS), the largest healthcare staffing organization in the country and the innovator of healthcare workforce solutions.

Over the course of 27 years of providing physician search services to the healthcare industry, Merritt Hawkins has worked with VA healthcare facilities in all regions of the country. Most recently, we have partnered with VA facilities on physician or advanced practitioner search assignments at VISN 20, VISN 4 and VISN 23. We are currently the only permanent placement physician search firm that has a GSA number and is listed on 738X. We also have gained insight into VA physician staffing practices and challenges from Staff Care, which also is a division of AMN Healthcare and has filled thousands of temporary physician days on behalf of VA facilities.

In addition, we have worked with hundreds of other government sponsored or supported healthcare facilities where the physician recruiting dynamics are similar to those typically present at VA facilities. These include numerous Federally Qualified Health Centers (FQHCs), Indian Health Service (IHS) facilities, and Department of Defense facilities. Based on our extensive work with FQHCs, Merritt Hawkins was selected as the endorsed permanent physician staffing partner of the National Association of Community Health Centers (NACHC), the professional association representing FQHCs. In 2011, Merritt Hawkins was retained by IHS to perform two national surveys of its facilities examining physician recruiting practices, compensation levels, physician satisfaction and related issues.

Merritt Hawkins is nationally noted for its physician recruiting expertise and knowledge of the physician staffing market and has been retained to conduct research on these topics not only by the IHS but by a number of other organizations, including The Physicians Foundation, Trinity University, the Association of Academic Surgical Administrators, the North Texas Regional Extension Center (a program funded by the U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology), and The American Academy of Physician Assistants. Our Academic Advisory Panel, from which we draw guidance and expertise, includes Tom Lawley, MD, former Dean of Emory Medical School, Philip Pizzo, MD, former Dean of Stanford Medical School, Arthur Rubenstein, MD, former Dean of the University of the Pennsylvania School of Medicine. Michael Johns, MD, also a former Dean of Emory Medical School, sits on the Board of Directors of our parent company, AMN Healthcare.

Based on our knowledge of physician staffing and physician practice patterns, Merritt Hawkins' president, Mark Smith, was invited in July, 2012, to provide testimony before the House Committee on Small Business on the decline of solo and small physician practices.

In addition to our work with VA and other government sponsored facilities, we have worked with thousands of private sector healthcare systems, community hospitals, academic centers, medical

groups, urgent care centers, retail clinics, and other facilities. We therefore have an extensive background from which to draw in comparing the best physician recruiting practices of government facilities such as the VA to those of a wide range of other facilities in the private sector.

I will make such comparisons further in this statement but will first briefly address prevailing conditions in today's physician recruiting market.

Medical Professional Recruitment: Market Context

Physician and advanced practitioner recruitment takes place today within the context of a growing physician shortage. The Association of American Medical Colleges (AAMC) projects a shortage of up to 91,000 physicians by 2025 (see *The Complexities of Physician Supply and Demand*, Association of American Medical Colleges, March 2015). The shortage is being driven by a growing and aging population, advances in medical technology, and the increased availability of health insurance through the Affordable Care Act. Fueling the shortage is the fact that residency training positions for medical graduates have grown only incrementally over the last 18 years, as federal funding for physician training was capped by Congress in 1997.

As a result, patient access to physicians can be problematic in both the public and private sector. Extended physician appointment wait times for VA patients have been extensively documented in the news media over the last year. Such wait times are unfortunate and my understanding is that the VA is taking steps to address them. However, extended wait times are not the sole province of VA facilities.

In 2014, Merritt Hawkins completed its third *Survey of Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates.* The survey examines the time needed to schedule a new patient appointment in five medical specialties in 15 major metro markets. One of the few surveys to quantify patient access to physicians, the survey has been cited numerous times in national media outlets and healthcare trade publications, often in the context of stories regarding long wait times for VA patients. All the metropolitan areas examined in the survey are characterized by a comparatively high number of physicians-per-population. It can be extrapolated that if extensive physician appointment wait times exist in these markets, wait times could be more extensive in markets where there are fewer physicians per population.

