S. HRG. 116–466

RECRUITMENT, RETENTION AND BUILDING A RESILIENT VETERANS HEALTH CARE WORKFORCE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

SECOND SESSION

JULY 1, 2020

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

45–059 PDF WASHINGTON : 2021

COMMITTEE ON VETERANS' AFFAIRS

JERRY MORAN, Kansas, *Chairman*

JOHN BOOZMAN, Arkansas	JON TESTER, Montana, *Ranking Member*
BILL CASSIDY, Louisiana	PATTY MURRAY, Washington
MIKE ROUNDS, South Dakota	BERNARD SANDERS, (I) Vermont
THOM TILLIS, North Carolina	SHERROD BROWN, Ohio
DAN SULLIVAN, Alaska	RICHARD BLUMENTHAL, Connecticut
MARSHA BLACKBURN, Tennessee	MAZIE K. HIRONO, Hawaii
KEVIN CRAMER, North Dakota	JOE MANCHIN III, West Virginia
KELLY LOEFFLER, Georgia	KYRSTEN SINEMA, Arizona

CAROLINE R. CANFIELD, *Staff Director*
TONY MCCLAIN, *Democratic Staff Director*

C O N T E N T S

WEDNESDAY, JULY 1, 2020

SENATORS

WITNESSES

APPENDIX

RECRUITMENT, RETENTION AND BUILDING A RESILIENT VETERANS HEALTH CARE WORKFORCE

WEDNESDAY, JULY 1, 2020

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

The Committee met, pursuant to notice, at 3:07 p.m., in room 106, Dirksen Senate Office Building, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present: Senators Moran, Boozman, Cassidy, Rounds, Tillis, Sullivan, Blackburn, Tester, Brown, Blumenthal, and Sinema.

OPENING STATEMENT OF CHAIRMAN MORAN

Chairman MORAN. Good afternoon. Thanks, everyone, for your patience waiting for my arrival. Perhaps you had no choice, but I appreciate the attitude that—I just came from the Indian Affairs Committee, where both Senator Tester and I are members. And before I came here, I wanted to make sure that I spoke.

The Indian Affairs is having a hearing on COVID–19 pandemic and its consequences in Indian and Tribal Country, and I wanted to make certain that we made clear the role that the Department of Veterans Affairs is playing in trying to make certain that individual Tribal members and Tribe communities are cared for.

Senator Tester and I have had weekly conversations by phone with the Secretary and often with Dr. Stone, and almost in every week's telephone conversation, we discuss what the Department of Veterans Affairs is doing to help assist in regard to the health care needs of Native Americans.

Good afternoon, everyone. Thank you very much for joining us. The Committee will come to order.

Here in this hearing, we are to discuss Veterans Health Administration's workforce and resources the VA uses in recruitment, in retention and resiliency——

[Audio distortion.]

Chairman MORAN. I knew my words were important and would be repeated many times.

First, I want to thank the 350,000 employees of VHA for the hard work they do day after day to care for our veterans. That occurs in easier times than this, but it occurs always. I have met a number of these professionals since being a Member of Congress and have always admired their dedication to the mission of helping veterans. In many cases, they are helping other veterans.

We know that in many instances, these men and women who work at the Department of Veterans Affairs are going above and beyond to help provide our veterans with the services and health care needs that they deserve.

This is especially true as our frontline VA health care workers fight against COVID–19. I was inspired by the story of Gary Kramer, an intensive care unit nurse at the Dole VA medical center in Wichita. Gary has gone the extra mile in caring for his patients suffering from COVID–19, offering up his own phone so patients could connect with loved ones unable to be by their side during their final days.

VA health care workers serve our veterans because they believe in the mission, and that is exactly the kind of person that we want to have serving those veterans. But as we know, the VHA has a number of vacancies, including 27 occupations listed as critical shortages by the Office of the Inspector General. These shortages of critical positions strain the rest of the workforce and make it tougher for them as they care for our veterans.

Reducing these vacancies must be a priority for the Department so that dedicated providers like Gary have the people and other resources around them to deliver the consistent, high-quality care that our veterans deserve.

Recruiting providers is challenging for everyone in the health care industry, but I worry that the VA is limited in its ability to compete with the private sector due to salary restrictions and bureaucratic hiring practices.

For health care providers, the VA does have authority to set pay based on market conditions in specific areas. One of the challenges, which we frequently see in rural areas, is that the qualified applicants are not in that market. The VA really needs to adjust the pay to attract doctors and nurses from other areas of the country.

I hope to hear more from our witnesses today how VHA can accomplish that and what our Committee can do to help.

Additionally, we often hear from hiring managers that it takes too long to hire good people. VHA's current hiring model for doctors and nurses allows for 34 days from closing a job announcement to issue a tentative offer of employment. It could take another 45 days from that initial offer to conduct the credentialing and privileging, background check, physical, and drug test before the new employee

can actually start working. If another area hospital provides an offer sooner and has a quicker onboarding process, that doctor or nurse may not be able to wait for the VA process.

I hope to hear more from our witnesses today on how this hiring model compares with practices in the private sector, including any additional requirements that the VHA faces.

I also want to hear more about how VHA has been hiring during the pandemic because I know, I understand—the Secretary has indicated this many times—the VHA alone has hired over 20,000 employees in the past 3 months. That appears to be more than double the number hired in the first 3 months of this year.

In our Budget hearing last month, Secretary Wilkie noted that many of these new employees were hired much more quickly than traditional processes allow for, and I am very interested in what changes VHA has made during the pandemic and which of those changes can be used to improve the hiring process on a permanent basis.

Again, I thank our witnesses for joining us.

I now yield to the Ranking Member, Senator Tester, for his opening remarks.

OPENING STATEMENT OF SENATOR TESTER

Senator TESTER. Well, thank you, Mr. Chairman, and I also want to thank the tech people in the room because the first part of your——

Chairman MORAN. Jon, just a suggestion. It seems odd for me asking to be able to hear you, but if you would speak into your microphone or turn up the volume.

Senator TESTER. I will get closer. I was just saying the same thing about you. I want to thank the tech people because they fixed it in the last couple minutes of your opening statement. I could hear it very well. The first part not so good, and I assume that it was a glorious statement as always. But I can hear you now, which is good.

Dr. Lieberman, I want to start by thanking you and your team for being here today. I also want to thank the VA frontline employees for all they have done to care for veterans and nonveterans alike during this pandemic, especially now as, once again, the VA case count is surging and staff are being pushed to extremes.

The staff, from providers to housekeepers to schedulers, are truly the backbone of the VA, and they work hard every day to make sure that veterans get the access to high-quality health care that they have earned.

I want to commend the VA for its success in quickly and efficiently hiring thousands of new staff during COVID-19. It use to

take 90 days to get a new employee in the door, and in the meantime, we lost some potential good employees because somebody else swept them up. So for the VA to bring on new staff not in 72 days but in 72 hours, 3 days, that shows what the agency is actually capable of when it sets itself to the task, but it should not take a pandemic for the VA to be able to fix some of its internal hiring processes, when many of the challenges, I think, could have been made years ago. And if they could not have, you can tell me why.

Over the years, Congress has given the Department numerous hiring authorities, and my concern is that the VA is dragging its feet when it comes to implementing them. Some of these authorities are several years old, and the VA has yet to put them to use.

Beyond that, the VA needs to make itself the employer of choice for health care professionals, and the first step of that is ensuring staff, current staff is feeling supportive. Think about it if you were out and going to go get a new job, and they offered you a job. The first people you would talk to, either before the interview or after, would be the people who work in that facility, and if they are not happy, we are not going to get the employees we need.

Quite frankly, we have got great employees within the VA. We just need more of them, and we need to retain them. The good ones we have got because they are, like I said before, the backbone of the VA.

One of the things about making the staff feel that they are wanted and supported is to guarantee they have access to PPE and testing that they need to be able to do their job safely, and VA leadership must recognize the sacrifices that staff are making by providing retention incentives and hazard pay when appropriate. I would also like to see the Department expand scholarship and training programs to help with recruitment and retention, especially in high-need areas like the rural parts of our country. We know that when a student trains at the VA, they are more likely to return and go to work at the VA. So recruiting and retaining staff also means treating the workforce with respect, listening to their concerns, and acting on them.

So we need the management to understand that because, quite frankly, when it comes to health care issues, those folks that work for the VA, for the vast majority of them, they are the best, and quite frankly, if we treat them as they need to be treated, as this pandemic continues to look like it is going to expand in many parts of this country, we will be well set up to deal with it.

Quite frankly, I look forward to your testimony, and I look forward to the questions that are going to come after that because we have got a number of things to talk about as this surge is upon this country.

Thank you, Mr. Chairman. I appreciate the opportunity.

Chairman MORAN. Senator Tester, thank you very much.

Now let me turn to our witnesses. Let me introduce the witnesses from the Department of Veterans Affairs. Dr. Steven Lieberman is the Acting Principal Deputy Under Secretary for Health at the Veterans Health Administration. He is accompanied by Ms. Jessica Bonjorni, the Chief of Human Capital Management at VHA. We also have Ms. Victoria Brahm, the Director of Veterans Integrated Services Network 12, joining us today. Thank you all very much, as I said earlier, for being with us. Thank you for the insight you can provide.

Dr. Lieberman, you are recognized for your testimony.

STATEMENT OF STEVEN L. LIEBERMAN; ACCOMPANIED BY JESSICA BONJORNI, AND VICTORIA BRAHM

Dr. LIEBERMAN. Good afternoon, Chairman Moran, Ranking Member Tester, and Members of the Committee. I appreciate the opportunity to discuss the Veterans Health Administration recruitment, retention, and hiring efforts during the COVID–19 pandemic. During this unprecedented challenge and transformational time in U.S. health care, VA is proud of the unparalleled dedication and resilience of our workforce.

From the front line to senior leadership, we are unified in our mission to deliver excellence for the more than 9 million veterans who entrust us with their care. We are also honored to serve as the backstop to the Nation's health care system, responding beside our Federal partners.

Having served Americans in 46 States and the District of Columbia through our Fourth Mission, we have provided expert consultation, testing, personal protective equipment and ventilators to community entities. Over 2,000 VA personnel raised their hand to deploy into areas of the Nation severely affected by COVID–19.

Recruiting and retaining top professionals has been our priority for the duration of the response. We hired more than 23,000 staff, 85 percent of whom are permanent employees, while decreasing the onboarding time from several months to as little as 3 days. We stayed ahead of increasing demand for care by quickly launching national hiring campaigns through amplified use of social media, targeting positions in highest demand. More than 4,700 nurses, 800 physicians, and 1,400 housekeepers joined our ranks.

VA has long been a leader in interdisciplinary team- based care. We enhanced the COVID–19 readiness of our clinical teams by empowering clinical staff to work to the top of their licenses, by augmenting role-based training, and by rapidly and exponentially expanding telehealth across the enterprise.

As in other VISNs, while COVID–19 cases were surging in the community, an inpatient bed capacity was in high demand. Ms. Brahm in VISN–12 led the cross-training of ambulatory care nurses and the construction of extra negative-pressure rooms. VISN–12 also activated a mobile medical unit for contingency purposes. These efforts exemplify our principles as a high-reliability and learning organization, where newly identified models of care are rapidly and effectively implemented across our health care system.

To recognize exceptional efforts of staff, VISN leaders offered retention incentive awards and special contribution awards. Our successful surge hiring was built in a foundation of human resources modernization achieved before the pandemic, whereby VHA consolidated more than 140 facility human resources offices into 18 VISN-level shared services, eliminating bottlenecks.

With the pandemic onset, we employed our existing flexibilities to reduce the hiring timeline and leveraged our capacity across the enterprise to optimize resources. We established an integrated staffing command cell to drive accelerated hiring and manage deployments of staff to affected areas of the country.

The Office of Personnel Management offered tremendous support enabling us to expedite our onboarding model by expanding our ability to hire noncompetitively and encouraging retired Federal employees to return to service using pay flexibilities.

While we are just passing the 90-day mark for many of these processes, our hope is to continue building on these improvements as we define the new normal. Congress' continued support for the recruitment and retention of talent to care for our Nation's veterans is vital.

VA being granted additional flexibility with the CARES Act allowed us to waive pay limitations for employees during the national emergency. The unique challenges and impacts of this can weigh heavily on even the most altruistic and dedicated of individuals.

We have been committed to support our employees' needs to face these times with resilience, and leaders at all levels of the organization have been working hard to support their teams emotionally and spiritually. We are succeeding.

Absenteeism rates have stayed consistently lower than average, and our retention rates remain stable. During these unique times, we are committed to providing excellence for those in our care. Our greatest asset is our talented mission-driven workforce.

We look forward to working with this Committee to maintain VA's ability to hire quickly and eliminate barriers to attracting and retaining top talent.

This concludes my testimony. My colleagues and I are prepared to answer any questions you may have. Thank you.

Chairman MORAN. Dr. Lieberman, thank you very much, and thank you and your colleagues for being here, as I said earlier, but especially for your care and concern evidenced by your statement, by your testimony for those who served our Nation. I appreciate your willingness to do so.

Let me start with a question for you, Dr. Lieberman. So my understanding is that VHA's goal for 2020 in the budget was to increase its workforce by 13,000 employees. I understand that VHA has hired over 20,000 employees since the end of March. Would you tell me how these two things fit together? How much of that increase in hiring is due to meeting the needs during a pandemic, and how much of that hiring is just more routine? Additionally, how does the 13,000 than fit into the 20,000 that you have for the goal, and how is the retention at least to date?

Dr. LIEBERMAN. Thank you, Mr. Chairman, for that question.

It is very important for us right now with COVID to continue to build that workforce to care for our veterans with their ongoing medical issues. Certainly, our veterans have 31 percent more diagnoses, more complications from those diagnoses, and we feel it is really important to continue to stay focused on staffing up as we continue to meet the surges from COVID.

We also continue to focus on replacing our priorities in areas such as mental health and women's health and a variety of other topics.

I will turn to Ms. Bonjorni to provide more details related to your question.

Chairman MORAN. Ms. Bonjorni?

Ms. BONJORNI. Yes, sir. So that hiring activity that you mentioned earlier is a great accomplishment, but we also have to keep in mind that we still have people who leave on a regular basis as normal turnover. So we did see a net increase in onboards for the fiscal year of upwards of 8,000 staff, and about two-thirds of that net increase happened since the end of March. So that expedited hiring and real focus made a big difference in our increases, and we do anticipate seeing continued increases for the rest of the year.

Chairman MORAN. I mentioned in my opening statement about the expedited hiring, the process. How much of that can continue on actions of the VA, or are there legislative changes required to allow the VA to continue to hire on an expedited process?

Dr. LIEBERMAN. So we are committed to moving forward to maintain as many of these improvements as we can. We have been so pleased with how we showed that this organization could literally

turn a ship rapidly when we needed to, to stay ahead of this COVID wave.

We are still just 3 months into this process, and so we will be paying close attention to this, making sure there are no unintended consequences to some of these improvements we have made, and we certainly are prepared to come back if we need any support from the Committee to share with you what that is as we do this assessment moving forward. We are just not ready to ask for that today.

Chairman MORAN. Ms. Bonjorni, I want to understand how the VA matches its patient needs.

Dr. Lieberman, I can address this question to you, and you can pass it around, if you would like.

But the MISSION Act was, in part, designed because of a strategic planning portion to try to get the VA to match its hiring practices with what the strategic plan showed the professionals needed by the patient, to match the patient's needs for their care with who we are hiring. Is that yet ongoing? The MISSION Act is relatively new. Is there sufficient strategic planning to make certain we are hiring based upon the needs of veterans?

Dr. LIEBERMAN. So we are continuing to pay attention, even with COVID going on, to every aspect of the MISSION Act and keeping track of where things are moving.

Certainly, with COVID coming along, it does make us want to take a step back and just make sure that nothing has changed as a result of this, as a result of how we are serving our veterans and what the priorities are as a part of our Fourth Mission. So we are continuing to look at that, but we definitely want to look even closer if there needs to be any changes in our strategy moving forward.

Chairman MORAN. I will turn to Senator Tester following this follow-up.

Is there sufficient implementation of a strategic plan that now would allow the VA to make decisions, hiring decisions based upon a plan, or is that something we would expect in the future? And if so, what kind of timeframe?

Dr. LIEBERMAN. So it would be sometime in the future, and it would be hard to commit to a timeframe today because of the uncertainty of COVID and the influence that that will have on our health care system and the national health care system.

Chairman MORAN. The follow-up to my follow-up is you did express the importance of strategic plan and following the MISSION Act, and I appreciate that. I share that view, and I was pleased to hear you say it.

Senator Tester?

Senator TESTER. Thank you, Mr. Chairman.

Dr. Lieberman, thank you for being here to talk about VHA workforce issues.

Obviously, the number 1 thing that is on everybody's mind right now is COVID–19, including the VA's, as we see cases surge nationally.

In April, the VA had to move to PPE austerity measures due to global shortages and could not guarantee that every VHA employee had a mask. Tell me right now who gets a mask?

Dr. LIEBERMAN. We currently have adequate PPE—and, certainly, this is something, as you know, is just of critical importance to us as we move forward with the COVID, and we maintain a focus on the number of PPE. We even have every different type. We look across the country. We talk about it every day.

Senator TESTER. My question is, though, Dr. Lieberman, who gets a mask and how often right now?

Dr. LIEBERMAN. We are still following the CDC guidelines. It has not changed. For anybody who is working where there is a potential for aerosolization of COVID, they would get the N95 mask. Other employees would be eligible to get the surgical mask, depending on where they work.

Senator TESTER. Do you anticipate with this surge that the VA will have to bring back any of the austerity measures that they had brought back earlier in April?

Dr. LIEBERMAN. We have really had a laser focus on this and continue to acquire PPE, and we believe that we will have adequate PPE moving forward.

As of today, we have enough PPE to last us at least 30 days, and that number continues to grow.

Senator TESTER. OK. That was my next question. So you are at 30 days right now. I am sure that you guys have run some projections on the surge because in parts of this country, it has gotten pretty crazy, quite frankly. You feel confident that you are going to be able to grow that PPE stockpile even while the surge is going on?

Dr. LIEBERMAN. We are focused on many different avenues for how to procure it, whether through the Federal Government, on our own, manufacturing of PPE. We are looking at opportunities with DOD, and so, yes, we believe we will stay ahead of it.

The beauty of the VA, as you know, is if there is a location of the country that is feeling pressure because of increased COVID, we can rapidly adjust and move our PPE around the country. That is one of the benefits of our health care system.

Senator TESTER. OK. As the Chairman pointed out earlier, he and I have conversations with the Secretary and Dr. Stone with some regularity, and they have talked about they are going to be

reopening different regions, different VA facilities, at different moments of time. Has the surge impacted the reopening plants?

Dr. LIEBERMAN. Yes, it has. Just as in the private sector, we focus on what is called the "gating criteria," and basically, we are keeping a close eye. So, certainly, if there is a surge, that leadership in that area will take a close look at that of what they have increased and certainly decide whether they should continue along the pathway, hold, or move backwards.

Senator TESTER. So what I would ask is this. If it has changed your plans for reopening—the surge, I am talking about—could you inform the Chairman and myself and anybody else on this Committee that wants it what those changes are?

The reason I ask that—and the Chairman will ask it from a Kansas perspective—is Montana was going to be opened up. We have seen cases increase greatly in Montana. We have not seen hospitalizations increase greatly, which is bad and good news, I guess, but if you could keep us informed on how the surge is impacting your reopening plans, we would very much appreciate that. Is that a possibility?

Dr. LIEBERMAN. Absolutely. Just again to reiterate, we will see a veteran if they have an urgent issue, if they have a time-sensitive issue.

Senator TESTER. I gotcha. But overall from a planning standpoint, it would be great to know what is going on and where you guys see the hotspots impacting the VA, only for the reason that we are here to help. I mean, this Committee is here to help you do your job. So more information is better.

I have got a few seconds left, but I will kick it back to you, Mr. Chairman.

Chairman MORAN. Thank you, Senator Tester.

Senator Boozman?

SENATOR JOHN BOOZMAN

Senator BOOZMAN. Thank you, Mr. Chairman and Senator Tester, again for having this hearing. I want to commend you all and your staffs that have worked so, so very hard in such a difficult time to make it such that you are able to come up with some flexibility and really do a great job of hiring people, as was desperately needed.

The VA, the bureaucracy—not only the VA. Just the government in general makes those things very, very difficult, as we all know, but working with OPM, what you did was remarkable.

Ms. Bonjorni, the VHA was able to reduce the hiring timeline for over 90 days down to, in some instances, 3 days. Again, I want to commend you in doing that.

During a recent interview on May 19th, you stated that you were able to do this by delaying the verification of new hires' education, medical license, medical references, drug testing, and other verification requirements. Some verification steps were given 3 months to be completed after being hired.

While I understand the need for hiring people quickly, as is done in the private sector, during the pandemic, we also want to ensure patient safety. So can you reassure us the steps that were taken are being taken to make sure that those expedited hires are qualified?

Dr. LIEBERMAN. Thank you, Senator.

So this is something we are paying close attention to.

First of all, let me assure you that we have not seen any untoward events occurring in our health care system to date. We also have not had to remove any clinical staff that we have hired under this expedited process.

We are following the Joint Commission processes for urgent privileging, and we do check three items right up front. And we make sure they have an active license. We check a reference, and one that I think is particularly helpful is we go to what is called the National Practitioner Data bank. And there, we can see if an applicant has had a payment with a malpractice suit, if they have a history of criminal activity or civil action against them related to health care, whether they have been denied an appointment to a health care program, State or Federal, whether there has been an action taken against their license by, again, State or Federal. So this is something we are paying attention to.

If we were to see any warning signs either during the application process or even following, we would take a very immediate look at what was going on with that individual and pull them away from patient care while we do a further investigation. This is really important to us, so we are taking a close look at this.

Senator BOOZMAN. Oh, good. Well, we appreciate that reassurance very much.

Under the CARES Act, Congress granted the Secretary a great pay flexibility. In your testimony, you highlight how helpful this pay flexibility was to recruit and retain your health care professionals. We understand VHA is utilizing existing pay authorities to provide recruitment and retention incentives for providers as well as examining additional potential authorities. What flexibilities does VA need, if any, that they currently do not have, that currently do not exist? How can we be helpful?

Dr. LIEBERMAN. Thank you.

Ms. Bonjorni?

Ms. BONJORNI. Sure. So the CARES Act has allowed us to waive a variety of pay limitations. The one that is most frequently been used thus far is the waiver of the biweekly premium pay limit, and I will just remind everyone that we are still in the middle of the year. And so most people are not going to come close to hitting up against their aggregate or annual pay limits, but we do expect that we are going to use more of those waivers as the year goes on while we are responding to not just the COVID pandemic but other simultaneous emergencies such as weather events and fires. So as we proceed down this, we expect that number of waivers will increase.

There are some flexibilities around our ability to offer incentives that are still somewhat restricted, and that is something we are exploring now to make sure that we have all the flexibilities we need for future emergencies.

Senator BOOZMAN. Good. We appreciate that.

Again, follow up if we need to do something in that regard.

Thank you, Mr. Chairman.

Chairman MORAN. Thank you, Mr. Chairman.

Senator Brown is recognized.

SENATOR SHERROD BROWN

Senator BROWN. Great. Thank you, Mr. Chairman. Thank you, Chairman Moran and Senator Tester. I appreciate that.

Yes, we know we are here to discuss the VA's workforce, those on the front lines. The workers at VA facilities caring for veterans are so important. We always thank them, but we do not pay them like we thank them.

A grocery store worker in southwest Ohio said to me, "You know, they call me essential, but I am really expendable because they do not pay me a decent wage. And they do not protect me on the workforce." And I just want that never to be said about the Veterans Administration.

Last month when Secretary Wilkie testified, I will say it again to you all that I urged VA to find a way to negotiate in good faith for VA employee unions. Veterans know they get better care if employees know their concerns are addressed when union representation is at the table. So I will urge you again to do that.

Building off earlier comments from the previous questioners, Chairman Moran and Ranking Member Tester and Senator Boozman, I want to talk for a second about vacancies and hiring.

Dr. Lieberman and Ms. Bonjorni, VA has shortened time to hire from about 90 days to 3 days, as we talked. During the pandemic, that is obviously amazing and should be commended.

As of the last vacancy report, VHA had about 47,000 vacancies. Walk me through, putting aside as much as you can, the pandemic, what you are going to do to fill those vacancies going forward, if you would walk through that.

Dr. LIEBERMAN. First, I just want to point out that an empty position does not mean a gap in care. We have ways to provide care via contingency plans. We have resource hubs around the country that provide care, can fill in if there is a gap, either face-to-face or via telehealth. Many of these positions are predictable, where somebody moves to a different position within their own organization or moves to a different facility, retirements, and so we are always planning for these with contingencies. Certainly in rare occasions, there are gaps in coverage, but those are actually unusual.

We also have vacancies from growth in positions. So we have—for example, right now we are planning to open a precision oncology program, and that requires new positions. So that gets added to this number.

Ms. Bonjorni, do you want to add to that?

Ms. BONJORNI. Sure. I will add that in the hiring that we have done so far in response to the pandemic, we have seen a higher number of temporary employees hired. We do anticipate that we will convert over a large number of those into full-time hires.

But we are also seeing some trends across the broader health care industry that will certainly impact the VA. As you are aware, other health care systems are laying off staff, are furloughing them, and so that may make us easier to convince people that we are an employer of choice, where we can offer greater job security and they might turn to look at VA as an employer.

So we do anticipate we will continue that hiring surge as we go forward using all the flexibilities we have already been granted.

You may be aware also that we are using incentives to retain the staff that we have on board in many areas where there is fierce competition. So we can target that at our key occupations and in our high cost-of-living areas.

Ms. BRAHM. If I could add, from the field perspective, we have been aggressively hiring because we want to make sure that no matter what the future holds for us, we are going to be able to support our veterans and give them the care that they deserve as well as support the Fourth Mission in the community.

Having Chicago in my VISN, we have gone through an initial pandemic. We had high rates of the COVID virus and were able to proudly not only serve our veterans but help the community at large.

We were able since March to increase our workforce by 9 percent, about 1,600 employees. Now we really not only want to continue

aggressively hiring but also retain those employees. So we have implemented a program where we have already shown over the course of a year, we were able to decrease RN—we had a turnover rate of about 16 percent in our RNs by instituting what we call "Stay in the VA" and stay interviews at incremental times during the RN, the new RN stay, 30, 60, 90 days. We have different levels of management meeting with them. How can we do better? What are we doing right? What makes you want to stay? Why are you here to serve? And we found that in the course of a year, we were able to reduce the turnover rate by 50 percent. So not only are we aggressively hiring, but we want to retain and make sure that we do have the staff that we need.

Senator BROWN. I wanted to ask one more question, if I could, to Ms. Brahm.

A lot of us, Senator Tester especially and I, are interested in pandemic premium pay for workers, and that is obviously people that work directly with patients. But it is also custodians and security guards. It is grocery store workers. It is bus drivers. They are not government employees, not VA. We are trying in the package that Senator McConnell has shown little interest in so far and the President seems to be mostly unaware of to provide premium pay paid by government up to $10,000 through the course of a year.

Talk, Ms. Brahm, if you would, about how many medical center directors are providing any kind of incentive pay or premium pay where they limit it to RNs and doctors. Do they include screeners and janitorial staff and others? What are you thinking, and what have you done so far, Ms. Brahm, about that?

Ms. BRAHM. Thank you so much for raising that question, Senator. I would love to answer that.

We are very much focusing on housekeeping, medical support assistance, all of the other employees that really make our care happen. We realize this is not just nurses and doctors, even though they are integral to what we do for our patients. It is the whole team.

So, in fact, we are not only using incentive retention awards across the board for both—all levels of employees but also special contribution awards across the board for those employees as well. VISN–12, every single hospital in VISN–12 is using that type of reimbursement at this time.

Dr. LIEBERMAN. And that is our approach across the country, Senator.

Senator BROWN. Thank you. Thank you all.

Senator Moran, thank you for your indulgence there.

Chairman MORAN. Senator Cassidy?

SENATOR BILL CASSIDY

Senator CASSIDY. Great. Hey, thank you all. Thank you for your service to our veterans and to our country.

I want to continue on this. I am looking at a spreadsheet. I wish I could show it to you, but one of my staff did excellent work pulling this up. And it is from some of the reporting requirements required for the MISSION Act.

It shows the average amount of turnover from Q3 2018 to Q2 2020, and it looks like the average turnover is probably about 33 percent. Walla Walla, Washington, is like 49 percent. I am not looking at it, but I remember seeing that was near 50. Big Spring, Texas, is at 50 percent turnover. New Orleans, Alexandria, Shreveport, my home state, those have anywhere from 25 to 30 percent turnover.

And that is not really the picture I had gotten from your testimony, but if you are having 25 to 50 percent turnover in an institution, that is incredible. Can you just kind of comment on those numbers from that MISSION Act reporting?

Dr. LIEBERMAN. Ms. Bonjorni?

Ms. BONJORNI. Sure. I would be happy to speak with you about the numbers in particular, but not having that massive spreadsheet in front of me, I cannot say to those specific locations.

Across our system, however, our turnover rate has stayed consistent for the past decade at around 9.5 percent——

Senator CASSIDY. Now, that is not what this—this is, by the way—this is VHA medical facilities, and this is something you provided. I apologize. If I had forethought, I would have had it posted for everybody to look at. But there is like no place with lower than 20 percent.

Now, this is all personnel. This is not just professionals, and I have another document which shows that for professionals, it is reported all the way from the physician down to the x-ray tech, not to diminish the x-ray techs, but just to say the range of education required, that that is lower.

On the other hand, it seems a little counterintuitive because it seems like professionals have more options than folks who might not have professional degrees.

So are you speaking, ma'am, just of the professionals, or are you speaking across the board?

Ms. BONJORNI. I am speaking across the board. Our average turnover is 9.5 percent. When we look at specific occupational areas, we see slightly higher numbers in certain areas. So housekeepers, for example, or medical support assistants or other food service workers, entry- level occupations, generally have higher turnover.

Our physicians and nurses, though, tend to trend—physicians stay around that 9.5 or 10 percent, and nurses lower, more closer to 8 percent turnover.

Senator CASSIDY. OK. Well, this is from your quarterly report, the MISSION Act reporting requirements in a table, the questions for the 2020 annual document. So maybe that should be a question for the record because it really seems to be a disconnect between that which is reported and that is what you are telling us. OK.

Dr. LIEBERMAN. Senator, we would be happy to get back to you about that.

Senator CASSIDY. Yeah. OK, that is fine.

Now, the other thing, the last time when we had a conversation, the statement was made that the time from the job offer to the onboarding has been greatly compressed.

But a couple years ago—so I am going to explain this and see if you can give me—if this is still the case. A friend who is a physician told me, "You know, I knew my nurse practitioner was leaving in 6 months, but I was not allowed to advertise for the position until she had left. So then when I advertised, it took me a process of hiring. We had to advertise. We knew she was leaving. She left. Then we had to advertise for a certain period of time, and then we had to onboard." So I think he said it was a year and a half between the time which he knew she was leaving until she was actually replaced.

So I guess my question is there are three segments to that. You know she is leaving. Then you advertise the position, and then you onboard once you make an offer.

I think I heard you specifically speak of the onboarding process. What about those previous two segments? You know they are leaving, and then the position is open. And you are now advertising for that.

Ms. BONJORNI. Yes, sir. So the data that we have been reporting, when previously it was referenced that our average time to hire was upwards of 90 days, that is a measurement from the time that you validate the need to make a hire. So that should have been from when you were notified a person was leaving until they actually come on board. So that encompasses all the steps of the hiring process.

The individual case you referenced, that sounds like they were not pulling that process, and we have certainly made clear as we have improved our time to hire that that is not a process we are following across the system.

Senator CASSIDY. So one more time, because I am almost out—I am out—on forbearance. If I know that—I am a physician, so I am going to speak as if I am the physician—that my nurse practi-

tioner is leaving in 6 months, I can begin to advertise to fill that position before she has actually left?

Ms. BONJORNI. Yes.

Senator CASSIDY. OK. Well, thank you very much.

I yield.

Chairman MORAN. Doctor, thank you.

Senator Blumenthal?

Senator TESTER. Mr. Chairman?

Chairman MORAN. Senator Tester?

Senator TESTER. With Senator Cassidy's consent, of course, could we get that spreadsheet, and then could we get the Department's response to that spreadsheet? I think this is really an important point, and I would love to see it. And I would love to see the Department's response to find out what is going on.

Senator CASSIDY. My staff member who did the great work on this is watching. I am going to ask him to send it to SVAC staff right now, and maybe it can be shown to folks now. And please send to Senator Tester's staff as well, speaking to my folks who are listening.

Chairman MORAN. We will accept that offer, and our staff looks forward to getting the report that you were describing.

Senator Tester, that is a very good idea. Thank you.

Senator TESTER. Thank you.

Senator CASSIDY. Thanks, Mr. Chairman.

Chairman MORAN. Senator Blumenthal?

SENATOR RICHARD BLUMENTHAL

Senator BLUMENTHAL. I am deeply concerned along with my colleagues about the spread of COVID–19 among veterans. I understand that the number of active cases has doubled in the last month, and that 1,574 patients have died along with 39 VA employees. Over 50 percent of VA acute care and ICU beds are occupied at present. I think those numbers are right. They are alarming, and what they indicate as well is the need for proper protection, PPE, which is financed in the CARES Act.

I am hearing from employees of the VA all over the country, my colleagues and I are, about the need for more PPE. I know these complaints are not new to you.

I am also hearing about the number of hours worked by VA employees, and I join Senator Tester and Senator Brown in expressing the view that these employees, all of them, deserve hazard pay.

The CARES Act waived the pay caps to allow frontline VA workers to work overtime, as you know, but I think more has to be done. I am in favor of the hazard pay provisions under the CARES Act for VA frontline workers. The kinds of hazardous duty pay that

it contemplates are well deserved. VA employees are putting themselves at risk every day to fight this virus.

So my question is, Dr. Lieberman, do you have data on which VA employees have exceeded the pay limitations provided under the CARES Act, and how many have?

Dr. LIEBERMAN. Ms. Bonjorni?

Ms. BONJORNI. Certainly. Looking at just the data for the first month that we were able to use the authority, we had upwards of 150 employees who exceeded the biweekly caps, and we are still waiting for the most recent month's data. So, again, that is a biweekly cap because we are early in the year. We anticipate more people will start to hit the cap as the year goes on.

Senator BLUMENTHAL. 150?

Ms. BONJORNI. Yes, sir.

Senator BLUMENTHAL. And you said for the first month?

Ms. BONJORNI. Yes.

Senator BLUMENTHAL. What dates does that——

Ms. BONJORNI. That is from mid April to mid May.

Senator BLUMENTHAL. Mid-April to mid-May. So presumably, you have more data from mid-May to mid-June?

Ms. BONJORNI. Yes, that I do not have yet.

Senator BLUMENTHAL. When will it be available?

Ms. BONJORNI. It should be within the next week or so.

Senator BLUMENTHAL. 150 sounds low, does it not?

Ms. BONJORNI. Yes.

Senator BLUMENTHAL. OK. Well, I would appreciate you providing that data as soon as it is available.

The second area I would like to ask about, the Office of Accountability and Whistleblower Protection. You know that the VA Office of Inspector General released a report at the end of last year that found systematic problems within the Office of Accountability and Whistleblower Protection. These issues concern the failure to hold senior-level executives accountable, the failure to conduct unbiased investigations, lack of transparency, failing to protect whistleblowers from retaliation.

A number of us wrote to Secretary Wilkie, and in response, he said, quote, " quality control team would review all whistleblower retaliation cases that were closed without action during OAWP's first 2 years."

Now, there are about 175 whistleblower retaliation cases that need to be reviewed. Can you provide an update as to the review of those cases?

Dr. LIEBERMAN. I do not have an update today, but I certainly can ask the agency to get that for you.

Senator BLUMENTHAL. Can you tell us how the VA decides whether or not to implement a recommendation action by OAWP?

Dr. LIEBERMAN. I can just speak on behalf of VHA. Certainly, we review closely what they recommend, consider it. It goes up to senior levels and take it under serious consideration and then make a determination if we believe what they recommend is consistent with what the facts show from our standpoint.

Senator BLUMENTHAL. My understanding is that the VA has closed only 3 of the 22 recommendations from the OIG report. I do not know whether you have an update on those recommendations.

Dr. LIEBERMAN. I do not today.

Senator BLUMENTHAL. Could you provide that update along with the 175-case status?

Dr. LIEBERMAN. Certainly.

Senator BLUMENTHAL. To the extent you can. Thank you.

Thanks, Mr. Chairman.

Chairman MORAN. You are welcome, Senator Blumenthal.

Senator Rounds?

SENATOR MIKE ROUNDS

Senator ROUNDS. Thank you, Mr. Chairman.

First, let me begin by saying thank you for the work that you are doing. Thanks for working through some real difficult challenges during this pandemic time.

I would like to focus on a couple of specific issues with regard to South Dakota, and I would like to use them as an example of some concerns I would have elsewhere within the United States as well.

At the Fort Meade VA in Sturgis, which is in the western part of South Dakota near the Black Hills, there is a Title 38 recruiter who works in an office down the hall from the Black Hills health care system director.

Now, we are a small State. We have small facilities. It is not very far from one office to the next.

He used to report to that director, and they worked together to identify local needs and staff critical positions successfully.

But last October, the recruiter got rolled up under the VISN. So even though he knows South Dakota, knows our veterans, and has brought quality providers to some of the most rural parts of our State, I am told that now his hands are tied by red VISN tape. He cannot even walk down the hall anymore to discuss recruitment with the health care system director. Instead, he has to go through the VISN.

Am I missing something here? How does adding a layer of bureaucracy help anyone in the VA working on recruitment and re-

tention to close the gap in filling critical vacancies or to meet a time to hire metric?

If you would like to refer to either one of your team members, that would be fine.

Ms. BONJORNI. Sure. I could speak to the overall setup of our VISN H.R. modernization.

The concern that you raised, thank you for raising it, and it is not one that should actually occur. There is nothing that would prevent a recruiter from speaking directly to the medical center director that they work with. It is certainly possible that the situation you are referencing involves someone who has been assigned to support the broader VISN overall, and there might be someone else assigned to do local work for South Dakota. But we would continue to encourage that strong relationship with the recruiter and the medical center director leader. It just might be different people.

Senator ROUNDS. We are not a real big facility. If you have got a facility as small as that, I doubt there are multiple recruiters in one facility. If you are sitting in the facility and now you are going to go through VISN 23 which is basically out of Minneapolis, that would be, what, 7-, 750 miles away? So you are now working your way through another facility. I do not know exactly how large the Minneapolis facility is, but I can guarantee it is a whole lot bigger than what we have got in Sturgis.

And then to be able to somehow work through that to get back down to do what you were doing successfully before, it seems to me that you have added a layer of bureaucracy, which is not necessarily defensible, particularly when if the suggestion is that you are using a recruiter that is not at that location now, that somehow they are supposed to do a better job than someone who is already there and has successful done it, it seems to me that there is something missing in it.

And the reason why I am bringing it up is not just because it is one location, but because if the reorganization of this is to provide an efficiency, it seems to me that there may be some lacking oversight with regard to whether or not that efficiency would actually be working. And if it is not working in a small facility like that, I wonder what is actually going on, on the job, at other locations throughout the country.

And I would simply ask, can you follow up and find out whether or not the statements as I have shared with you are accurate, and second of all, if they are accurate, why we would not get back down to allowing a normal, more reasonable approach in a local region to exist?

Ms. BONJORNI. Yes, sir. I can absolutely commit to looking into that specific situation you reference, and then when we look at the

way the model is set up, there are some staff who are doing shared services work for the whole network. And then there are staff who are strategic business partners who are dedicated to that facility. So that did not actually change in the model. It sounds like we need to look into your specific case to figure out where the disconnect may have occurred.

Senator ROUNDS. And I thank you for that because it seems since fiscal year 2015, this Congress has literally authorized funding for about 35 percent more in terms of FTE to meet demand from 295,000 up to and authorized 357,500 fully funded for fiscal year 2021. And if we are going to do that, we need the most efficient and reasonable approach to actually getting these folks in place. If we have got a system that has been designed, but it may not be working as hoped for, I just hope there would be a reasonable expectation that modifications could be made to actually get the results we are after.

Ms. BONJORNI. Yes, sir. We share the same goals of making sure we have the most efficient and effective H.R. processes we can.

Senator ROUNDS. OK. And when would you be able to get back to us with this?

Ms. BONJORNI. Within the next couple of weeks, I anticipate, once we speak with the network.

Senator ROUNDS. Five, 6 weeks should be more than adequate?

Ms. BONJORNI. Yes, sir.

Senator ROUNDS. OK. Thank you very much.

Thank you, Mr. Chairman.

Chairman MORAN. Senator Rounds, thank you.

Senator Sinema?

[No response.]

Chairman MORAN. Senator Sinema, if you are there or join us, we will come back.

Senator Tillis?

SENATOR THOM TILLIS

Senator TILLIS. Thank you, Mr. Chairman. Thank you all for being here.

I want to go back and just do a quick mental math exercise. How many total employees do we have in VA health?

Dr. LIEBERMAN. About 352,000.

Senator TILLIS. OK. 350,000. And the average attrition rate, you said is 9 among documents? So it is 9 right on the average? Among nurses, it is 8? So I am looking forward to getting the spreadsheet, but I do not see how the math works. It would mean for non-doctors and non- health officials, you had an attrition rate of—if you extrapolated beyond these facilities of 40 or 50 percent. My guess

is if you had that, it would be something you would be well aware of. So I will be interested in seeing how we normalize those numbers for the benefit of the Committee.

I did have a question for Ms. Brahm. You cover Great Lakes, right? That is VISN–12?

Ms. BRAHM. Correct.