The chart below shows average wait times to schedule a new patient appointment with a family physician in the 15 metro markets examined in the survey:

Wait Time in Days to Schedule a New Patient Appointment With a Family Physicians in 15 Metro Markets

City	Shortest Time to Appt.	Longest Time to Appt.	Average Time to Appt.
Boston, 2014	12 days	152 days	66 days
Boston, 2009	6 days	365 days	63 days
New York, 2014	14 days	38 days	26 days
New York, 2009	6 days	61 days	24 days

Atlanta, 2014	1 day	112 days	24 days
Atlanta, 2009	3 days	21 days	9 days
Seattle, 2014	3 days	129 days	23 days
Seattle, 2009	2 days	14 days	8 days
Philadelphia, 2014	1 day	98 days	21 days
Philadelphia, 2009	3 days	15 days	9 days
Los Angeles, 2014	1 day	126 days	20 days
Los Angeles, 2009	1 day	365 days	59 days
Houston, 2014	1 day	178 days	19 days
Houston, 2009	1 day	29 days	17 days
Denver, 2014	1 day	62 days	16 days
Denver, 2009	1 day	45 days	14 days
Detroit, 2014	1 day	74 days	16 days
Detroit, 2009	3 days	31 days	14 days
Wash., D.C., 2014	1 day	62 days	14 days
Wash., D.C., 2009	3 days	365 days	30 days
Portland, 2014	3 days	45 days	13 days
Portland, 2009	3 days	16 days	8 days
Miami, 2014	1 day	56 days	12 days
Miami, 2009	1 day	25 days	7 days
Minneapolis, 2014	1 day	30 days	10 days
Minneapolis, 2009	2 days	23 days	10 days
San Diego, 2014	1 day	17 days	7 days
San Diego, 2009	1 day	92 days	24 days
Dallas, 2014	1 day	10 days	5 days
Dallas, 2009	1 day	27 days	8 days
Total, 2014	**2.87 days**	**79.3 days**	**19.5 days**
Total, 2009	**2.47 days**	**99.6 days**	**20.3 days**

As these numbers indicate, average family physician appointment wait times exceed 14 days in ten of the markets, and equal or exceed 21 days in five of the markets. In other markets with fewer physicians per capita, it is likely that wait times may be more protracted. VA facilities face a variety of patient access issues typically not faced by private sector facilities, including a patient base that may have more limited options for care to choose from than private sector patients, and a patient base that has special needs relating to post-war physical and mental trauma that only VA facilities may be able to address.

Another characteristic of the physician recruitment market, in addition to provider shortages and the extensive physician appointment wait times they can generate, is increased competition for physicians and advanced practitioners, including physician assistants (PAs) and nurse practitioners (NPs). In the past, hospitals were the principal recruiters of physicians, whether recruiting for their own staffs or on behalf of independent practices.

Today, a proliferating number of sites of service are competing for a limited pool of physicians, PAs and NPs, as healthcare delivery transitions from a hospital based model to an outpatient and "convenient care" based model. Thousands of urgent care centers, ambulatory surgery centers, retail clinics, FQHCs, free-standing emergency rooms, major employers, and insurance companies are actively recruiting physicians, along with more traditional types of employers, including hospitals, hospital systems, academic medical centers, and government facilities such as the VA.

The type of physicians that VA facilities historically have been able to recruit, including active military and former military physicians, are increasingly being contacted and recruited by a wide range of private sector facilities.

The market for physicians therefore is highly competitive and recruitment activity is as intense or more intense than Merritt Hawkins has seen in our 27-year history. In its *2015 Survey of Final-Year Medical Residents,* Merritt Hawkins determined that 63% of physicians in their final year of training received 51 or more job solicitations. Close to one half (46%) received 100 or more job solicitations.

Due to this competitive climate, it is important for healthcare facilities to have a strategic recruiting plan, to accurately forecast their needs, to be nimble and responsive, to offer competitive incentives, an attractive work environment, and, of most importance, to bring a consistent sense of urgency to the recruiting process.

VA Facility Recruiting Methods and Challenges

In our work with VA facilities, Merritt Hawkins has encountered several recurring, serious challenges that have impeded our ability to recruit medical professionals, challenges which the VA may wish to consider.

The first and most important is the recruiting process itself, as administrated by the various VA facility human resource departments. As referenced above, a sense of urgency and the ability to be agile is critical in today's physician recruiting market. Physician, PA, and NP candidates being sourced by the VA typically also are receiving job offers from many other organizations. The great majority of VA facilities with which we work are handicapped by the prolonged time needed to process candidates who have been selected for VA employment through security and other bureaucratic requirements. Processing times at VA facilities to receive clearance on hiring candidates often can run as long as six months. By contrast, efficiently run private hospitals typically turnaround the same level of paperwork in no longer than four weeks. In the private sector, this process often occurs concurrently with the recruiting process.