Senator TILLIS. OK. So that is a portion of Michigan, northwest portion of Indiana, Illinois, Wisconsin. You have got a good mix of rural and urban areas.

Tell me a little bit about how well you all have done with the COVID response specifically for any of the veterans that you are serving and, comparatively, if you know this, against your peer group in the private sector.

Ms. BRAHM. Yes. And thank you for the opportunity.

It has been really beneficial for us to have both regions because, as we were struggling with Chicago area, the Illinois area going through a massive surge, we were able to leverage from the Wisconsin side, the northern tier, to help us. So we were able to flex very quickly staff, PPEs, supplies, ventilators.

And when we did even come up to a point where we needed additional help, where not only was the private sector occupying ICU beds at a rate of 87 percent, we were able to get the region, so the entire Midcon region to help support us very quickly on the ground. That was amazing.

We also were able to very closely collaborate with our private-sector partners. We created triage systems, whereby when Mission Four was activated, even though we were under a surge ourselves, we were able to support the private sector in moving civilians into our hospitals and taking care of them.

The great thing about having both the remote and the urban hospitals are that you can activate in one hospital that is not suffering. For instance, Iron Mountain, Michigan, was able to help support us in the Chicago area. Madison, Wisconsin, at one point was able to support us in the——

Senator TILLIS. So you were able to do a lot of load leveling because there were clearly hotspots in other areas that were not.

At any point during the peak or do you fore see any—so looking back, at any point during the peak, were you out of beds, out of ventilators?

Ms. BRAHM. No.

Senator TILLIS. Out of PPEs?

Ms. BRAHM. We were able to create surge plans, and some of that was due to the ability of our engineers, our biomed people to create negative-pressure rooms.

Senator TILLIS. Were you ever out of PPEs?

Ms. BRAHM. No, we did not. We were able to cross- leverage and predicted. That was ongoing. Of course, we set up incident command, and we have had up to five meetings a day, consistent communications.

Senator TILLIS. Were there any instances where you were actually providing care to private sector logistically or through PPEs?

Ms. BRAHM. We did help. We were in daily communication with our State veterans homes and the contract nursing homes that take care of our veterans. We did supply——

Senator TILLIS. How well have the State veterans homes done? We have done a lot of work with North Carolina, with the State-run veterans homes, co-resident with some of our VA facilities. How well did they do compared to the facilities that you have with seniors?

Senator TILLIS. We had one that did phenomenally well, with no cases to date, and then others that needed not only PPE support, but some consultation in terms of how to set up COVID, non-COVID, and emergency response, especially of nursing personnel. So we were able to go into those homes and help them to help themselves. It was very much appreciated.

Senator TILLIS. Do you have any peer-level review of how well you all did within VISN–12 and how well that rough geography did within the private-sector health care response for seniors, congregate facilities, other ones?

Ms. BRAHM. I do not think I understand the question.

Senator TILLIS. So you have got congregate care facilities outside the VA system.

Ms. BRAHM. Yes.

Senator TILLIS. They had a crisis. It looks like they were a little bit later or behind the VA in implementing protocols. So I was kind of curious as to how well you all did as a health care facility for the VISN–6 as compared to the elderly and congregate care facilities in the private sector.

Ms. BRAHM. I think comparatively, subjectively, knowing we did open a Mission Four to take community care, nursing home patients from the private sector. So we did take those type of patients. We did, and we implemented our protocol very early. And we are very protective of our nursing home patients. So I think we did extremely well, comparatively.

Senator TILLIS. Mr. Chair, just in closing, I have done a little looking into this in VISN–6. I work very closely with my VISN director, the VA facility directors, and everything I see there, obviously we could always improve. But everything I see there is most likely a best practice for how to handle congregate care facilities in the private sector.

So I hope after we get through this, we share some of those best practices because I believe what we are going to find, by and large—there could be some exceptions in certain areas, but by and large, you as a national health care system probably performed more admirably than any other major health care system in the yesterday. And I thank you all for the work you did.

Thank you, Mr. Chairman.

Chairman MORAN. Thank you, Senator Tillis.

Now Senator Sinema?

SENATOR KYRSTEN SINEMA

Senator SINEMA. Thank you, Chairman Moran, and thank you, Ranking Member Tester, for holding this hearing today.

I also want to thank our witnesses for being here today.

In Arizona, the VA health system covers a lot of rural areas, and this represents an additional challenge to recruiting and retaining VA employees, and now with COVID–19 cases rising dramatically across our State, we are struggling to ensure we have enough staff to support the need. And, of course, that is critical.

So my question for Ms. Bonjorni is last week, I served as Ranking Member for a Homeland Security and Government Affairs Subcommittee hearing on the National Commission on Military, National, and Public Services' final report. This report identified agency culture as strongly contributing to hiring challenges.

In recent years, stakeholders and Congress have worried that many of those hiring barriers have prevented the VA from fully addressing its vacancy challenges, yet in the midst of a pandemic, the VA has hired nearly 20,000 new employees very quickly.

So what has this surge taught you about the culture of the VA around hiring? And how will you continue to build on this recent momentum?

Ms. BONJORNI. Thank you for the question, Senator.

Certainly, we have learned a great deal from our surge hiring efforts. I have not read the specific report that you reference, but certainly, when you look at any process, there are people who may be resistant to changing it. And sometimes the complexity of our hiring process makes it feel to the average user of the process that it cannot be changed.

I think what the pandemic showed us on our lofty goal that we push toward to get to a 3-day onboarding timeline was it made us very creative to think through what were the things that we could change and what help did we need.

It is unusual to have the level of support that we have had just among each other and from other Federal agencies. So we are really grateful to see the amount of collaboration that we had from

OPM and other partners to help us really think through how we could break down those barriers, and now we are starting to evaluate each one of those changes that we made and figure out how many days it shaved off of the process and how we can retain many of those changes.

I will note that we will not probably be able to retain all of them without additional support, either through legislative change or regulatory change.

Senator SINEMA. Thank you.

My next question is for Dr. Lieberman. The Commission report also noted specific challenges at the VA in filling open positions for health care professionals. The report recommended streamlining the hiring process by implementing a single personnel system, Title 38, for all health care providers and support staff at the VA, but stakeholders have expressed concern regarding moving away from the competitive service hiring system of Title 5. So what are the challenges and benefits of this recommendation for the VA?

Dr. LIEBERMAN. Senator, thank you for that question.

I would defer to Ms. Bonjorni, who really is the greatest expert here on this topic.

Ms. BONJORNI. Sure. Thank you.

When you look at perhaps prior testimony that we have given, we have expressed some of the challenges we have with having upwards of 120 different appointment authorities for new hires. It makes it very complex for H.R. professionals and for managers to understand how the hiring process works due to those complexities.

Having a streamlined process where there were fewer laws to learn, I think would be helpful for our staff, and having more flexibility all the time in our pay-setting policies would also be extremely helpful for us to continue to meet the needs of our hiring managers.

As we can see right now, the market is changing significantly. We do not know what the pay flexibilities might look like a year from now, given what the private sector is doing. We just need to be agile.

So if we had a system that was consistently agile, that would be something we would certainly be happy to discuss with you.

Senator SINEMA. Thanks.

My last question for you is how does the VA ensure local facilities have the flexibility they need to meet specific hiring challenges they face, like adjusting incentives and pay rates based on the high cost of living in certain areas?

So, for example, the Prescott area in Arizona has a high cost of living, but it does not qualify for the locality pay that Phoenix does.

So this has led to problems hiring and retaining positions such as housekeepers.

Ms. BONJORNI. Yes. We share that concern, and I think the way that pay setting works for both Title 5 GS employees and for wage grade employees, the pay-setting considerations are not the same across those different groups. An area like Prescott, in particular, faces a challenge just based on the number of people there and the number of people who work for the Federal Government and how those calculations occur.

What is within our control in the VA is to look at the use of incentives, so recruitment, relocation, and retention incentives, which we can use at any facility, regardless of geography, and so that is what we focus on.

In the future, if there are changes to how pay setting works for those different occupations, we definitely would be interested in talking about that.

Senator SINEMA. Thank you.

Thank you, Mr. Chairman. I yield back.

Chairman MORAN. Thank you, Senator.

All right. I think that may conclude those we think are with us remotely or certainly I can tell those who are not with us present, in person.

Let me see. Senator Tester, I have a series of questions I want to ask. Let me give you the opportunity to go first for a second round.

Senator TESTER. I appreciate that, although Senator Blackburn is on my screen. I do not know if she is out there or not.

Chairman MORAN. She is not, and I think if she was, we would hear from her.

Senator TESTER. OK. That is true.

Chairman MORAN. Thank you.

Senator TESTER. So, Dr. Lieberman, there have been plenty of examples in the private sector. There have been plenty of examples at VA. In times of health care crises, medical, mental, and physical well-being is important. How is the VHA addressing the issue of mental and physical well- being, and what resources are out there for our staff?

Dr. LIEBERMAN. Senator, I just want to make sure I understood. You are asking of our staff?

Senator TESTER. Yep, of your staff.

Dr. LIEBERMAN. Thank you.

Senator TESTER. Mental and physical well-being of your staff. Are there resources available to them? How are you addressing to make sure that you are——

Dr. LIEBERMAN. So thank you for that question. This is a really important issue at a time like this, and we have been focused on this really since the beginning of starting to see the numbers of COVID increase in certain parts of the country.

By definition, VA staff are resilient. They come to VA to work because of the special mission we have, and yet we have to pay attention to this.

One of the things is focusing on certainly our leadership. We expect them to—and we know that they are—following the principles of servant leadership where they really are there for the success of the employees, and a big part of that is the well-being of the employee. That is what we are hearing of what is going on in the field about being out there, getting out there, talking to employees, hearing what their experiences are.

We also early on focused on some of our national experts in mental health, in whole health, and the National Center for Organizational Development to give us ideas on how we could focus to make sure that our frontline staff as well as our leadership, which were truly also working 24/7, to making sure that every aspect of care was taken care of, had what they needed to be successful.

So we did provide a number of resources for them and tools and also had people available to talk to them, whether it was a chaplain or employee assistance program or the National Center for Organizational Development certainly would meet with leadership who really just wanted to have a confidential conversation with someone about the stress that they were experiencing and what they were going through as a leader.

I would ask if either of my——

Senator TESTER. I was going to redirect it to Victoria Brahm, anyway——

Dr. LIEBERMAN. Sorry. OK.

Senator TESTER [continuing]. Because I wanted to hear what her perspective is as being a director of VISN–12. What are you seeing as far as burnout, and do you think you have adequate resources to deal with the issue?

Ms. BRAHM. Thank you for that question. That is a very extremely important priority for us.

I am a big proponent of whole health, especially for—it is for our veterans and our employees. We have done multiple—we have implemented multiple strategies in that area. We have virtual stress relief. We have tai chi. We have yoga. We have created areas in the hospitals where our staff can go to rejuvenate, relax.

We have created areas where staff can come to vent, speak, either in listening sessions that are larger and psychologically safe

or in private practice like Dr. Lieberman has suggested with our mental health professionals.

We are moving forward also with increased communication. It is very important because a lot of anxiety is caused when you do not communicate. So we do virtual discussions very frequently with the staff not only across the VISN, but the directors do it in the hospital. And we share mantras and share stories about what is going on in the COVID epidemic, because what staff do not know tends to be sometimes worse than it really is, so really sharing what is going on, what are we doing as leaders, how are we helping you, and what do you think we need to be doing.

So actually with the implementation of whole health, with the activation of all of our mental health professionals, in looking for stress relief, and then in creating environments for psychological, safety, and listening sessions and constant communication, I think we have been able to manage.

I would just tell you that this staff is awesome. They have the resilience. I am shocked. We have very little coli strain, an epidemic that is very scary.

We have had—people come back that were retired. I have a nurse that came back after retiring after 40 years of service. She was an infection control person and came back over the age of 60. I can say that because I am too, but over the age of 60 that came right back into an epidemic and helped do intensive infection control surveillance.

I have a retired respiratory therapist who came back to activate a medical hospital on one of my hospital campuses. In case we ran out of room for ICU beds, we would be ready to activate a mobile hospital.

They are just awesome. Every day, I am amazed at the resilience.

And I have also worked with the military to do resilience training for our staff. So we have done quite a bit of military culturation and resilience training, which has seemed to have been very effective for the staff as well.

Senator TESTER. Thank you.

Mr. Chairman, I have one more question, if you will give me that flexibility.

Chairman MORAN. Please proceed.

Senator TESTER. OK. This is for Victoria Brahm again as director of VISN–12. Are you collecting from your frontline staff—are you collecting information on sufficient PPE and testing, both for the vets and for staff themselves? Are you collecting that information?

Ms. BRAHM. Absolutely. Twice a day. In an ongoing manner, we are looking at testing capacity. We want to make sure and guar-

antee that every employee that wants to be tested can be tested, and we have been able to achieve that. We want to make sure that if there are any PPE issues, we address them quickly, and as I stated before, we were able to leverage across the VISN. If we are not, we look at the regional level, and if we are not, we have had great support for the Central Office level.

At this point, since we have been able to lower the curve in my VISN, we are now trying very much to help other VISNs as well in the need for PPE, employees—I mean PPE, staffing, and equipment.

We are also working at the Milwaukee VA to start production. We have been working on laser cut shields, controlled air purifying respirators, and swabs, and we are in production now, not only to guarantee enough for our VISN but to share across the Nation.

Senator TESTER. I will yield back now, Mr. Chairman. Thank you.

Chairman MORAN. Thank you, Senator Tester.

I have a few questions, and then maybe we can conclude.

First of all, let me ask about funding. The hiring that has occurred in the last several months during the COVID pandemic was funded by Congress, by the American taxpayers with increases through the various phases, but particularly the CARES Act. When that money is gone—is that money being—what money is still available for hiring from the CARES Act? As we look at the next phase of spending on the pandemic, are there going to be needs for dollars for hiring to address COVID?

Dr. LIEBERMAN. Thank you for that question.

We thank Congress for the generosity to the Veterans Health Administration at VA from the CARES Act, and between that and our regular funding and our request for 2021, we expect to have enough funding.

Certainly, COVID is unpredictable in some ways, and so we may come back and ask to have the monies moved from one account to another. But at this point, we expect to be fine.

Chairman MORAN. So let me put that in, I think, the same words that you just said but make sure that I understand it. The money that was appropriated both in the regular appropriations process and in the various phases, the four phases of legislation that we have passed to date that provided money to the Department of Veterans Affairs for payment, of costs associated with COVID–19 and the pandemic, those dollars are sufficient? And unless things change, you would not expect a request for additional dollars?

Dr. LIEBERMAN. That is correct, Senator.

Chairman MORAN. Thank you.

Let me raise the topic of discrimination, particularly racial. What can you do to assure me that both in the hiring practices and in the daily work of the VA workforce that there is not discrimination based upon race or other factors?

Dr. LIEBERMAN. Thank you for that question, Mr. Chairman. This is something that is a very important topic to Dr. Stone and myself as well as the Secretary. Certainly, we have been hearing about concerns voiced at the VA in your home state.

We are taking a variety of different approaches to this. Number 1, for the facility in your State, we are planning to really listen a lot and find out about experiences that staff are having, and we certainly are doing this at other places across the country.

We also have developed a survey that will go out to staff, starting again at a facility in Kansas, to hear from staff, first line, what do they think is going on and what do we need to do to change.

Sometimes we in leadership just think we have all the answers that we know from reading textbooks, and I think at a time like this, we really need to make sure we take the time to listen to frontline staff what they have to stay. So that is what we are going through right now.

Additionally, even before the events of recent months, we felt that this was such an important topic in the Veterans Health Administration that we wanted to make sure that our workforce, both frontline, mid-level, and top-level staff truly reflected as much as possible the population of veterans that we cared for.

So we, Dr. Stone and I, had set up a group, advisory group involving a lot of people from the field, more people from the field than headquarters, and looking what are best practices out there with diversity and inclusion.

We spoke to health care systems such as the Cleveland Clinic and the University of Pennsylvania, non-health care systems such as Google, and based upon feedback from all these different organizations, this group advised Dr. Stone and I, gave us almost 50 recommendations on what we need to do to move forward.

So we have agreed to make this a priority and set up a new improved diversity inclusion office that will report directly to myself and Dr. Stone, and we are in the process of beginning the search for the individual that will head up that office.

This is really just the beginning of a journey we are on to make sure that we get this right moving forward.

Chairman MORAN. Thank you for your answer, and I appreciate the intentions of additional efforts in regard to this.

Ms. Brahm, something that I should know from your perspective as a medical center director on this topic?

Ms. BRAHM. Yes. Well, we also take this very seriously in the field, and as you know, there has been a lot of civil unrest. I feel like one of the major things that we are doing is working with our leaders and to develop resources on how to have these conversations, not only how to listen to what is actually the feelings that are out in the frontline workers, but how do you respond when it is a difficult conversation. So we have been working very much with our leadership on those kinds of things as well, as well as putting out mechanisms for our staff at the local level to be able to address their leadership when they feel there is this kind of behavior.

I have personally at the VISN level been receiving information from the staff at the hospital level. So we take it all very seriously, and anytime we do receive some kinds of concerns, we follow up on that. But mostly at this point, it is education. It is communication. It is the toolbox and how do you handle these kinds of situations.

And in addition, we have set up committees at the VISN level to monitor and look at this and to look if we do not have appropriate representation in our diverse workforce and what can we do about that. So we also are in a learning phase to do better.

Chairman MORAN. Thank you for your answer.

Perhaps Ms. Brahm, but it could be you, Dr. Lieberman. My experience has been that generally when we talk about employment at the VA, we think of those who are caring for patients. But I want to highlight the importance of the leadership, Ms. Brahm, your position, but others within the various VISNs.

The medical center director is hugely important in the way that a hospital cares for our veterans, and we have had—what is it that needs to take place to make certain that there is long-term stability in that position, in the position who is the medical center director in our medical hospitals across the country?

I do not know which direction to look. Dr. Lieberman is looking at you, Ms. Brahm.

Ms. BRAHM. OK. Here I am. Thank you for that question.

Having been a medical center director and now a new network director and been with the VA as a nurse for 39 years, I can tell you that our succession planning for these positions is critical, and we do a wonderful job of that.

But I think it is developing enough confidence of the leaders that we do have within the VA system to step up and take the role. I think they hear negative publicity sometimes. I think the job, it is very stressful. It is a senior leadership position. It has a lot of accountability.

But I think talking to people, as I mentor multiple people in the field that are leaders, part of what I do is try and develop their confidence to step up and take the role.

Chairman MORAN. I thank you for that answer.

Dr. Lieberman, I would tell you that at one of our hospitals, the medical center director, it is now filled by an interim, and it seemed like for a decade, we had the same medical center director. And then it has been a series of changes ever since then.

I just want to express to you the importance of having stability in that position, certainly stability with somebody who is good at their job, somebody that performs well, but they are seemingly—and I do not know how prevalent that is across the country, but my experience in Kansas, at least in one of our hospitals, is the directors seem to come and go. And that certainly diminishes my ability to develop the relationship that I think is helpful to me and hopefully to the center director but also, more importantly, to the patients and to the staff that work in that hospital. Am I missing something?

Dr. LIEBERMAN. We agree on everything there, Senator. This is so important, and certainly, it is important to hire right, to make sure we get the right person. A part of that is making sure you have the right network director who is also keeping an eye on this.

Sometimes we have to give incentives if we do not get the right applicant in a particular location, but we are aiming for somebody not to be there for a short time but to be there a significant amount of time, to develop the relationships with the veterans there, with the veterans service organizations, with the staff and their leadership. And that stability is critical to the success of any organization. So I agree with you.

Chairman MORAN. Thank you.

Let me raise the issue of the MISSION Act and maybe then a couple categories of people who do and could work more at the VA.

So the Choice Act, not the MISSION Act, but the Choice Act was originally passed for a number of reasons. There was a crisis going on within the VA it was intended to address, but one of the reasons that we supported and passed the Choice Act was to fulfill the ability for veterans to more quickly access care as a result of a shortage of health care professionals within the VA.

So at least from a congressional point of view and certainly from my perspective, a reason the Choice Act made some sense was the VA does not have the capability because of lack of professionals, employees, to meet all the needs of veterans, meet the demand, and therefore, let us bring in the community providers and give them the opportunity to meet those needs.

There were other reasons associated with the Choice Act, and in my world, the distance of travel for a veteran in rural Kansas is significant. So Choice became a significant opportunity to reduce that travel time.

Now we have the MISSION Act. How do you see the role of the VA and its hiring practices in determining—it goes back perhaps to the strategic plan that I was asking about earlier. How do we make certain that we are pursuing community care in the appropriate level at a time in which we are hiring more people in the VA? How do we know where the demand for those services is going to be, back related to that strategic plan that the VA is still developing?

Dr. LIEBERMAN. Certainly—and thank you for that question. Certainly, a big part of that are the market assessments, which unfortunately because of COVID, we have had to stop the face-to-face part of it. A lot of useful information, a lot of data was being reviewed. A lot of analyses were ongoing, and so that certainly was an important process. We hope to continue that as long as COVID does not escalate——

Chairman MORAN. Well, I understand that the implementation of the MISSION Act may not fall directly to you. The point I want to make is as we utilize community care to the level for which it is determined to be in the best interest of veterans, it has a consequence on what professionals and how many are needed inside the VA, internal employees, and how many contracts, how many opportunities we utilize community care. There is a relationship between the two. Does that make sense to you? Am I missing something or something I should know about that?

Dr. LIEBERMAN. No, it makes sense.

Chairman MORAN. OK. I want to mention a couple of professions specifically. One of them, of course, is mental health. It would be a mistake on my part if I did not raise the continued need for an increase in number of mental health providers in this country and the private sector, within the VA. They are in short supply.

One of the things that we have—let me start with a different example first. So even before the Choice Act, I was advocating back in my days of chairing the House Subcommittee on Health Care what we have in Kansas is community mental health centers, and they are groups of counties that generally at the local level, with some State support, provide mental health services across the State. But they are probably the only provider in most of rural Kansas. Many veterans in Kansas live in the rural parts of our State, and access to health care, particularly mental health care, particularly at a time in which suicide is so prevalent, timeliness matters greatly.

I just would again use this opportunity to express my belief in the value of what we call community health centers, which now should be contracted with. In the days in which I started this conversation, there was not the formal—there was not the MISSION Act, and there was not the Choice Act. But please make certain that those community mental health centers—I know this may be the third-party administrator issue as well. But please do not forget, at least in a State like ours, the folks in the community who provide mental health services can be of great value to the veterans who live in those communities.

Then I would highlight once again, as we have done before, about the importance of some of the professions, licensed professional mental health counselors and marriage and family therapists. There are opportunities for the VA to further hire outside the psychologist, the social worker, the psychiatrist, and there are other professions that the VA is not able to hire.

We have encouraged that to occur, particularly at a time in which there is such a shortage. There are those professions who are ready, willing, and capable licensed to provide mental health services that could be of value to our veterans. I am encouraging the VA to continue to pursue the hiring of those individuals, those professions.

Dr. LIEBERMAN. If I may respond, we see the value in this as a member of our mental health team. Actually, our Office of Academic Affiliation is offering, I believe, 55 stipends for the upcoming year for individuals, for both of those job series, to undergo training. We actually have been growing in both of those jobs, 20 percent for the licensed professional mental health counselors and 10 percent for the marital and family therapist over this fiscal year compared to last fiscal year so far this year. So we do see the value in that.

Chairman MORAN. Thank you for that answer, and thanks for that action.

Musculoskeletal disabilities, which generally, I think, mean back pain, is a significant complaint, symptom of veterans, and I would ask how do you see chiropractic care fitting in the VHA's staffing model for rehabilitation and other medical services. I would indicate to you that it has always seemed to me that the VA is slow in implementing programs to include chiropractic care within the VA.

Dr. LIEBERMAN. There certainly is a value of chiropractic care as a part of a whole variety of therapies for including whole health, for musculoskeletal pain, and certainly chiropractic care is among the options to help in that area.

Chairman MORAN. Nothing that you know from a structural, from an attitude point of view that is diminishing the opportunity for chiropractic care to be utilized within the VA or within community care?

Dr. LIEBERMAN. Certainly, it is on the list of items to consider. There are many different options. You have to speak to the veteran to see what it is that they are interested in participating in.

Ms. Brahm, did you have something to add?

Ms. BRAHM. Yes. If I could add, from the VISN perspective, we are encouraging the hiring of chiropractic, acupuncture, and massage therapy as alternative methods versus opioids.

Chairman MORAN. Is there a problem in hiring more of those individuals? Are they not available?

Ms. BRAHM. No. Actually, we are doing very well with that. Right. When you look at the kinds of services that veterans are looking for when we do refer to the community, at least in my VISN, acupuncture was very high, chiropractic. So we are investing in that.

Chairman MORAN. Thank you, Ms. Brahm.

I have a number of other questions, but for the sake of my colleagues, I will submit a couple in writing.

I think that Senator Cassidy has rejoined us. Senator Cassidy, do you have questions or comments?

Senator CASSIDY. Yeah, a couple things. One, I have sent the spreadsheet, but the spreadsheet is actually a compilation of other spreadsheets. So I will give you time to look at it and make my staff available to discuss it.

But we were speaking about mental health, and I know mental health provision has been difficult. I also know that from speaking to patients and physicians that there is a relatively high no-show rate in many places, just if people are having to drive an hour and a half to an appointment, and somebody begins with mental illness, it may be difficult to pull off.

We spoke last time about tele-mental health, and I know—I think I know there are some private providers providing tele-mental health, which seems appropriate seeing that there is a shortage of mental health providers within the VA. Can you give me a status of tele-mental health and maybe how we are going to continue to provide these services and whether or not this is going to be an enduring change after COVID, the tele-mental health aspect?

Dr. LIEBERMAN. So I will start, and then Ms. Brahm will add, I am sure.

Even before COVID, all the evidence out there was that the consumer, including the veteran, would—and this is not 100 percent, but certainly the veteran's preference would be "I do not want to

drive into the hospital. I would like to do it from my home or from my place of work." So the prediction was always there would be more telehealth—and that was what we were working toward, to give the veteran the choice. Certainly, if they want to come in, they can come in, but if not, we would provide the services at the location of their choosing. And that is what our program is, VA Video Connect. That is exactly what it is about.

So one of the things that has occurred during COVID is that we have just rapidly accelerated and grown our VA Video Connect.

At the same time, we have been encouraging through our community partners, through our third-party administrators, that they grow the same telehealth, so that for the veteran who is already getting therapy in the community, they should not have to—even if it is driving 5 or 10 minutes, if they can be in the safety of their home and the comfort of their home, why should that not happen? So, to us, that is really important for the future.

Ms. BRAHM. I can tell you from the VISN perspective, we have been doing telehealth, mental telehealth for quite a while. We are finding that we have a great satisfaction rate, around 86 or 87 percent satisfaction rate. Our providers like it. We are doing it not in a local Walmart. We are doing it in a VSO office. We have increased since COVID about 200 percent actually and finding that it works very well. Providers are happy with it, and it seems that at an 86 percent satisfaction, many of our veterans like it as well.

Senator CASSIDY. So can you give me metrics as in if we ask people to come in, this is our no-show rate; if we have tele-mental health, this is our no-show rate? Are the average times——

Chairman MORAN. Dr. Cassidy, could you get closer to the mic?

Senator CASSIDY. I am sorry.

DO you have metrics that you can give, for example, this is the no-show rate within office versus this is the no-show rate via telehealth or this is the average time to next appointment in office, average time via telehealth, those sorts of metrics, which are intuitive as to how you would assess compliance with the program?

Dr. LIEBERMAN. So, as you pointed out, we know the no-show rate is high for face-to-face mental health appointments. I have not seen data yet during the COVID months. So, certainly, we are going to be taking a look at that.

One would predict that, as I believe you are surmising, the no-show rate would go up, and one of the things that we have been talking about, even before——

Senator CASSIDY. Would go up or go down?

Dr. LIEBERMAN. Would go down, would be better.

So one of the things that we want to work toward—and we even were talking about this before COVID—would be that if a veteran

calls to cancel their mental health appointment or does not appear for their mental health appointment, that someone on the staff would call the veteran and offer them on the spot, "We see you are not here today or you could not make your appointment. Would you like to have a video appointment? We can help walk you through that appointment for the first time, give it a try." So that is something that more and more, we will be working toward.

But, again, I think during the COVID era, we kind of have gotten there anyway for a lot of our appointments.

Senator CASSIDY. Would you allow somebody to do it over Facetime or Skype, or do they have to have something which is more fancy than that?

Dr. LIEBERMAN. We have a system that is just literally a link is sent to the veteran, and the veteran clicks the link. As long as they have a smartphone or a programmable computer, that works.

There are some security issues with some of the different—information security issues, and so they do not all work for that.

But, actually, sir, during COVID, we are utilizing whatever modality is available while we work in the long term the security issues that you raised.

Senator CASSIDY. Thank you.

Thank you, Mr. Chairman. I yield back.

Chairman MORAN. Thank you, Senator Cassidy.

Senator Tester, anything to conclude with?

Senator TESTER. No, Mr. Chairman. You have done a masterful job of having this hearing, and I look forward to hearing the responses back from the panelists. So thank you.

Chairman MORAN. That is a nice conclusion. Thank you.

I always have the practice of allowing our witnesses to tell us anything they wish they had said or wish they had not have said, they can correct, or something you wished we had asked that we did not. Anything you would like for us to know, Doctor?

Dr. LIEBERMAN. Just that we are, all of us, so proud of our 350,000 employees. They are true American heroes for what they do every day, particularly during this COVID crisis, and we are just so proud of them and thank them, and also for our veterans, this is certainly a scary time for many. We in VA, we are here for you. You do not have to come in. You can just call, and we will take care of you. So thank you for giving us this opportunity to make some comments.

Chairman MORAN. Thank you for sincerely expressing both of those sentiments.

Ms. BRAHM OR MS. Bonjorni?

Ms. BRAHM. Boy, I could not have said it any better. Thank you, Dr. Lieberman.

It is all about the staff, and I just cannot tell you about how passionate and dedicated, as I said before, these staff are to the veterans. And I am so thankful, after being with the VA for as long as I have, about that mission that we are all driven by. So I just really do want to extend my thanks to the staff. Thank you to the veterans, and we are here for you. Thank you.

Dr. LIEBERMAN. Thank you.

Chairman MORAN. We will begin to wrap up our hearing, then. I thank our witnesses for what they had to tell us and for joining us today. I think this is an important discussion that this Committee will continue to pursue answers. How well we treat our veterans is determined in part by how well we treat our staff and those who care for our veterans, and we want to make certain that the VA has the tools necessary to hire the appropriate number of people with the right kind of opportunities for them to care for those who served our Nation.

Our hearing record will remain open, so that any Member of the Committee can submit a question in the next 5 days, and then we would ask that you submit your answers for the record as quickly thereafter as you can.

With that, our hearing is adjourned.

[Whereupon, at 4:50 p.m., the Committee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

Senate Veterans' Affairs Committee Hearing
Recruitment, Retention and Building a Resilient Veterans Health Care Workforce

Opening Statement of Chairman Jerry Moran
Wednesday, July 01, 2020

"Good afternoon, everyone. The committee will come to order.

"We are here to discuss the Veterans Health Administration's workforce and the resources VA uses for recruitment, retention, and resiliency of that workforce. First, I want to thank the 350,000 employees of VHA for the hard work they do day after day to care for our veterans. I have met a number of these professionals since serving in Congress and have always admired their dedication to the mission of helping veterans. We know that in many instances, these men and women are going above and beyond to help provide the customer service our veterans deserve.

"This is especially true as our frontline VA health care workers fight against COVID-19. I was inspired by the story of Gary Kramer, an intensive care unit nurse at the Dole VA Medical Center in Wichita, Kansas. Gary has gone the extra mile in caring for his patients suffering from COVID-19, offering up his own phone so patients could connect with loved ones unable to be by their side during their final days.

"VA health care workers serve our veterans because they believe in the mission, and that is exactly the kind of person we want serving our veterans. But we know VHA has a number of vacancies, including 27 occupations listed as critical shortages by the Office of the Inspector General. These shortages of critical positions strain the rest of the workforce and make it tougher on them as they care for our veterans. Reducing these vacancies must be a priority for the department so that dedicated providers like Gary have the people and other resources around them to deliver the consistent, high-quality care our veterans deserve.

"Recruiting providers is challenging for everyone in the health care industry, but I worry that VA is limited in its ability to compete with the private sector due to salary restrictions and bureaucratic hiring practices.

"For health care providers, VA does have authority to set pay based on market conditions in a specific area. One of the challenges, which we frequently see in rural areas, is that the qualified applicants are not in that market, and VA really needs to adjust the pay to attract qualified doctors and nurses from other areas of the country. I hope to hear more from our witnesses today on how VHA can accomplish that and what this committee can do to help.

"Additionally, we often hear from hiring managers that it takes too long to hire good people. VHA's current hiring model for doctors and nurses allows for 34 days from closing a job announcement to issue a tentative offer of employment. It could take another 45 days from that initial offer to conduct the credentialing and privileging, background check, physical, and drug test before that new employee can actually start working. If another area hospital provides an offer sooner and has a quicker onboarding process, that doctor or nurse may not be able to wait for the VA process.

"I hope to hear more from our witnesses today on how this hiring model compares with practices in the private sector, including any additional requirements VHA faces. I also want to hear more about how VHA has been hiring during the pandemic. I understand that for the past three months, VHA alone has hired over 20,000 employees. That appears to be more than double the number hired in the first three months of this year.

"In our Budget hearing last month, Secretary Wilkie noted that many of these new employees were hired much more quickly than traditional processes allow for. I am very interested in what changes VHA has made during the pandemic and which of those changes can be used to improve the hiring process on a permanent basis.

"Thank you."

STATEMENT OF
STEVEN LIEBERMAN, M.D.
ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

July 1, 2020

Good afternoon, Chairman Moran, Ranking Member Tester and Members of the Committee. I appreciate the opportunity to discuss recruitment, retention, and building a resilient Veterans healthcare workforce. I am accompanied today by Jessica Bonjorni, Chief, Human Capital Management and Victoria Brahm, Director, Veterans Integrated Service Network (VISN) 12.

Introduction

During the COVID-19 pandemic, VHA has hired new staff, redistributed current staff across the system to areas of greatest need and maximized competencies of current staff practicing at the full extent of their licenses. Recruitment has been occurring for both short-term (up to 120 day) temporary appointments and permanent positions. In response to the projected need for surge staffing, VHA launched national hiring announcements, amplified through social media and recruitment marketing for Advanced Practice Registered Nurses, Registered Nurses (RN), Certified Registered Nurse Anesthetists, Licensed Practical Nurses, Physicians, Respiratory Therapists, Housekeepers, Supply Technicians, Health Technicians/Intermediate Care Technicians and numerous other occupations. Applicants interested in temporary appointments were encouraged to apply directly through the Department of Veterans Affairs (VA) Careers website.

Prior to the COVID-19 pandemic, VHA's Time to Hire was slightly better than the government average at 94 days, but still far longer than private sector health care systems with whom VHA competes for talent. This timeline would not support the rapid hiring we needed to boost our onboard strength to fight COVID-19; therefore, VA sought out all possible ways to drastically reduce the time to onboard.

VHA had tremendous support from the Office of Personnel Management (OPM) to help us reform our antiquated Federal hiring practices in pursuit of an expedited 3-day onboarding model. We were able to do this by restructuring pre-employment requirements, moving some of these to be completed after the initial onboarding occurs, allowing new hires to begin work very quickly. Additional authorities granted from OPM, such as expanded Direct Hire Authority, temporary non-competitive appointment authorities and dual compensation waivers to attract retired Federal employees, all contributed to our recruitment success.

Within VHA, we also modified policies and used existing flexibilities to further reduce the timeline. For example, we used an expedited credentialing process for clinical hires that reduced a 30-day process down to as little as 3 days by decreasing the contacts and verifications initially required. VHA also finalized changes to the appointment and pay setting process for Hybrid Title 38 employees, which eliminated the requirement to use a Professional Standards Board, further shaving off days from the hiring process. As a result of these combined changes, time to hire during the COVID-19 hiring surge has averaged 10-12 days, with hires in as little as 3 days occurring in some instances. We hope to continue building on these improvements through these challenging times and upon the return to normal operations.

Hiring Surge

As a direct result of our extremely dedicated human resources staff maximizing these flexibilities, VHA hired more than 20,000 employees between March 29 and mid-June 2020, including over 3,800 RNs, more than 250 Nurse Practitioners, and over 1,000 Nursing Assistants. Approximately 85% of the new hires have been hired on permanent appointments, with the option to convert some of the remaining 15% to permanent positions.

The hiring surge resulted in a net onboard increase of 2.2% since the start of fiscal year (FY) 2020 (8,020 net gain), more than half of which occurred since the COVID-19 hiring surge began (4,900 net gain). Nurses have grown at even higher rate of 2.7% since the start of FY 2020 (2,820 net gain).

Shifting Resources

In addition to our hiring surge, VHA leveraged our internal capacity as the nation's largest integrated health care system to optimize resources across the system. We established an integrated Staffing Command Cell to drive accelerated hiring and manage deployments of staff to affected areas across the nation, supported by the Disaster Emergency Management Personnel System (DEMPS) and Travel Nurse Corps. Our nursing workforce – the backbone of any health care system – rose to the challenge caring for our Nations' heroes. A total of 1,893 staff have been mobilized to meet the needs of our facilities and 4th Mission requests. Eight hundred seventy-seven, staff were deployed to meet Federal Emergency Management Agency Mission requests; 420 personnel were deployed as DEMPS response; 414 employees were mobilized to "cross level" staffing needs within their VISN; 69 employees were mobilized to support needs in another VISN; and 113 Travel Nurse Corps staff responded specifically for COVID-19 staffing support.

Additionally, facilities shifted clinical staff in administrative settings to direct care settings and provided skills training as staff moved to a different specialty area of practice. Our nursing leaders implemented surge and crisis level staffing models to support additional intensive care unit (ICU) and acute care beds. These nurses augmented team-based care provisions via telehealth including Tele-ICU and other Tele-Specialty care. VHA Call Centers implemented COVID-19 triage and crisis

management strategies to enhance patient access to care. In preparation for ongoing Coronavirus concerns, Nurse Executives at each facility will assess the demographics of their nursing workforce for future surge planning while also identifying reallocation of facility clinical resources.

It is important to note that hires made in support of the COVID-19 surge may fill both existing vacancies as well as newly created temporary positions specifically identified for the COVID-19 surge in the position inventory (HR Smart). All valid vacancies hires and losses will continue to be reported per Section 505 of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (commonly referred to as the MISSION Act) to ensure a full accounting.

The Coronavirus Aid, Relief and Economic Security Act

VA is extremely appreciative of the work Congress has done and continues to do in providing flexibilities to support the recruitment and retention of talent to care for our Nation's Veterans... The Coronavirus Aid, Relief and Economic Security (CARES) Act (section 20008) allows VA's Secretary to waive pay limitations for VA employees during the national emergency. Through policy, VA specifically authorized waivers of pay limitations on aggregate pay, annual premium pay, and in rare instances, basic pay. These pay flexibilities have been key to VHA's ability to recruit and retain clinical and support staff. VA will be glad to discuss with the Committee what pay flexibilities may be appropriate after this national emergency ends to ensure VA can uphold a high level of service to Veterans by attracting and retaining the most qualified medical personnel.

Conclusion

Veterans' care is our mission. We are committed to providing high-quality health care to all our Veterans and having appropriate staffing levels in all our facilities even during these unprecedented times. VHA has radically altered its hiring practices to respond to the increased staffing requirements due to COVID-19. We look forward to working with this Committee to maintain VA's ability to hire quickly and eliminate barriers to attracting and retaining top talent. Your continued support is essential to providing this care for Veterans and their families. This concludes my testimony. My colleague and I are prepared to answer any questions you may have.

CONGRESSIONAL TESTIMONY

STATEMENT FOR THE RECORD

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

PROVIDED TO THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

HEARING ON

"RECRUITMENT, RETENTION AND BUILDING A RESILIENT VETERANS HEALTH CARE WORKFORCE"

JULY 1, 2020

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO
80 F Street, N.W., Washington, D.C. 20001 (202) 737-8700 www.afge.org

Chairman Moran, Ranking Member Tester, and Members of the Committee, The American Federation of Government Employees, AFL-CIO (AFGE) and its National Veterans Affairs Council (NVAC) appreciate the opportunity to submit a statement for the record on today's hearing titled "Recruitment, Retention and Building A Resilient Veterans Health Care Workforce." AFGE represents more than 700,000 federal and District of Columbia government employees, 260,000 of whom are proud, dedicated Department of Veterans Affairs (VA) employees. In our comments on needed changes to strengthen the VA health care workforce, we discuss how VA policies and practices have undermined recruitment and retention at Veterans Health Administration (VHA) facilities and created unnecessary obstacles for the health care personnel who take care of our nation's veterans. We hope that you find our recommendations constructive and reasonable, and we stand ready to work with the Members of the Committee to make necessary and positive changes.

Increased VHA Direct Hiring Authority Is Unnecessary and Harmful

Proposals to increase VHA direct hiring authorities are often promoted as a shortcut to build the workforce, especially for highly trained medical professions such as physicians and nurses. However, these practices are contradictory to merit system principles that the system was built upon and ignores the fact that VHA already has direct hiring authority for the majority of its workforce. Instead, VA should use alternative methods to strengthen the VHA workforce that avoid the unintended negative consequences of direct hiring authorities.

AFGE believes hiring should be done under merit-system principles, with veterans' preference and public notice to guard against cronyism or a federal workforce

comprised of only political appointees. Direct hiring raises concerns about fundamental fairness for both internal and external candidates. It is no secret that direct hire appointments are often used to bypass veterans' preference and merit promotion consideration of current agency employees. Overuse of these appointment authorities unfairly limits competition and dishonors the promises we have made to veterans of military service who continue to serve their nation at the VA. VA has long been a model employer of veterans for the rest of the federal government and should remain so.