These waiting times do not include the process required to approve candidate interviews before a job offer is made. The process to approve candidate interviews may be channeled through four or five individuals who have a variety of duties and may not appreciate the urgency of approving physician interviews quickly. In Merritt Hawkins' experience, it may take up to three months to schedule two to three interviews for the same position. It also may be difficult for candidates to submit required information, and their applications may be rejected for lacking certain basic information without the candidate's knowledge. They simply do not hear back and assume they did not get the job.

A key part of the problem in Merritt Hawkins' experience is that VA facilities tend to follow the same recruiting process for all types of personnel. The same HR systems and processes used to recruit an

administrative support position are used to recruit a neurosurgeon, though the urgency of recruiting a neurosurgeon may be considerably greater than the urgency of recruiting other positions. As a third party, Merritt Hawkins is unable to contact VA HR personnel to help facilitate interviews or help ensure candidates have the information they need to make a decision. Moreover, the same person at the VA managing the recruitment of administrative personnel also may be managing the recruitment of highly trained medical professionals, when the skill sets required for these two disparate tasks vary considerably.

Without an efficient, timely method for screening, credentialing and responding to candidates, the VA is losing well qualified and motivated physicians and other professionals to employers who do have such systems in place.

This is particularly unfortunate as the VA offers a style of practice that is appealing to many of today's physicians. The VA typically offers set hours, generous vacation times, the security of government employment, an absence of reimbursement and other practice management challenges physicians face in the private sector, freedom from the stress of malpractice and a rewarding sense of mission. Many physicians are not aware of this, as a stigma about VA practice still is prevalent among some doctors, but these perceptions can be overcome. Indeed, ***none of the key physician recruiting challenges facing the VA are related to an inability to persuade candidates to accept VA employment.*** The key challenges lie in candidate sourcing and processing.

Resource Allocation

In our experience, the VA also is investing considerable resources in acquiring the services of temporary physicians, known as locum tenens. While locum tenens physicians can be a vital part of the overall medical staff (Merritt Hawkins provides locum tenens staffing through its sister company, Staff Care) it can be counterproductive to continually use what is an interim solution to address a long-term priority. The current system allows for considerable flexibility for each VA facility to budget for locum tenens staffing resources. Millions of dollars can be spent on temporary staffing services when it is extremely difficult to obtain approval for a $25,000 investment to recruit permanent physicians to the same positions.

Compensation and Incentives

It also may be necessary for the VA to allocate resources to enhance physician compensation packages. In the private sector, base salaries for primary care physicians, including family physicians and internists, average approximately $200,000, not including signing bonuses, production bonuses, relocation allowances, and benefits. At VA facilities, compensation for primary care physicians varies, but can be considerably less than what is common in the private sector.

While VA physician salaries may never equal those to be found in the private sector, and it is not necessary that they do so given the other incentives the VA can offer, it is important that they at least be competitive in today's evolving physician market. It also is necessary to communicate effectively to candidates that VA opportunities have advantages that make them attractive even if salaries are not always commensurate to those in the private sector.

Contracting Issues

VA and other government contract set-asides for small businesses have been in place for decades and are admirable in intent and often in execution. However, it has been found that in some endeavors results can only be achieved through contractors that have the most robust resources and the most comprehensive expertise. Production of high-priority, high-tech weapons systems, for example, frequently is allocated only to those contractors with the broadest capabilities and experience.

Small-business set-asides are particularly prevalent in VA staffing, and in many cases only small businesses can submit requests for proposals (RFPs). These companies then seek to fill openings through a model in which temporary candidates are expected to opt to become permanent employees, but seldom if ever do. This is in part because staffing companies benefit more when temporary clinicians choose not to accept permanent positions.

Because such companies do not have the resources to fill multiple VA assignments, they frequently contact Merritt Hawkins and seek to sub-contract with us. This only adds an unnecessary layer of engagement and expense to physician staffing projects. One VA facility which has received widespread media attention for long patient appointment wait times continues to operate this way, most likely unaware that other options could be more effective.

Conclusion

In closing I would like to state that while the institutional challenges the VA is facing in physician and advanced practitioner recruitment are daunting, they are not confined to the VA. Academic medical centers and increasingly large and consolidated healthcare systems in the private sector also struggle with implementing streamlined systems for processing physician candidates. The first healthcare facilities to do so are the most likely to achieve consistent recruiting success, which is attainable even in today's rapidly evolving healthcare system.