Direct hiring authority can also have a negative impact on diversity in federal hiring and simultaneously threatens the merit system principle of open competition for federal jobs, undermining the apolitical, professional civil service. Therefore, we urge the Committee to reject all proposals that increase the use of direct hiring authority and weaken Title 5 rights and merit system principles.

Furthermore, expanding direct hire authority is unnecessary as VHA already has direct hire authority for "full Title 38" personnel, i.e. physicians, registered nurses (RN), and other medical professionals appointed under 38 USC 7401(1). VHA medical center directors have virtually unlimited discretion and flexibility at the local level to hire full Title 38 employees. As the hiring surge during the pandemic has shown, when VHA has the need and the will it can hire quickly. What VHA instead needs is more effective use of existing hiring tools already provided by Congress for human resources (HR) personnel who currently are not adequately trained or supervised.

AFGE has also strongly opposed proposals that invoke the virtues of direct hire authority to weaken Title 5 protections currently afforded to Hybrid Title 38 personnel (Hybrids) such as psychologists and pharmacists and full Title 5 VHA personnel who

provide many essential support services to medical facilities. Here too, greater direct hire authority is unwarranted because medical center directors can already hire Hybrid Title 38 personnel directly at the local level. The VA should not be permitted to remove current requirements to comply with veterans' preference and merit-system principles through direct hire authority when there are many other recruitment and retention tools that Congress has already provided including special pay authorities.

In addition to the loss of Title 5 veterans' preference and merit-based principles, moving Hybrids over to the full Title 38 system would cause them to lose nearly all their collective bargaining rights. AFGE has already shared with the Committee several more effective ways to address psychologists' concerns about compensation and working conditions that do not require them to surrender their critical collective bargaining rights.

AFGE urges the Committee to instead enact S. 462, the "Department of Veterans Affairs Employee Fairness Act of 2019" to restore equal collective bargaining rights to VHA full Title 38 medical professionals. We thank Senator Brown for his leadership on this very important front-line provider issue, and we thank Senators Murray and Sanders for co-sponsoring the legislation.

VHA Recruitment, Retention and Hiring Practices

Widespread vacancies: The VA has been chronically understaffed for years, and COVID-19 has shed light on the scope of the problem. System-wide, the VA has operated with nearly 50,000 positions languishing unfilled. At every opportunity to address this failing, multiple VA Secretaries of both parties have demurred and insisted that the public look the other way. Yet, as soon as a major public health crisis began to

grip our nation, the VA swiftly moved to hire over 10,000 people in the course of a month. It is imperative that VA make the same effort to fill the remaining vacancies across the system with permanent, fulltime professionals.

Since the enactment of the VA MISSION Act, the VA has been required to publish quarterly data on the vacancy rate. In that time, we have seen virtually no movement – except more positions going unfilled – to increase hiring and retention. We now see that the VA is able to hire when it wants to, so Congress must act and insist that the agency continue to prioritize the filling of these positions so that veterans can receive the best care and services possible at the VA.

Urgency in the hiring process: Too often VHA loses medical professionals to other more attractive employers either before they come on board or shortly after they come on board (and after the VA has invested significant time and resources to credential and orient them). HR personnel take too long to bring applicants on board and do not keep with their commitments as to start date, compensation and work duties. Here too, if labor and management were working together, the VA could more effectively partner with professional schools to attract new recruits in a timely manner and offer more competitive packages to prospective applicants.

Credentialing: It is widely acknowledged that VHA's credentialing process for bringing on new medical professionals is cumbersome and slow. Members tell us that the lack of coordination between HR personnel carrying out the credentialing process, coupled with insufficient training and supervision often cause the process to be chaotic and confusion. One suggestion has been to conduct credentialing in a more condensed process that is offered during non-work hours. More generally, management would

benefit from restoring dialogue with front line providers and their labor representatives to improve credentialing and other aspects of the hiring process. A good starting point would be to determine how VHA was able to credential and hire so many new employees during the pandemic and replicate lessons learned.

Compensation: Frustrations over pay continue to be a leading cause of high attrition at VHA. Pay policies during the COVID-19 pandemic confirm VHA's longstanding flawed and unfair pay policies. The Secretary delegated all decisions regarding the provision of additional pay during the pandemic to VISN and medical center directors, including which employees were eligible and the amount of additional pay and duration of the payments. The results were unfair, counterproductive, and demoralizing.

Many facilities provided no additional pay to any of their employees even though they also experienced the additional work and risk of treating a surge of patients impacted by COVID-19. In other facilities, the director provided additional pay to physicians, RNs and other employees based on position and/or whether they were working in a high-risk unit, while denying additional pay to others also facing increased risks such as licensed practical nurses, nursing assistants and medical technologists.

While the COVID-19 Pandemic highlights this fact, this is not a new problem. VHA compensation practices appear to be especially problematic for certain clinicians in the long term as well. Yet, full Title 38 personnel have no recourse when the agency refuses to bargain over violations of pay and policies. Additionally, RNs often have to fight for years to get management to conduct third party locality pay surveys that are mandated by statute. Similarly, physicians, dentists and podiatrists (who are all under the same pay system) entitled to biannual market pay adjustments are forced to go

through secret management-only market pay setting processes that no longer involves a panel of peers, as a result of a change in law during 2016.

The annual performance pay awards for physicians, dentists, and podiatrists have become meaningless to many providers because management fails to comply with requirements to set fair performance criteria or to carry out this annual process in a timely manner. AFGE urges the Committee to examine ways to restore and strengthen the market pay peer panels that were established by Public Law 108-445 that were designed to ensure accountability, transparency and fairness to the pay setting process.

Lack of support for providers: VHA does not have enough support personnel (clerks, Nursing Assistants, orderlies) to take care of administrative tasks and other support duties that divert providers from patient care and require them to work many additional hours on a regular basis. AFGE urges the Committee to investigate whether VHA has appropriate staffing models throughout its medical facilities, especially in primary care clinics, mental health clinics, emergency departments and other units that regularly treat large numbers of patients.

Hiring retirees: At the outset of the pandemic, VA stated that it wished to bring back retired VHA medical professionals. This makes sense since they already have most or all of the training and orientation they need. Sadly, we have heard from a number of retirees that VA dropped the ball and did not follow up when they expressed interest. AFGE encourages the VA to again consider developing a program for employing former VHA medical professionals to meet staffing and health care delivery needs during the current pandemic. Here too, labor-management cooperation would significantly increase

the effectiveness of such an initiative because the local unions are well acquainted with recently retired personnel.

Improvements Needed in VHA Training

While AFGE commends the VA for filling its long standing 50,000 vacancies by reportedly hiring over 10,000 new VHA employees during the pandemic, management must simultaneously address issues involving personnel training or VHA will continue to lose new hires. Our nurses observe that lack of training is one of the leading reasons that nurses are terminated. When they come on board or are promoted or transferred to a different unit, they cannot do their jobs safely or properly when VA fails to provide proper training. Secretary Wilkie has refused to work collaboratively with federal employee unions representing VHA personnel or recognize our longstanding, productive labor-management partnership. As a result, workers' voices have been ignored by VA leadership during VHA's response to the pandemic, and specifically, the joint labor-management health and safety trainings and committees that have made the VA a model of patient and workplace safety over many decades.

Another long-term training deficiency relates to the lack of continuing medical education (CME) support for VHA licensed professionals. If VHA wants to be a more competitive employer, it must vastly increase the amount of CME financial support and time it allots to its licensed professionals. Currently, only physicians and dentists are

entitled by statute to some financial assistance. Unfortunately, that amount is only $1,000 per year and has not been adjusted since 2001. Our physicians tell us that the process for obtaining funding is extremely cumbersome and there are often delays to get the funds and the time off, causing them to give up and use their own funds and leave instead. This is surely not the way to compete with other health care employers who offer more time for training and more realistic amounts of CME consistent with current costs.

There is no statutory right to CME reimbursement for RNs, physician assistants, pharmacists and other licensed medical professionals who are already hard to recruit. These employees only get financial assistance and time off if management exercises its discretion to provide it. They are regularly told by management that there are insufficient funds for their CME needs.

AFGE urges the Committee to amend 38 USC 7411 to provide more competitive amounts of CME reimbursement to physicians and dentists and create new statutory entitlements to CME for other licensed professionals that allow for adequate reimbursement and time for training. AFGE further urges the Committee to investigate the significant lack of fairness and objectivity in current pandemic pay policies. We strongly support the HEROES Act pay provisions that would provide the same amount of additional pay to all essential employees facing increased risks.

Telehealth

AFGE strongly believes in the use of telework and telemedicine and believes that the VA's growing and improving telemedicine capabilities can make the VA an attractive workplace for medical professionals, particularly during the COVID-19 pandemic and beyond. As the COVID-19 pandemic has proven, treatment for many different types of conditions can be conducted easily via telehealth, particularly for treatment of conditions that do not require physical contact, including mental health. This has improved safety for veterans and providers alike by reducing the risk of transmission of COVID-19 and other easily communicable diseases, particularly among higher risk individuals, and without the added inconvenience and expense of travel and PPE. With the VA's vast network and number of patients with access to and familiarity with telehealth, the VA's continued development of this ability can serve as a recruitment tool now and in the future.

Standard Requirements for All Practitioners Serving Veterans

AFGE has often raised the inequity of the higher standards, requirements, and risks it places on its own internal providers compared to contractors. It is demoralizing and distressing for VHA providers to see their patients treated through the Community Care Network and other VHA contract care programs, knowing that many of these non-VA providers lack the competencies and veteran-centric medical experience that they and their VA colleagues have. AFGE strongly believes in the quality and care that our VHA members provide, and calls on Congress to force the VA to raise the bar on its contractors to make sure they both have and meet the same requirements and standards that VA providers do.

The Accountability Act: One of the greatest obstacles to building a resilient workforce is the continued existence and misuse of the "Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017" (Accountability Act) P.L. 115-41. This severe, unprecedented reduction in due process and collective bargaining rights has allowed the VA to launch an attack on all civil service protections that was allegedly aimed at mismanagement. This law has devastated the rights of every rank and file non-management employee who made no management decisions but who was also a valuable front-line witness to management misdeeds.

Under this statute, shorter timeframes to respond to proposed removals and to file appeals with the Merit System Protection Board, coupled with lower evidentiary standards to review appeals, have resulted in managers terminating employees without an adequate opportunity to respond to management allegations. It has also encouraged managers to fire employees with good records without an opportunity to improve, who would have faced lesser discipline in the past or would have had opportunities to improve their performance or conduct.

Knowing the repercussions of the Accountability Act and the damage it can do to a career has caused medical professionals to leave the VA and served as a deterrent to recruiting new staff. Restoring the due process rights that were eliminated by this law would help with employee morale and ease the concerns of prospective employees.

Conclusion

Long hours, too many administrative duties, broken hiring promises, a hostile workplace, lack of equal bargaining rights for full Title 38 employees, and the ongoing

open attacks on unions that are felt throughout the medical centers demoralize VHA employees on a daily basis. These factors are also considered by others considering VHA employment. AFGE stands ready to work with the Committee on all the steps needed to improve the VHA workplace and the morale of its dedicated employees who have chosen to care for veterans. Thank you.

Questions for the Record from Chairman Moran

Question 1: **Please provide a list of the staffing models currently in use by VHA, and a list of those staffing models under development, along with the planned completion for each model still being developed.**

VA Response: The response is provided below.

Background on Staffing Methodologies
There are two fundamental approaches to determining staffing requirements: staffing models or staffing studies. In general terms, both use a basic approach of determining the amount of workload multiplied by a per accomplishment time or productivity standard divided by a standard productive labor hour factor to determine the full-time equivalent (FTE) employees needed to meet the workload requirements.

Staffing models are generally used for similar functions across many components of the organizations (for example, primary care is a function across all medical treatment facilities). Ideally, staffing models use transactional workload data to determine the amount of workload performed or projected to be performed and industry or internal benchmarks to determine productivity standards or per accomplishment times. If transactional data are not available, workload data must be collected. Staffing models usually cover a greater percentage of the positions more quickly than staffing studies. The ability to cover these positions more quickly is due to the relative availability of workload data and the number of positions covered in the model.

Staffing studies are generally used for estimating workload requirements for a single organization with multiple functions (for example, headquarters activities). Unlike staffing models, transactional workload data are not usually available, and the functions and tasks are not clearly defined. This makes staffing studies far more labor-intensive to complete. Data are collected through a time-intensive interview process with subject matter experts, review of policy documents, or process mapping.

About 80% of VA's positions can be evaluated for workload requirements, and about 20% require the time-intensive review of a staffing study. Fortunately, the Veterans Health Administration (VHA) has a lengthy history of developing staffing models or standards for those areas of similar functions across multiple organizations.

Current Staffing Models, Benchmarks, and Tools
Currently, VA staffing models are generally seen as decision support tools to assist managers with determining the most appropriate use of resources. This approach is needed so managers at the facility level can contextualize the staffing or productivity

analyses to adjust staffing levels to potentially unique characteristics such as facility limitations; availability of contract support; and the ability to recruit and retain a workforce consistent with its mission and infrastructure.

Most of VHA's positions are within VA Medical Centers (VAMC). VHA's Office of Productivity, Efficiency and Staffing (OPES) has been conducting efficiency and staffing analyses for VHA's direct health care system since its establishment in 2007. The purpose of OPES is to assist VHA leadership in developing effective management tools, systems and studies to optimize clinical productivity and efficiency so that informed staffing decisions are made in support of the goals of clinical excellence, access and the provision of safe, efficient, effective and compassionate care. The accepted industry approach for addressing staffing needs is to compare staffing against workload using benchmarks internal to the organization. OPES accomplishes that using VHA's extensive data systems and analytic capability.[1] Where available, VHA uses the industry-accepted metric of the Centers for Medicare and Medicaid Services (CMS) work Relative Value Units (wRVUs) to measure and set targets for provider productivity (clinical work per provider).[2] OPES' analyses consist of productivity, efficiency and staffing tools. Models developed by OPES that are currently in place relevant to this question focus on productivity and staffing.[3]

- Key productivity tools include the following:
    - Physician Productivity Cube is a comprehensive database of the physician workforce and workload (wRVUs). This tool assists managers and leadership in effectively managing their specialty physician practices that: (1) tracks specialty care practice and provider level productivity performance over time for over 30 specialties and a physician workforce of over 25,000 FTEs; (2) provides comparative data for physician workload, staffing and productivity performance at the national, medical complexity group (MCG); (3) facility and individual physician levels; and (4) monitors the percentage of "worked" FTE and the labor distribution deployed to clinical and non-clinical missions.
    - The Advanced Practice Provider (APP) Productivity Cube and Dashboard: APPs included are Nurse Practitioners (NP), Clinical Nurse Specialists (CNS), Physician Assistants (PA), and Certified Registered Nurse Anesthetists (CRNA). This tool provides detailed workforce (based upon labor mapping),

[1] VHA tracks specialty care practice and provider level productivity performance for over 30 areas of specialization as well as Advanced Practice Providers.
[2] Physician clinical workload, measured in wRVUs, adjusts for the differences in time, intensity and complexity of medical services.
[3] VHA Directive 1065(1), *Productivity and Staffing Guidance for Specialty Group Provider Practice* requires VAMCs to use the OPES standards to inform resource decisions for their specialty provider group practices. When practices are out of range (high/low), VAMCs should develop and implement remediation plans to improve specialty physician group practice productivity.

workload (wRVUs) and productivity information on APPs from the VHA database.

- Anesthesia Productivity contains workload and workforce data for Anesthesiologists and CRNAs. The purpose of this dashboard is to: (1) accurately measure anesthesiologist workload independent of workload location; (2) define data streams to be used for identifying anesthesiologist workload and implement processes to accurately capture workload for measurement; and (3) develop a future path for measuring and benchmarking anesthesiologist productivity including auxiliary staff productivity.

- Rehabilitation and Prosthetic Services Productivity provides an annual summary and range of expected performance provided the most objective approach to monitoring and maximizing productivity within the targeted disciplines.

- Social Work Productivity cube and dashboard provides detailed workforce, workload and productivity information on social worker providers.

- Key staffing tools include the following:

  - The Operational Workforce Report was developed to provide insight into the current strength (absolute and standardized) of key health care workforce members and critical infrastructure support necessary for safe and efficient health care delivery for all functions within the VAMCs. This report compares staffing across similar functions within facilities of similar MCG to identify variations in staffing when benchmarked to the average for that function and MCG. This report provides managers with tools to determine appropriateness of staffing levels across all functions within their facility.

  - The Provider Workforce Report includes the integrated elements of supply and demand to provide system level staffing norms by geographic location (Veterans Integrated Service Network (VISN)) and practice setting (MCG) to provide benchmarks and comparative staffing levels.

  - The Mental Health Workforce Report provides comparative data for mental health providers at the station level by assessing productivity using metrics of FTE, wRVUs and the number of encounters. Productivity data include labor from psychiatrists, psychologists, CNS', NPs, PAs, and social workers. FTE for non-Clinical and Administrative Staff in mental health programs are also reported. The Mental Health Workforce Reports are designed to provide a management tool for the systematic, longitudinal measurement and reporting of clinical productivity, efficiency and staffing in VHA.

  - The Administrative Staffing Model Detail Reports are a drill down report from the OPES Efficiency Opportunity Grid (EOG) that contains monitors of several

dimensions of resource efficiency that are widely recognized as key cost drivers in health care. The EOG provides a tool for VISNs and facilities to understand where opportunities exist for efficiency improvement. This drill down report allows the user to look at some of the model's dependent variable source Administrative FTE components using current data.

- Medicine and Surgery Staffing Models measure appropriate physician staffing within the medicine and surgical specialties. OPES developed actual demand-based models employing multivariate lognormal linear regression to evaluate staffing requirements by examining factors related to patient care needs in the areas of medicine surgery. The models are designed to level the playing field by accounting for patient disease severity, reliance and facility characteristics. The resulting models demonstrate the relative level of overstaffing and understaffing at the facility and VISN level based on the characteristics of the parent facilities.

In addition to the staffing or productivity models developed by OPES, most VHA program offices have staffing models that are documented in VHA directives and are used to monitor staffing needs and intervene when needed. Notable among these program offices with directives that specifically address staffing are the staffing methodology for VHA nursing personnel and the Office of Mental Health Services.[4] Other program offices, such as Patient Aligned Care Team (PACT), geriatrics and extended care have embedded the staffing methodologies or guidelines within their policy directives.[5] The guidelines in these directives are used in conjunction with OPES analysis to determine appropriate staffing levels for each facility.

In support of VHA, VA Manpower Management Service has developed staffing models for emerging issues such as field-based police services, the Caregiver program (with expansion), appointment scheduling and Electronic Health Record (EHR) scanning.

---

[4] VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel,* December 20, 2017; VHA Directive 1161, *Productivity and Staffing in Clinical Encounters for Mental Health Providers,* April 28, 2020;
[5] VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook, February 5, 2014; VHA Directive 1140.11, Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics, October 11, 2016.

Plan to Implement Staffing Model Across the VA

In April 2017, the Office of Management and Budget (OMB) directed Federal agencies to review and revise organizational structures and to determine appropriate required staffing levels using career field benchmarking and time studies versus relying on previous budget allocations to set FTE levels.[6] On May 31, 2017, VA announced the intention to "establish a fully functioning manpower management office by December of this year, which is a first step in a position management system." While full implementation of a VA manpower management program took longer than the Secretary anticipated, this program was established in March 2018 and has been rapidly evolving to full implementation since that time. The, VA has been methodically developing the foundations for effective manpower management, to validate requirements and apply rigor to manpower position management. At the end of Fiscal Year (FY) 2019, VA conducted a comprehensive review of existing staffing models, benchmarks or standards and identified gaps in staffing analysis to inform a plan of action to develop workload-based manpower requirements.

At present, the current focus is on leveraging existing staffing models to document which positions are covered by a valid workload-based staffing requirement within an authoritative data source. This is a critical step to conducting a comprehensive position validation review to identify funded and unfunded requirements. By the end of FY 2020, foundational elements for VA's manpower management to enable documentation of requirements using current validated staffing approaches and to fill in the gaps of the staffing analysis will be in place. VA's authoritative data source for positions (HR•Smart) does not currently have a field to identify those positions that have a valid workload-based requirement based upon a staffing standard, model or benchmark. The HR•Smart field to label a position as having a valid workload-based requirement will become available in Fall 2020.

Through this combination of approaches – leveraging current staffing models, standards or benchmarks, contracting for manpower analysis and using internal VA resources to conduct staffing models or develop models – by the end of FY 2021 about 80% of VHA's positions will be covered by some type of workload-based staffing (manpower) analysis and have the workload requirement documented in a source system. The remaining 20% will require a more labor-intensive approach of a staffing study to conduct interviews with subject matter experts by each work center to determine workload factors and per accomplishment time for each of the functions and tasks to determine staffing requirements.

Question 2: **VA's annual report on vacancies and staffing indicated VA will conduct a comprehensive position validation review this fiscal year to assess all current vacancies Are you on track to complete that position validation by the end of the year?**

---

[6] OMB memo 17-22, *Comprehensive Plan for Reforming the Federal Government and Reducing the Federal Civilian Workforce,* April 12, 2017.

VA Response: This position validation will not be completed by the end of FY 2020 but will be completed in early FY 2021. In early March, VA announced internal system changes to the HR•Smart system that were designed to put controls in place to enhance position management processes with better data integrity and as a result, gain fidelity in the reported positions, particularly vacant positions. It was expected that these HR•Smart system and business process changes would enable a comprehensive position validation review that would clean up position data starting in March and ending in May 2020. This validation process was also designed to include participation from financial managers to ensure positions marked as "budgeted" have available funds to support actual hiring. Unfortunately, due to the impact of the Coronavirus Disease 2019 (COVID-19) pandemic, those system changes were postponed.

In the current system there are thousands of Human Resources (HR) professionals who can create or reactivate a position resulting in inconsistent application of manpower position management policies. This results in creation of a significant number of positions in error or adding new positions vice using the existing unencumbered position for recruitment actions. Limiting the ability to create or reactivate a position is critical to attaining success with maintaining position quality and sustainable position validation. When the HR•Smart manpower management module is in place in FY 2021, this access will be limited to manpower users only. Additionally, the accounting line to note funding availability will move from the person to the position, with the accounting line controlled by manpower users. These changes, in addition to close collaboration with financial managers, will ensure that HR•Smart positions labeled as funded have allocated resources to support that designation.

Question 2a: **If not, why not, and when can we expect that to happen?**

VA Response: VA anticipates that the policy, process and system changes will be in place by the end of FY 2020 to enable completion of the position validation by the First Quarter, FY 2021.

In anticipation of the policy, process and system changes to maintain position validity, the VA Office of Human Resources and Administration/Operations, Security, and Preparedness has been working closely with the VA Office of Management to develop a memo directing organizations to align their budgeted positions in HR•Smart to the available funding levels. These position changes will be put in place to coincide with the tightened controls and systematic changes to how positions are managed in early FY 2021. The combined impact of the policy, process and system changes will be a significant reduction in invalid HR•Smart positions and increased accuracy in vacancy reports.

Question 3: **VHA has a mental health staffing model of 7.72 clinical mental health employees per 1,000 outpatients, and 1.22 psychiatrists per 1,000 outpatients. VA's report on Mental Health Transparency, cites the direct correlation of higher staffing levels with better patient mental health outcomes. When a veteran patient**

dies from suicide, what is the requirement for reviewing the care provided by VA and what role do clinical staffing levels play in that review?

VA Response: VHA must ensure appropriate mental health staffing levels are present to conduct treatment and to ensure review of Veteran care, as required by policy. VHA has several requirements for reviewing the care of Veterans who died by suicide including the following programs.

- **Behavioral Health Autopsy Program (BHAP):** In December 2012, VHA began BHAP as a national initiative to collect demographic, clinical and other related information on Veteran suicides to improve its suicide prevention efforts by identifying information that could be used to develop policy and procedures to help prevent future Veteran deaths. As part of this initiative, VHA medical facility suicide prevention coordinators are required to complete standardized medical chart reviews for all Veteran suicides known to facility staff and reported on or after October 1, 2012 (VHA Memorandum 2012-12, *Behavioral Autopsy Program Implementation*, dated December 11, 2012).

- **VHA Issue Briefs (IB):** VHA medical facility staff are to report serious incidents—including on-campus Veteran suicides—through VHA IBs which are reports provided by VHA medical facilities to VA leadership to notify them of unusual incidents, unexpected deaths such as suicides, disasters or anything else that might generate media interest or impact care delivery. For an on-campus Veteran death by suicide, facility officials are required to report details such as the suspected cause of death, whether the Veteran had received VA health care, including any mental health care, and the date and type of the last appointment when this information is available, but usually within 2 business days from the time of the incident (*VHA 10N Guide to Issue Briefs*, dated June 20, 2017).

- **Root Cause Analyses (RCA):** When a Veteran dies by suicide during or soon after receiving care at a VHA medical facility, VHA medical facilities are required by policy to complete an RCA—a process to identify and evaluate systems or processes that caused an adverse event; recommend changes to the systems or processes to prevent the event's recurrence; and determine whether the recommended changes, when implemented, are effective. According to VHA policy, an RCA must be conducted for: (1) any inpatient suicide; (2) all outpatient suicides deaths that occur within 72 hours of discharge from status as an inpatient; and (3) all outpatient suicides deaths that occur within 7 days of discharge from inpatient psychiatric treatment (VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook,* dated March 24, 2011).

  RCAs are used to identify the factors that contributed to adverse events or close calls and any steps VHA medical facilities could implement to prevent similar events in the future. A close call is an event or situation that could have resulted in an adverse event but did not, either by chance or through timely intervention.

Such events have also been referred to as "near miss" incidents (VHA Handbook 1050.01).

- **Peer Reviews:** VHA medical facilities are also required to complete peer reviews for all suicide attempts and deaths by inpatients; suicide deaths within 7 days after discharge from inpatient Mental Health treatment or residential care; and outpatient suicide attempts within 3 days after discharge from Mental Health treatment or residential care. Peer reviews for quality management are used when there is a need to determine whether a provider's actions associated with an adverse event were clinically appropriate—that is, whether another provider with similar expertise would have taken similar action (VHA Directive 1190, *Peer Review for Quality Management,* dated November 21, 2018).

Question 3a: **How common is it for low staffing levels be a potential factor in veteran suicide?**

VA Response: Mental health staffing is a key requirement for ensuring access to high quality health care. Prior analysis, comparing 2005 to 2009, indicated that VISNs with greater than median increases in VHA mental health staffing had reductions in suicide rates, while other VISNs experienced increases in suicide rates (*Katz IR, Kemp JE, Blow FC, McCarthy JF, Bossarte RM. 2013. Changes in Suicide Rates and in Mental Health Staffing in the Veterans Health Administration: 2005 to 2009. Psychiatric Services 64(7):620-625*).

Questions for the Record from Ranking Member Tester

Question 1: **VA has been able to reduce time-to-hire from an average of 90 days down to about 3 days during COVID-19. How does VA sustain the 72 hours' time-to-hire moving forward?**

VA Response: Overall, time to hire is measured from the "Hiring Need Validated Date" to "New Hire Actual Start Date." The Office of Personnel Management's (OPM) suggested target is 80 calendar days for this measure. The 72-hour timeframe is strictly referring to the time it takes to onboard an employee, which is the time from when an offer is made until the employee reports to work.

Given current resources, it will be difficult to sustain accelerated hiring. VA used Direct Hire Authorities and temporarily suspended pre-employment processes to streamline onboarding. VA is exploring possible regulation changes to continue onboarding employees before typical pre-employment processes are complete. Pre-employment processes include fingerprints, I-9 verification, personnel suitability and credentialing. VA's Office of the Chief Human Capital Officer (OCHCO) is assembling a multidisciplinary team to assess the feasibility and appropriateness of the continued use of a number of these flexibilities and policy changes. Some of the flexibilities will require statutory or regulatory relief. Congress may be able to assist with approving any

proposed relief that VA identifies as the most beneficial in assisting with meeting the needs of our Nation's Veterans, and that would be appropriate for continued use during normal and/or emergency operations.

VA is also exploring ways to expedite recruitment and hiring processes for Housekeeping Aides (HKA) in VHA.

Question 1a: **Do you need additional authorities from Congress accomplish this?**

VA Response: Yes, VA needs additional resources and authorities to help bring on more and retain staff. Given current resources, it will be difficult to sustain accelerated hiring. For example, VA is currently exploring ways to expedite recruitment and hiring processes for Housekeeping Aides (HKA) in VHA.

Since the flexibilities were put in place to respond to a specific emergency, most have specific time limits and are intended for use to exclusively support COVID-19-related operations. Some of the flexibilities may require statutory or regulatory relief. VA will propose and request changes for those flexibilities that are identified as having been the most beneficial in assisting with meeting patient care needs and are appropriate for continued use during normal and/or emergency operations.

Question 2: **VHA requested an increase of 14,185 FTE in the FY21 budget request. How do the 20,000+ new hires during COVID-19 impact VA's requested increase and plans for future hiring?**

VA Response: The new hires in FY 2020, including those during COVID-19, have contributed to a 2.5% net increase in the VHA workforce of 8,656 employees to date. This year's net increase will not impact plans for future hiring against the FY 2021 budget due to increased Veteran demand.

VA continues to successfully recruit and retain staff in support of our COVID-19 mission, thanks to the additional hiring and pay flexibilities Congress generously provided. At this time, we do not anticipate that the COVID-19 hiring impacts will alter our 2021 budget request or target FTE. We plan to use Coronavirus Aid, Relief, and Economic Security (CARES) Act funding to support the costs of these new hires above the 2021 President's Budget (PB). While COVID-19 hiring will enable us to reach our 2021 staffing target earlier in the year than anticipated, we plan to let attrition right size our staffing level as COVID-19 demands dissipate moving forward. If necessary, we will work with Congress in 2021 to communicate our staff and funding needs above the 2021 PB should the pandemic continue to require a heightened response.

Question 3: **In recent years, Congress has given VA at least 15 new authorities and authorized more than $800 million for recruitment and retention, yet vacancies continue to rise. How is VHA making use of the authorities and funds that Congress has provided for recruitment and retention?**

VA Response: VA is very appreciative of the assistance, additional authorities and funds Congress has made available over the past several years. Efforts to utilize every available flexibility in the recruitment and retention of VA employees is a paramount focus of HR offices. Some increase in the number of employee vacancies can be attributed to an increase of the overall number of new positions that have been added throughout VA to support growing demand for services.

In addition to surge hiring, VA also had an eye on retaining our dedicated staff. VA accomplished this through authorization of group incentive awards for frontline clinical staff and other occupations providing support to health care operations. VISN leadership authorized group incentives to recognize increased workload and demands placed on frontline staff in addressing the special needs of the agency, as well as to prevent poaching from other health care systems.

So far in FY 2020 through July 4, 2020, VHA has spent almost $165 million on recruitment, retention and relocation (3R) incentives, and of that amount, 87% has gone to top shortage (i.e., hard to recruit and retain) occupations, as identified by the facilities and at the national level. Prior to the pandemic, VHA had spent approximately $6 million on retention incentives. Since the beginning of April, VHA has spent nearly $128 million on retention incentives with the bulk of the post-COVID incentives (71%) going to physicians and nurses, specifically, and clinical occupations, generally (91%). Another $178 million has been spent this fiscal year on performance-based awards.

Clinical providers in hard to recruit and retain positions will receive $69 million in education loan repayment through the Education Debt Reduction Program (EDRP) this year. Also, an additional $47 million will be spent this year on scholarships to grow our own clinical providers, including through the expanded Health Professions Scholarship Program (HPSP).

Question 3a: **Are there barriers to their use?**

VA Response: Every effort is made to utilize all available flexibilities in order to recruit and retain VA employees. There are some logistical barriers to implementing statutory pay flexibilities quickly based on systems limitations (such as the PA conversion to a locality-based pay system), but VA is working closely with our payroll provider to speed up our ability to make those changes. VHA must navigate the laws and regulations associated with multiple personnel systems, rather than a single, market-based pay system for all employees, which impacts our ability to provide pay equity across various health care and ancillary occupations.

Question 4: **What steps is VHA taking towards reducing vacancies of the positions with the highest shortages, such as nurses and medical officers?**

VA Response: Ensuring that VHA has the workforce to meet the needs of Veterans is the most important human capital management priority in VHA. Over the past 3 fiscal

years (FY 2017 – FY 2019), VHA has grown its workforce by an average of 2.9% for an increase of nearly 29,000 additional employees, In FY 2019 alone, VHA experienced a growth rate of 3.3% and increased the number of employees by more than 11,000. To achieve this growth, VHA has hired an average of 40,000 external employees each year for the past 3 fiscal years. VHA has grown the physician workforce by an average of 1.8% annually for the last 3 fiscal years, translating to an additional 1,384 physicians available to serve Veterans. This growth was realized by hiring an average of 2,700 new physicians each year for the past 3 fiscal years. In addition, the nurse workforce has grown by an average of 3.5% annually over the last 3 years, for an additional 7,200 nurses onboard.

While vacancies are an important demand signal for recruitment, they are not a good measure of adequate staffing. Instead, they primarily reflect the churn associated with turnover; internal movement due to promotions and job changes; and growth. Turnover rates in VHA are relatively low compared both to other large Cabinet level Federal agencies and the private sector. Growth rates continue to keep pace with increased demand for services.

Some of the steps VHA takes to recruit and retain the workforce and especially clinical providers like nurses and physicians include the following:

- **Trainee Recruitment Events (VA-TRE)**
  One of the most exciting developments over the last year has been in recruitment of health professions trainees (HPT) who are receiving training in VA. Each year, VHA invests more than $2 billion to train approximately 122,000 clinical HPTs. VA-TREs aim to connect, match, place and retain highly-trained and interested HPTs in the VHA workforce by extending tentative employment offers well before they graduate. To date, VHA has successfully matched and hired 171 HPTs in psychology and other mental health occupations at facilities across the country and has VA-TREs scheduled for psychology, mental health social work, psychiatry and Licensed Professional Mental Health Counselors/Marriage and Family Therapists in FY 2020.

- **Exhibits/Job Fairs**
  VA attends and exhibits job opportunities at regional health care career fairs and professional conferences to create awareness of VA positions and engagement with providers.

- **VA Partnership with National Rural Recruitment and Retention Network**
  This partnership provides visibility of VA practice opportunities to the rural patient care provider market.

- **Education Debt Reduction Program (EDRP)**
  VA uses this program to secure health care providers in specific, difficult to fill clinical positions for up to 5 years by providing student loan payment reimbursements of up to $40,000 annually, for a total reimbursement of up to $200,000 for qualifying student loans. Jobs eligible for EDRP are prioritized for hiring based on local recruitment and retention requirements to meet specific staffing needs

- **Student Loan Repayment Program**
  Through this program employees in most clinical and nonclinical occupations may be eligible to receive up to $10,000 per year (with a lifetime maximum of $60,000) to help repay student loans.

- **Health Professions Scholarship Program (HPSP)**
  HPSP awards scholarships to students receiving education or training in a direct or indirect health care services discipline to assist in providing an adequate supply of these personnel. HPSP provides scholarships to selected students along with a monthly stipend and an annual book stipend in return for a service obligation in hard to recruit and retain positions at health care systems that serve rural and non-rural Veterans.

- **VA National Education for Employees Program**
  This program supports the National Nursing Education Initiative by providing replacement salary dollars to facilities so that scholarship participants can accelerate completion of their degrees by attending school full-time.

- **Offering competitive salaries, performance pay and base pay increases**
  VA compensation is based on training, experience and the local labor market. Physicians can receive up to $15,000 in additional annual performance pay; cost of living increases annually (when signed into Federal law); and longevity increases every 2 years.

- **Adequate support staffing**
  VA works to ensure adequate support staffing to reduce burnout.

- **Continued use of flexible work schedules**
  Physicians with a full and unrestricted active U.S. license have the flexibility to work at any of VA's sites of care; relocate if needed during their career; and take their benefits with them. VA physicians can start their career in the highest available leave tier, which provides 49 days of paid time off each year that

includes paid vacation, unlimited accumulated paid sick leave and 10 paid Federal holidays.

- **Total Rewards Brochure**
  VHA has developed a total reward brochure for physicians to promote the comprehensive benefits and total value of a long-term career at VA. These brochures can be used by recruiters, program offices, managers and anyone needing to promote VA employment to targeted jobseekers across various channels to highlight the rewards of choosing a career at VA.

- **Special Salary Rates**
  These rates allow specific VA occupations to remain competitive with local labor markets by establishing higher salaries when needed for a particular occupation. Competitive salaries are essential in the recruitment of candidates for critical hard to fill vacancies.

- **Relocation Incentives**
  These incentives allow VHA to provide an incentive for a Federal employee to move from one geographic area to another for highly qualified candidates for positions that are difficult to fill.

- **Recruitment Incentives**
  These incentives are a financial incentive for highly qualified candidates to accept offers of employment with VHA.

Question 5: **VA has yet to implement multiple new recruitment authorities from the VA Choice and Quality Employment Act of 2017. What is the status of implementing the authorities for physician assistant pay and promotion tracks for technical experts?**

VA Response: VA is eager to do all that is possible to enhance VA's delivery of timely and high-quality care to Veterans. Implementation of improvements have been complex. In the case of securing competitive pay for PAs, the VA Choice and Quality Employment Act of 2017 requires that VA secure competitive pay for PAs by converting them to the VHA Nurse Locality Pay System (LPS). The process has been complex and involves multiple steps, to include developing a new PA qualification standard; revising pay administration policies; and developing and implementing Information Technology (IT) system changes.

A group of highly qualified subject matter experts and leadership within VHA developed a new PA qualification standard based upon the health care industry standards for the profession and licensure and certification requirements. VA also had to revise its Pay Administration policy to address the statutory requirements regarding PA pay rates in the law. This agency policy provides guidance on converting PAs to a five-grade structure and creates pay schedules with a minimum rate range of 133% and 12 steps.

Because of these policy revisions, major system changes are needed to fully implement and support the conversion of PAs to the LPS.

VA has updated internal VA HR Information Systems and worked with the Defense Finance and Accounting Service to develop a plan to implement these system changes. We anticipate that all PAs will be converted to the new Title 38 grading system and converted to the Title 38 LPS prior to the end of this calendar year.

Question 6: **In recognition of the risks staff are facing during COVID, and especially during any times where VA could not guarantee them a mask or PPE, will VA be providing hazard pay to staff?**

VA Response: There are two types of pay related to "hazards" that can be authorized for VA staff: Hazardous Pay Differential (HPD) or Environmental Differential Pay (EDP). HPD covers General Schedule employees and EDP covers Federal Wage System (FWS) employees. See 5 U.S.C. 5545(d) and 5 U.S.C. 5343(c)(4).

Title 38 employees, specifically employees appointed under 38 U.S.C. 7401(1)—i.e. physicians, dentists, podiatrists, chiropractors, optometrists, Registered Nurses (RN), PAs, and expanded-functional dental auxiliaries are not eligible to receive HPD under current law.

VAMC Directors make the decision on the appropriateness of HPD or EDP on a case-by-case basis; however, VA policy requires that OCHCO reviews and approves all requests for HPD before payments are authorized. EDP does not require prior OCHCO review and can be approved locally by the VAMC Director.

To be eligible for HPD, a determination must be made that the employee is exposed to a qualifying hazard through the performance of his or her assigned duties and that the hazardous duty has not been taken into account in the classification of the employee's position. HPD is not payable if safety precautions have reduced the element of hazard to a less than significant level of risk, consistent with generally accepted standards that may be applicable. See 5 CFR 550.904-550.906 and Appendix A to subpart E of 5 CFR part 550.

FWS employees may be eligible to receive EDP when exposed to a working condition, physical hardship or hazard of an unusually severe nature. See 5 U.S.C. 5343(c)(4); 5 CFR 532.511. A list of approved differentials is included in Appendix A to subpart E of 5 CFR part 532.

Question 7: **How is VA encouraging and collecting feedback from frontline staff to ensure that each medical center or clinic is providing sufficient PPE and testing to its workforce?**

VA Response: Currently, VA does not have a requirement for this type of enterprise-wide approach to collecting this information, and it would be up to each facility to implement a tool to collect this.

Question 8: **What is VHA doing to ensure that the mental and physical wellbeing of VHA staff is being addressed during this pandemic and beyond? What resources are available to them?**

VA Response: VHA is helping employees during the pandemic with support, adaptive coping skills and employing other effective strategies to combat the effects of these difficult times and beyond. Several resources have been developed and made available to employees to help ease burnout at all levels across the organization. These resources include the launch of self-care resources for whole health website; the development of a national toolkit that includes guidance and other resources for local implementation of supplemental local support in addition to Employee Assistance Program (EAP) services; the continuation of consultative support to leaders aimed at creating an engaged and effective workforce; the development of resources that combine current empirical literature with real-time feedback from field leaders to address build resilience; and the launch of a toolkit to help local leaders effectively communicate with employees about diversity and consciousness.

Additionally, the VA's EAP is a voluntary, work-based program that provides cost free and confidential assessment, short term counseling, referral and follow-up services to employees who have personal and/or work-related problems that may affect attendance, work performance and/or conduct such as substance abuse, biopsychosocial problems or life stressors. VA's EAP was highlighted in national HR COVID-19 guidance and included a link for employees to obtain background information about the program, contact lists for EAP counselors and other pertinent resources related to VA's EAP.

Question 8a: **What resources are available to them?**

VA Response: Please see response above.

Question 9: **What specifically is being done to address provider burnout?**

VA Response: In response to the pandemic, the National Center on Homelessness Among Veterans (NCHAV) created an educational series and podcasts promoting self-care and wellness in direct support of VA homeless program staff. Over 900 staff have participated in the educational series, and over 3,400 have downloaded the podcasts. Additionally, the Homeless Program Office (HPO), in collaboration with VA's National Center for Organizational Development, has developed a feature in VA's 2020 All Employee Survey that will specify if a respondent is a VA homeless program employee. This will provide HPO with insights into rates and causes of burnout among homeless program staff. In addition, NCHAV has convened a workgroup to better understand burnout among frontline homeless program providers and has developed a draft

questionnaire to disseminate to select VAMCs. Results from this questionnaire and the 2020 All Employee Survey will inform HPO's strategy to address burnout among homeless program staff.

In addition, the HPO COVID Response Team, created in March 2020, disseminates daily briefs to the field and updates HPO's internal-facing website (the Homeless Program Operational Planning Hub) for VAMC homeless program staff daily. These briefs include the most recent guidance provided by VA and the Centers for Disease Control and Prevention on topics related to infection control and personal protective equipment (PPE) guidelines; resources to support mental health and physical well-being for direct service staff; and updates to HPO guidance.

Question 10: **IT training and systems change is a huge cause of provider burnout. How is VA balancing the new electronic health record roll-out with preventing provider burnout?**

VA Response: To prioritize the health and safety of our Veterans and front-line staff, the Office of Electronic Health Record Modernization (OEHRM) remains in a non-intrusive posture to respect and support increased patient demand amid COVID-19. VAMC Directors, VISN and VHA National Program Office directors will continue to permit facility staff to re-engage in OEHRM activities as long as COVID-19 responses are not inhibited.

During site implementation, VA will provide clinicians dedicated hours to focus on EHR training and implementation preparedness; clinicians will not share this time with their clinical responsibilities. Additionally, if needed and arranged, facilities will receive VA staff support to help manage clinical responsibilities while training of the new EHR is underway. All end users will receive at-the-elbow support from super users and adoption coaches post Go-Live.

Using lessons learned from the Department of Defense's (DoD) EHR deployment, it is anticipated that VA providers will temporarily see a reduction in the volume of non-emergent cases of Veterans seen as they adapt to the new EHR solution. These providers will be able to return to their former level of efficiency after implementation activities conclude. Additionally, Initial Operating Capability sites are implementing plans developed by VHA and its Office of Healthcare Transformation to mitigate the loss in provider productivity as a result of EHR implementation. VHA reviews productivity plans with VISN leadership to determine whether local providers are able to mitigate the impact of productivity losses or if additional VA resources will be required.

In addition, VHA's Office of Community Care and Office of Veterans Access to Care, in coordination with OEHRM, implemented planned mitigation strategies for pre-existing staff shortages at VA sites prior to COVID-19 impacts.

Question 11: **How has VA streamlined the ability to quickly and easily hire current or past trainees?**

VA Response: VHA is committed to improving Veteran access to health care by connecting, matching, placing and retaining highly qualified VA-trained HPTs in critical vacancies. The VA-TRE standardized model is a virtual event focused on providing a streamlined non-competitive recruitment and hiring process that connects facilities and qualified VHA-trained HPTs who are interested in staying with VA and finding ideal job opportunities. VA-TREs are occupation-focused and are scheduled based on proximity to peak recruitment periods. Optimally, the calendar is designed to recruit during or prior to private sector recruitment efforts. VA-TREs have expanded from 1 planned event in FY 2019 to 19 planned events for FY 2021, covering 17 clinical specialties. To date, these events have led to 158 VA trainees hired for future openings. This model is very popular with both candidates and hiring managers to leverage trainees from one location into other VA locations Nationwide with hiring needs.

In addition to this standardized model, VHA is building and implementing best-practice recruitment and onboarding models, a time-to-hire (T2H) guidebook and additional supporting educational materials for trainee recruitment and hiring. VHA routinely provides educational training sessions to the field on trainee recruitment and hiring best practices.

OCHCO, HR IT is developing the capability to share information across VAMCs about physician trainees for purposes of filling vacancies. The system-wide method used for this purpose is a combination of HR•Smart and USAStaffing. HR•Smart captures personal, job, facility, education and discipline information for paid and non-paid appointments to include not to exceed (NTE) dates for physician trainee appointments. USAStaffing captures information needed to onboard trainees and ensure they have credentials and access to facilities and systems to work. USAStaffing is up and running in two locations. HR•Smart and USAStaffing will be available VHA-wide in September 2020 and used to transition physician trainees from NTE positions to permanent positions before appointments expire.

Question 11a: **Does VA need any additional authorities or funding to improve this?**

VA Response: VHA must be able to move with agility and flexibility where and when needed to rapidly respond to a diverse set of patient care needs. The multiple appointment and compensation laws and regulations are complex and can hinder the ability of VHA to recruit and retain the very best employees for our Veterans. VA will continue to request new legislative authorities in the President's Budget requests.

Question 12: **What is VA doing to increase training opportunities and build the health workforce, specifically in Rural America?**

VA Response: VHA understands the critical needs of rural health facilities and utilizes scholarships and other programs to ensure we recruit and retain highly qualified candidates including the following:

- 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. Participants incur a 1 to 3-year service obligation following completion of their academic program. During FY 2019, EISP awarded 79 new scholarships to 17 rural health facilities with a commitment of $1.3 million in scholarship funding.

- Health Professions Scholarship Program (HPSP) awards scholarships to students receiving education or training in a direct or indirect health care services discipline to assist in providing an adequate supply of these personnel. HPSP provides scholarships to selected students along with a monthly stipend and an annual book stipend in return for a service obligation in hard to recruit and retain positions at health care systems that serve rural and non-rural Veterans. During FY 2019, the Scholarships & Clinical Education Office reported 119 HPSP participants completing service obligation periods. Of those in their service obligation period, 8.4% went to rural locations.

- The Veterans Access, Choice, and Accountability Act of 2014 (VACAA) and subsequent extension in the 2016 Omnibus Bill required that VHA increase Graduate Medical Education (GME) physician trainees by up to 1,500 positions by 2024. One of the focus areas for VA was establishing new GME positions in VA facilities with no prior GME, which were often rural. VA's Office of Academic Affiliations (OAA) also established planning and educational infrastructure grants to support facilities—rural and nonrural—to help them develop and maintain a high-quality educational environment for trainees. At the end of academic year 2018-2019, 6% (75.9/1303.27) of FTE GME trainee positions were in rural areas.

- As qualified educators are needed to increase rural health professions training opportunities, OAA in partnership with the Office of Rural Health began the Rural Interprofessional Faculty Development Initiative (RIFDI) in 2018. The 58 sites with no or low GME identified through VACAA were invited to participate in the 2-year RIFDI course. Twenty-three sites responded to the invitation, and 45 participants are now actively engaged in training to become health professions educators.

- Since 2012, partnering with VA's Office of Mental Health and Suicide Prevention, OAA began a phased inter-professional expansion of mental health trainees in VHA. Approximately 100 Associated Health trainee positions were added at rural sites over 7 rounds of funding.

Question 13: **How have training programs at VA been impacted by COVID-19?**

VA Response: OAA oversees over 120,000 clinical trainees rotating through VA sites of care. During the height of the COVID-19 pandemic this spring, trainees from many programs were pulled out of VA for varying lengths of time but are now being re-introduced under VA safety guidelines. Many trainees were given telework flexibilities and contributed to Veteran care in a variety of virtual ways, such as Veterans Video Connect. Some training programs are also being extended if trainees require extra clinical time for graduation.

Question 13a: **Does VA plan to pause any residency, rotation, or training programs?**

VA Response: VA has no plans to pause any residency, rotation or training programs; the heath care workforce pipeline remains critically important for Veteran care.

Question 13b: **If so, which programs?**

VA Response: Not applicable.

Question13c: **Will they resume for the upcoming 2020-2021 school year?**

VA Response: Not applicable.

Question 14: **With the potential rise in homelessness and housing insecurity due to so many veterans being unemployed as a result of the pandemic, what steps are you taking to recruit more HUD-VASH case managers and fill these critical positions?**

VA Response: Recognizing the continued challenges with recruitment of Department of Urban Development-VA Supportive Housing (HUD-VASH) case managers, VA's HPO has developed a policy memo, currently under review and pending clearance, which establishes a requirement that 90% of all HPO-funded positions must be filled at any given time. The memo requires expedited hiring for VA HPO-funded positions and announces funding availability during FY 2021 for recruitment and retention incentives at VAMCs with high vacancy and turnover rates. HPO has established an implementation team of hiring and operations subject matter experts to provide intensive technical assistance, consultation and direction to VISNs and VAMCs with high vacancy rates. The team is currently working with multiple VAMCs and VISNs to develop actionable plans to support increased hiring rates, and once the memo is cleared, HPO will have increased authority to implement concrete actions to increase filled rates for homeless program positions.

Questions for the Record from Senator Brown

Question 1: **Please provide a breakdown of VISN 10 VAMCs incentive pay to workers.**

VA Response: So far, VISN 10 has spent $2.2 million this fiscal year on recruitment, retention and relocation (3R) incentives. The breakdown is provided in the table below.

Station	3R Spent FY 2020	Percent of VISN Total
VAMC Saginaw, MI	$ 5,956	0.3%
VISN 10: Serving Veterans in IN, MI, and OH	$ 66,078	2.9%
VAMC Chillicothe, OH	$ 73,077	3.2%
VAMC Battle Creek, MI	$ 105,943	4.7%
ACC Columbus, OH	$ 115,029	5.1%
VAMC Dayton, OH	$ 134,526	5.9%
VAMC Cincinnati, OH	$ 181,474	8.0%
VAMC Indianapolis, IN	$ 238,308	10.5%
HCS Northern Indiana (Ft. Wayne)	$ 242,289	10.7%
VAMC Detroit, MI	$ 299,423	13.2%
VAMC Ann Arbor, MI	$ 304,081	13.4%
VAMC Cleveland, OH	$ 506,914	22.3%
VISN 10 Total	**$ 2,273,098**	100%

In VISN 10, short-term group retention incentives were authorized based on the special needs of VA to retain essential employees during COVID-19 at their facilities in Cleveland, Ohio and Indianapolis, Indiana. The determination was made in these locations that there was a high risk that a significant number of employees working in the Intensive Care Unit (ICU), Emergency Department and Respiratory Therapy would likely leave Federal service due to competing private sector pay practices.

Additionally, VISN 10 authorized $5,000 special contribution awards to those employees who volunteered for 14-day physical deployments to assist with the COVID-19 response in Detroit, Michigan specifically for demonstrating superior accomplishments and acts in the public interest related to COVID-19 (i.e.: screening patients, expanding negative pressure rooms, expanding ICU beds, upskilling employees and matrixing care plans with new employees).

Question 2: **Was the incentive pay limited to RNs and doctors, or did it also include screeners, janitorial staff and all others who could have come into contact with COVID-19?**

VA Response: In VISN 10, incentive pay was not limited to RNs and physicians but was also offered to Medical Support Assistants, Health Technicians, Intermediate Care Technicians, Respiratory Therapists, Electrocardiogram Technicians, Licensed Practical Nurses (LPN) and Certified Nursing Assistants.

In VISN 10, the majority of 3R recipients were RNs, followed by police, physicians, general health science officers and LPNs.

VHA Summary Level Plan	Submission	Received	FY 2020	FY 2021	Total	Obligated through EOM June	Percent of FY 2020 Plan
Care Delivery Costs (includes community care)	**$15,069,372,310**	**$16,882,272,310**	**$4,664,000,000**	**$9,675,000,000**	**$14,339,000,000**	**$1,883,966,381**	**40.4%**
Hospital Costs	$9,988,500,630	$11,490,923,430	$3,481,000,000	$5,209,000,000	$8,690,000,000	$1,594,539,149	45.8%
Personal Services (Salaries & Awards)						$432,562,067	
Travel & Transportation						$6,084,614	
Contracts including Rents, Communications & Utilities						$171,995,462	
Phamaceuticals						$166,878,675	
Supplies and Materials (including test kits)						$432,676,011	
Equipment						$373,612,489	
Land & Structures including NRM						$10,729,833	
PPE	$3,030,871,680	$3,030,871,680	$500,000,000	$2,200,000,000	$2,700,000,000	$55,720,198	11.1%
Emergency / Urgent Care	$2,050,000,000	$2,100,000,000	$323,000,000	$1,777,000,000	$2,100,000,000	$29,815,451	9.2%
Homelessness			$360,000,000	$489,000,000	$849,000,000	$203,891,583	56.6%
Emergency Management Activities	**$100,560,000**	**$100,660,000**	**$126,000,000**	**$552,000,000**	**$678,000,000**	**$9,787,454**	**7.8%**
Emergency Management Coordination	$16,560,000	$16,560,000	$100,000,000	$500,000,000	$600,000,000	$5,561,803	5.6%
Public Affairs	$9,150,000	$9,150,000	$1,000,000	$2,000,000	$3,000,000	$87,660	8.8%
Physical Security	$74,850,000	$74,850,000	$25,000,000	$50,000,000	$75,000,000	$4,137,991	16.6%
Expanded Telehealth Capacity	**$255,067,690**	**$255,067,690**	**$290,000,000**	**$10,000,000**	**$300,000,000**	**$40,919,093**	**14.1%**
Grants for Construction of State Extended Care Facilities	**$0**	**$150,000,000**	**$0**	**$150,000,000**	**$150,000,000**	**$0**	**0.0%**
TOTAL:	**$15,425,000,000**	**$17,388,000,000**	**$5,080,000,000**	**$10,387,000,000**	**$15,467,000,000**	**$1,934,672,928**	**38.1%**
Transfers pending from base funding						$238,896,338	
			$5,080,000,000			$2,173,569,266	42.8%

Future Unidentified Costs **$1,921,000,000**

Acceleration of DMLSS to improve ordering and tracking of supplies
Regional Readiness Centers pre-place
supplies to level set supply needs for normal
operations and emergent situationsVaccines
for Veterans and VHA staff

Anticipated Transfer Requests

Veterans Canteen Service Support
Level setting appropriations based on actual and anticipated expenditures

Question 3: **Will incentive pay be provided to those workers for the length of the pandemic?**

VA Response: VISN 10 approved retention incentives for occupations across many disciplines. However, the focus was on those occupations where there was an

identifiable risk in losing staff to other health care organizations who offered enticements such as sign-on bonuses or unusually high salaries. These retention incentives are scheduled to be reviewed at the end of October and will either be extended or expired based upon operational needs.

Some VISNs, VAMCs and other VA organizations have determined that short-term retention incentives due to VA's special needs (i.e. COVID-19 response) are appropriate in order to retain key staff who would be likely to leave Federal service without an incentive. Local leadership has the ability to make the determination regarding which individual employees, or groups of employees (e.g. by occupational series at a specific work location), will receive incentive pay. Incentive percentages authorized are determined based on budgetary considerations and the estimated percentage required to retain the individual or group. In VISN 10, the group incentives were authorized for a 6-month period initially, with the option to review and reauthorize after assessing the state of the pandemic, as well as local labor market conditions.

Of note, retention incentives differ from hazard pay in that the intent is to retain staff via increased compensation in exchange for a commitment to remain with the organization.

Question 4: **Please provide a detailed background of the disciplinary action taken under the Whistleblower Protection and Accountability Act to include, pay grade, demographic data and racial breakdowns.**

VA Response: As agreed by the Committee, this response will be provided at a later time using the Request for Information format.

Question 5: **Can you tell us how the CARES Act telehealth and teleworking funding has been allocated thus far?**

VA Response: VA has allocated CARES Act funding to manage the exponential growth of the Telehealth VA Video Connect program advanced by the COVID-19 pandemic. As of July 23, 2020, VA has allocated approximately $56.2 million for clinical support equipment and peripherals, provider training, 24/7 help desk support and expansion,

additional application licenses and application design development and implementation. Listed below is a breakdown of the purchased items.

FY 2020 COVID-19 Purchased Items	Allocated Funding
VA Video Connect (VVC) **Provider** Equipment (Headsets and Webcams)	1,298,359.50
Patient IPAD Tablets with Data Plans (6,000)	1,967,794.00
DigiCert SSL Certificates (Add Capacity to *Care.va.gov*)	64,020.00
Memorandum of Understanding for Additional Training Staffing	20,851.00
National Telehealth Help Desk 24/7 and Additional Staff	268,681.83
PROVIDER iPad and Accessories	7,999,984.14
Telehealth Sys and App Release, Implementation and Deployment Support	546,012.00
PROVIDER Apple iPads (9,000)	12,201,554.25
PATIENT Apple iPads (4,000)	3,212,060.40
PROVIDER DELL Monitors	804,000.00
NTTHD/MSD Additional Helpdesk Staff (30) thru 8/31	2,383,837.00
SMS Gateway Services Expansion	77,184.00
Remediation Optional Tasks (App development and Implementation)	5,834,499.32
DigiCert SSL Certificates (Add Capacity to *Care2.va.gov*)	80,902.50
Adobe Connect 2,000 Additional Licenses	52,972.00
Telehealth Clinical Technician Optional -Contract# 203	538,985.00
iPad Pro Distribution @ Mobile Service Help Desk	369,690.00
Memorandum of Understanding VC-CORE - Mental Health Support	800,000.00
Authority to Operate (Stoneware, AIP, CHAT)	500,000.00
PATIENT iPhones for Homeless	8,065,868.00
PATIENT iPads (7000)	7,636,970.00
Project Integration and Program Support	633,500.00
CHISS Optional Tasks (# 224)	895,000.00
Total	**56,252,724.68**

Question 6: **What are VHA's plans for the unallocated funding?**

VA Response: The attached spreadsheet contains the VHA spend plan for CARES Act resources through the end of FY 2021 and shows execution against that plan as of the end of June. VA will continue to monitor and notify Congress should estimates change.

Question 7: **Please provide VHA's staffing model and explain what steps VHA puts in place to ensure providers have the appropriate support staff- nursing, clerical, etc. to meet their patients' needs.**

VA Response: OPES was developed to assist VHA leadership in developing effective management tools, systems and studies to optimize clinical productivity and efficiency

so the informed staffing decisions are made in support of the goals of clinical excellence, access and the provision of safe, efficient, effective and compassionate care. Multiple tools are provided to the leaders at VAMCs to assist them in making the most appropriate decisions for staffing at their individual facility.

Specialty Provider Workforce Report

The accepted industry approach for addressing staffing needs is to compare staffing against workload using benchmarks internal to the organization. VA accomplishes that using its extensive data systems. VHA maintains a comprehensive database of the provider workforce with near real-time reporting (by pay period) of staffing levels, clinical workload and productivity by specialty and practice setting. The Provider Productivity Leadership Dashboard provides detailed information about the staffing levels and clinical workload for each VAMC. VHA uses an industry accepted metric of a wRVU to measure provider productivity (clinical work per provider). Provider clinical workload, measured in wRVUs adjusts for the differences in time, intensity and complexity of medical services. This provides an analytical tool designed to assist VHA managers and leadership in effectively managing their specialty provider practices towards the goal of ready access to quality specialty services. VHA tracks specialty care practice and provider level productivity performance for 30+ areas of specialization as well as Advanced Practice Providers.

Within health care, approaches exist to model staffing requirements; however, there is no consensus on a definitive methodology or technique. Recent literature suggests that an integrated approach that combines elements of supply and demand with that of benchmarking. VHA maintains a Provider Workforce Report that includes these integrated elements. The Provider Workforce Report delivers system level staffing norms by geographic location (VISN) and Practice Setting (Medical Center Complexity Group). Staffing levels per population (Core Facility Unique Patients and Specialty Specific patients treated) are included in this report as well as provider productivity levels. Additionally, the composition of the care team (Physicians, Advanced Practice Providers and Support Staff levels) are included. This report can be used to determine comparison staffing levels; however, local facility managers must contextualize these data to their potentially unique characteristics such as patient reliance and the ability to recruit and retain a workforce consistent with its mission and infrastructure.

Medicine and Surgery Staffing Models

Within VHA, demand projections are complicated as a result of variation in VA reliance and more recently the Choice Act and VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act legislation. OPES has specifically engaged in several different approaches to monitoring physician staffing; specifically, OPES targeted physician productivity to ensure appropriate staffing considering appropriate workload for the staff available.

OPES developed a secondary approach to measuring appropriate physician staffing within the medicine and surgical specialties. OPES developed actual-demand based models employing statistical analysis of available data to evaluate staffing requirements

by examining factors related to patient care needs in the areas of SC-Medicine and SC-Surgery. The models are designed to level the playing field by accounting for patient disease severity, reliance and facility characteristics. The resulting models demonstrate the relative level of overstaffing and understaffing at facility and VISN levels based on the characteristics of the parent facilities. The FTE analyzed in these models represent a focused group of employees (VA paid physician staff plus estimated contract staff within selected specialties). OPES methodology provides an overall picture of physician staffing at the aggregate medicine specialty and aggregate surgery specialty level while taking into account all types of physician workload and staffing practices.

Mental Health Workforce Report

Mental Health is an increasingly important component of health care. VHA must be able to understand and evaluate the care Veterans receive in this field. The Mental Health Workforce Report provides comparative data for mental health providers at the station level by assessing productivity using metrics of FTE, wRVUs and the number of encounters. Productivity data include labor from psychiatrists, psychologists, CNS, NP, PA and Social Workers. FTE for non-Clinical and Administrative Staff in mental health programs are also reported. The Mental Health Workforce Reports are designed to provide a management tool for the systematic, longitudinal measurement and reporting of clinical productivity, efficiency and staffing in VHA.

Operational Workforce Report

The Operational Workforce Report (OWR) was developed to provide insight into the current strength (absolute and standardized) of key health care workforce members and critical infrastructure support necessary for safe and efficient health care delivery. This report includes all occupations at individual facilities and is benchmarked against like facilities.

In addition to these models, other tools produced by OPES are useful to determine staffing needs and solutions include the following:

- Operating Room productivity;
- Anesthesia productivity;
- Sterile Processing Service Charts and triggers;
- Efficiency Opportunity Grids;
- Emergency Department Utilization Model;
- Acute Bed Days of Care Model;
- End of Life Expenditure Model;
- Administrative Staffing Model;
- Social Work Productivity; and
- Specialty Productivity-Access Report and Quadrant.

Questions for the Record from Senator Hirono

Question 1: **At a hearing three weeks ago, Dr. Stone acknowledged that the VA would like to be able to provide on-demand testing for its employees, and one current barrier was an insufficient supply of cartridges and swabs. Providing employees access to on-demand testing is absolutely vital to ensure the health and safety of both VA employees and our veterans. Can you please provide an update on VA's progress toward establishing on-demand testing?**

VA Response: Access to on-demand testing for Veterans and VA staff remains constrained due to limitations in reagents and supplies for COVID-19 testing equipment. For example, VA is currently running one type of equipment at 12% capacity due to shortages of consumables from manufacturers. Until recently, VA used commercial laboratories for some testing needs; however, that system now has test turnaround times in excess of 1 week. VA continues to balance the various testing platforms available in VA to address testing demand for symptomatic Veterans and staff, high risk exposures, outbreaks, surveillance and expanding services.

Question 1a: **Are swabs and cartridges still in short supply, and if so, what are you doing to obtain more?**

VA Response: VA has procured supplies through local and national contracts and through support from Federal stockpiles. VA has adequate sample collection supplies (e.g. swabs) to test Veterans and staff. Supplies required to run the various testing platforms in VA remain constrained. VA continues to work with testing platform vendors to reinforce commitments and to increase supplies when possible. In addition, VA continuously reviews new testing options where equipment and testing supplies are not constrained for potential use at VA facilities.

Question 1b: **Would it help to fully mobilize the Defense Production Act to help address nationwide medical supply shortages like what we've seen with swabs?**

VA Response: Defense Production Act (DPA) orders are just one tool the Government may use to address Nationwide medical shortages, and they are not appropriate in every situation. For example, industry can see a DPA order as a negative enticement that puts manufacturers at risk if there are no future, long-term commitments to purchase the medical item in question at a level to keep the manufacturer solvent.

Question 2: **Because of national shortages, many VA facilities have had to implement austerity measures for masks and PPE during COVID-19. Although VA has said all VHA staff with direct patient care roles should be receiving one new mask per shift, VA has not issued guidance to that effect and the Nurses Organization of Veterans Affairs reports that its members indicated they are reusing PPE. Will VA issue guidance that VHA staff with direct patient care roles receive one new mask per shift?**

VA Response: VA facility leadership develops a localized plan for PPE use based on the duties and responsibilities of each VA employee. All VA staff are provided with the

PPE appropriate for conducting those duties which may include more than one mask (or a given type of mask) per shift. A national policy would not capture the nuances required to ensure that employees and Veterans are protected from COVID-19 infection.

Question 2a: **What is VA doing to avoid implementing austerity measures for PPE and masks in response to the increase in COVID-19 cases?**

VA Response: VA has expanded and added contracts with several PPE manufacturers to limit exposures to shortages at one or more companies. VA has also partnered with the State of Vermont to procure PPE that meets U.S. Food and Drug Administration requirements directly from manufacturers in China.

Question 3: **COVID-19 is an unprecedented public health and economic crisis, and our health care workers are on the front lines risking their health and safety every day. Undoubtedly, this pandemic will wear on them and many employees may experience burnout or have mental health needs. What is VA doing to support the mental health needs of its health care workforce?**

VA Response: In response to the pandemic, NCHAV created an educational series promoting self-care and wellness in direct support of VA homeless program staff. A series of offerings have been provided and include the following:

1. On April 6, 2020, the #LiveWholeHealth blog series was launched to provide self-care resources that anyone can experience at home. This ongoing series includes breathing exercises, stretching, meditation, fitness, yoga, tai chi and more. This series continues to provide valuable resources that can be used by Veterans, family members, caregivers, employees and the public. Forty-one unique episodes have been published through July 31, 2020.

2. On April 10, 2020, under the leadership of the National Center for Organization Development, "Self-Care Resources for Your Whole Health" was launched to provide resources and virtual tools to help employees manage stress and promote Whole Health. Content is updated weekly to support employee physical, mental and emotional well-being. There have been 23,816 page views through July 31, 2020.

3. On April 15, 2020, a national webinar, "Self-Care in the Time of COVID-19: Ways You Can Cope with Coronavirus Stress, Anxiety and Isolation" was conducted with VA homeless program staff. Over 900 homeless program staff attended this webinar.

4. In May 2020, a podcast series, "Self-Care for VA Homeless Program Staff" was published and features seven episodes with experts from across VHA addressing ways to balance personal and professional life

through wellness and self-care during the pandemic. Since publication, these podcasts have been downloaded over 3,400 times.

5. The VA COVID-19 Employee Support Toolkit was developed by the VHA Organizational Health Council to provide a framework for successfully navigating the implementation of support systems for staff.

6. VHA's Office of Patient Centered Care & Cultural Transformation has collaborated and continues to partner with multiple program offices to share Employee Whole Health support and self-care strategies on national forums. Examples include Office of Mental Health and Suicide Prevention, Specialty Care Services and Spinal Cord Injury Services.

7. VAMCs have created Employee Whole Health virtual approaches to support mental health and well-being and collaborate with VISNs to create shared calendars of Whole Health resources for access by all employees.

8. Many VAMCs have aligned their existing employee support programs around the well-being and resiliency of their workforce as a part of their Incident Command Response to COVID-19. This includes coordination between the EAP, Employee Whole Health, Occupational Health, Chaplain services and leadership support to respond quickly to employees' mental health needs.

Additionally, the HPO COVID Response Team disseminates daily briefs to the field and updates HPO's internal-facing website for VAMC homeless program staff daily, to include the most recent guidance provided by VA and CDC on topics related to infection control and PPE guidelines; resources to support mental health and physical well-being for direct service staff; and updates to HPO guidance.

Question 4: **In recent weeks, our country has been experiencing a tremendous acknowledgement of the racial disparities that have existed for so long. The pandemic has further exposed the disproportionate access people of color have to critical services like health care. One way to start to address racial disparities in health and health care is to have a more diverse health care workforce that is reflective of the communities it serves. Does VA collect data on the diversity of its health care workforce? If so, what does the data show?**

VA Response: The VHA health care workforce is generally more diverse than the Relevant Civilian Labor Force (RCLF), a metric from the U.S. census that allows us to compare diversity representation with the diversity of relevant occupations in the civilian labor force. Currently, the total VHA workforce is 57% white; 25% black; 9% Asian; 7% Hispanic; 1.5% Native American; 0.4% Native Hawaiian/Pacific Islander; and 0.6% mixed race/other. The workforce is also 63% female and 37% male. VHA's workforce is at least as high or higher than the RCLF for all minority categories with the exception of Hispanic males and females, who are underrepresented compared to what we would

expect at 3.1% and 4.0% in VHA compared to the RCLF of 8.5% and 6.2% for males and females, respectively. The following table provides the break-down of race for the total workforce, clinical occupations, physicians and nurses:

	All		Clinical		Physician		Nurse	
White	202,744	57%	133,666	60%	16,288	61%	45,003	60%
Black	89,824	25%	43,828	20%	1,455	5%	14,162	19%
Hispanic	25,322	7%	14,539	6%	1,506	6%	4,522	6%
Asian	31,369	9%	26,489	12%	7,000	26%	10,032	13%
Native Hawaiian/Pacific Islander	1,602	0.4%	898	0.4%	75	0.3%	305	0.4%
Amer Indian	5,218	1.5%	3,114	1.4%	378	1.4%	1,087	1.4%
Other	2,208	0.6%	1,147	0.5%	77	0.3%	364	0.5%

Question 4a: **What steps is VA taking to recruit, retain, and promote to higher leadership position diverse candidates?**

VA Response: Internal leadership development programs are one pathway, or step, for VA employees to move toward higher leadership positions and may contribute to retention. Broad recruitment efforts for these VA leadership programs include marketing in different mediums such as website, email, newsletter and virtual sessions. Data indicate that there is a diverse applicant pool of VA employees for these VA leadership programs, which is reflective of the current VA population. However, diversity does slightly diminish as applicants are reviewed and selected for program participation. VA is taking several steps to explore this disconnect. An operational study is currently underway to assess the application process and its components, and a second operational study will launch in January 2021 to measure the current review process against a standardized tool assessing leadership potential. These efforts may remove the unconscious bias that may be inherent in the application process. Ultimately, these operational studies will help improve program processes to ensure that our diverse VA applicant pool is better reflected in the participant and graduate pools of our internal VA leadership development programs.

Although participation in a leadership program does not guarantee a leadership role, VA recognizes that graduates interact with current VA leaders on committees, projects and stretch assignments, which adds to their experiences.

Question 5: **Across the country – both within VA and in the broader health care system – recruiting providers to serve in rural communities remains a challenge?**

VA Response: Recruiting health care professionals to rural areas remains a difficult challenge both within VA and in the broader health care system. The U.S. Census Bureau reports that about 19.3% of the U.S. population lives in rural areas. Similarly,

most health care providers choose to live in urban and suburban areas. However, several factors are predictive of health care providers choosing rural areas to practice:

- Growing up in a rural area;
- Desire for rural practice at time of medical school admission;
- Significant training in a rural area; and
- Post-graduation rural practice "pay-back" requirement.

Many medical schools are using this knowledge to tailor their acceptance criteria and develop rural educational tracks. These rural tracks allow trainees to directly experience the benefits and challenges of practicing in a rural environment before choosing a location to practice. Rural VAMCs participate in some of these rural track training programs.

Question 5a: **What is VA doing to help recruit and retain providers in rural areas?**

VA Response: Several sections in the VA MISSION ACT of 2018 address recruitment and retention of health care providers into rural areas and other underserved areas. These sections include:

- **Section 301** - Health Professional Scholarship Program for Physicians and Dentists (HPSP). A minimum of 50, 2 to 4-year medical or dental school scholarships (tuition, fees and stipend), are offered in exchange for VHA service. This scholarship will function similarly to the HPSP offered through DoD. After completing their training, participants are given a VHA assignment in an area of critical need that matches their specialty training. The number of scholarships available will be based on VHA determined provider shortages. This authority is set to expire in 2035. This year, 50 scholarships have been awarded.

- **Section 303** - The Specialty Loan Repayment Program offers $40,000 per 12 months of clinical service in VHA to physicians in residency training, with a maximum repayment of $160,000. Awardees will then select their location of service from a VHA-issued list of facilities where there is a high demand for their specialty. This program is scheduled to begin in FY 2021.

- **Section 304** - "Veterans Healing Veterans" Medical Access and Scholarship Program. This 1-year pilot program for Academic Year 2020-2021 offers 18 scholarships that provide 4 years of tuition, fees and stipend support for Veterans at five Teague-Cranston medical schools and four historically or predominantly black medical schools in exchange for 4 years of clinical practice at a VA facility after completion of post-graduate specialty training. The Teague-Cranston Act of 1972 created five medical schools in conjunction with established VAMCS to provide care to Veterans and community members in rural and other medically-underserved areas. Fifteen scholarships have been awarded in this 1-year pilot program.

- **Section 403a** - Enables VA-paid residents to provide care in "covered" Federal facilities outside of the traditional VA campus. A minimum of 100 physician residents will train in facilities of the Indian Health Service, tribal health care organizations or designated underserved VA areas, augmenting both the current health care workforce and creating a new workforce pipeline. Federally Qualified Health Centers and DoD Military Treatment Facilities are also included on the list of covered facilities as potential resident training locations. Regulations for the pilot project have been drafted and are being prepared by VA for publication in the Federal Register.

- **Section 403b** - The pilot project authority gives VHA the ability to assist with development costs of new residency programs starting in VA designated underserved communities. Regulations for the pilot project have been drafted and are being prepared by VA for publication in the Federal Register.

Question 5b: **What is VA learning from this expansion of telehealth use during COVID-19? Is VA considering permanently expanding any telehealth authorities to improve access for rural communities?**

VA Response: VA continues to review and analyze the exponential growth of telehealth services advanced by COVID-19 pandemic feedback from the experiences of Veterans, their caregivers and families to compile lessons-learned, to forecast future needs in alignment with VA strategic objectives. To understand patient experiences and outcomes related to the use of virtual care during COVID-19, VA's Office of Connected Care has established a research core to analyze virtual care tools in use. Here are related facts in current analysis:

- VA's Veterans Experience Office conducted structured interviews with Veterans from across the country who had done a video visit during the COVID-19 pandemic and found that Veterans overwhelmingly preferred video over phone calls, noting that it made them feel more connected to their providers.

- From March 1 to May 31, 2020, there has been an increase of 401,200 (560,300 to 961,500) Veterans using telehealth. This represents 16% of all Veterans who receive care at VA.

- There were 21,674 Providers in Primary Care, Mental Health and Specialty Care who had provided at least one visit to an off-site location by the end of February 2020. At the end of May 2020, 30,273 providers had completed at least one visit, an increase of 8,599 providers. Also, at the end of May, 87% of Mental Health Providers, 83% of Primary Care providers and 42% of Specialty Care providers had provided at least one visit to an off-site location.

- Week-over-week, telehealth video appointments have increased by 1,065% since February 2020, increasing from approximately 10,000 appointments a week in early February to more than 127,000 appointments during the last week in May.

- Despite representing 8% of the total Veteran population, women Veterans made up 25% of all video-to-home visits; 17% of users launching secure messaging (secure e-mail through VA's patient portal); and 14% of VA loaned tablet recipients between February and June 2020.

- To prevent COVID-19 exposure, many VA providers are teleworking completing telehealth video sessions with Veterans from their homes using personal equipment or Government-furnished equipment. The ability to do this, particularly in COVID-19 hotspots, has resulted in sustained access to care across multiple modalities (secure messaging, telephone, video and via mobile applications) and many specialties.

- During the pandemic, VA-supplied tablets have been used on the hospital wards to facilitate timely communication with patients and to optimize infection control.

- Remote Patient Monitoring-Home Telehealth is a program where Veterans enroll and are monitored remotely using telehealth-provided biometric devices from their home or other remote locations. The Veteran responds daily with biometric data as well as responding to questions on their health status. Since the advent of COVID-19, specific disease management programs were developed that monitor Veterans for symptoms related to COVID-19. Through July 13, 2020, more than 5,000 Veterans were monitored daily for COVID-19 symptoms using this program.

VA's patient portal, My HealtheVet, which leads the industry in customer satisfaction scores and in the percentage of enrolled patients who use the portal, has seen a consistent increase in utilization, which has accelerated further during the COVID-19 pandemic. On the portal, VA processed over 9.37 million prescription refill requests and managed over 9.5 million secure messages between Veterans and their health care teams from January to May 2020. In the context of the COVID-19 pandemic, this represents approximately 770,000 additional prescription refill requests and more than 2.11 million additional secure messages initiated by VA patients and their health care teams from January-May 2020, compared to January-May 2019.

Questions for the Record from Senator Sinema

Question 1: **Delays in credentialing has been identified as a major barrier to timely hiring for medical professionals at VA. In your testimony, you identified some of the changes made to the credentialing processes to expedite hiring during the pandemic. Of those changes made to the credentialing process, which does the VA want to keep in place and what is needed to do so?**

VA Response: Credentialing is one small portion of the onboarding process for providers coming to VHA. VHA has always had a method of expedited credentialing to meet urgent patient care needs in accordance with Joint Commission standards. The use of this process has been expansive during COVID-19 to meet the urgent patient care needs throughout VHA. The expanded use was supported by Joint Commission's modifications of their standards to also address COVID-19 needs throughout the health care industry. Full credentialing remains a requirement for all health care providers who require maintenance of licensure, certification or registration who have been onboarded to meet urgent patient care needs. The average credentialing time in VHA is 30 days, which is exceptional. The industry standard is 90-120 days, on average, to credential and onboard physicians.

VHA will continue to provide an expedited credentialing process to meet urgent patient care needs. The process in place is guided by Joint Commission standards.

Question 2: **With the rapid onboarding of so many new employees, how has VA adjusted its training and supervision processes to ensure new hires learn to successfully navigate VA procedures?**

VA Response: VHA has remained agile with meeting the demands of training and supervision processes to ensure new hires successfully navigate VA procedures. VHA implemented a Mandatory Training Moratorium to reduce impact and stress of non-mission critical training on VHA clinicians during COVID-19 surge response and deferred suspense dates for non-COVID-19 related training by 120 days.

VHA recognized the need to onboard and upskill staff to prepare for potential pandemic related surges and rapid deployment needs. Nursing staff were onboarded utilizing adjusted criteria to ensure COVID-19 competency while streamlining lower priority traditional onboarding materials/processes. Additional "Nurse Skills Updating" training was offered for critical care, medical surgical, Community Living Centers, Emergency Departments and post-acute COVID-19 nursing care; however, these trainings were not included for onboarding but were developed to better meet needs. Additionally, clinical staff leveraged Society of Critical Care Medicine best practice training modules.

Also, the use of Mandatory Training for Transient Clinical Staff (MTTCS) enabled local facilities to more rapidly and efficiently onboard temporary employees (120-day hires). The MTTCS is a consolidated and abbreviated course containing the requisite VA

mandatory and required training curriculum. Additionally, new staff were provided with specific content related to COVID-19 and PPE precautions as well as other mission-critical training per local requirements.

Question 3: **In her testimony, Ms. Bonjorni stated that VA won't be able to retain all of the new hires without regulatory or legislative changes. Please expand on what new hires VA would like to keep but does not have existing authority to do so.**

VA Response: In response to the COVID-19 pandemic, OPM authorized the use of 5 CFR 213.3102(i)(3) Schedule A appointing authority, which offers great hiring flexibility during a pandemic as VA can hire nearly any T5/non-clinical position noncompetitively; however, this appointing authority is temporary in nature, so VA can only appoint individuals on a temporary basis.

Question 3a: **What policy or statutory changes are needed if the VA wishes to retain these new hires?**

VA Response: Appointments, made using Schedule A emergency appointing authority, are temporary (limited to 1 year with the possibility of a 1-year extension) and limited to those positions that were hired to directly respond to the COVID-19 pandemic. VA will continue to request new legislative authorities in the President's Budget requests.

Question 4: **During the pandemic response, VA afforded pay incentives to certain frontline positions. What frontline positions received pay incentives, and how did VA determine which positions received these incentives? Please provide a chart showing the breakdown of this data.**

VA Response: The following table shows a breakdown of 3R incentives (and specifically retention incentives) for the top 20 occupations (based on the amount of 3R money received in FY 2020) and the portion that was delivered post-COVID overall. The top 3 occupations receiving incentives in FY 2020, are RN, Physician and LPN, but many other frontline occupations are represented in this top 20 list.

Occupation	3R Post-COVID	FY20 Total	Retention Post-COVID	Retention FY20 Total
610 - Nurse	$62,292,235	$65,237,738	$60,717,309	$61,574,602
602 - Medical Officer	$39,020,221	$50,912,685	$33,205,184	$33,829,111
620 - Practical Nurse	$2,846,476	$2,962,976	$2,790,138	$2,817,014
601 - General Health Science	$2,224,550	$2,954,881	$2,062,416	$2,485,095
679 - Medical Support Assistance	$2,669,702	$2,733,519	$2,668,202	$2,700,644
621 - Nursing Assistant	$2,474,639	$2,533,004	$2,445,330	$2,465,696
660 - Pharmacist	$2,154,265	$2,442,858	$2,064,605	$2,191,611
185 - Social Work	$2,213,458	$2,409,776	$2,085,804	$2,085,456

180 - Psychology	$1,308,389	$2,182,255	$851,187	$1,104,525
3566 - Custodial Working	$1,696,060	$1,998,108	$1,667,482	$1,938,527
605 - Nurse Anesthetist (Title 38)	$1,633,665	$1,857,346	$1,585,160	$1,767,011
603 - Physician Assistant	$1,252,505	$1,792,300	$1,135,132	$1,306,748
644 - Medical Technologist	$875,010	$1,621,766	$696,908	$1,304,153
83 - Police	$895,633	$1,616,082	$634,263	$1,125,966
647 - Diagnostic Radiologic Technologist	$1,157,715	$1,451,923	$1,104,974	$1,308,553
640 - Health Aid and Technician	$1,134,162	$1,253,134	$1,127,314	$1,227,739
670 - Health System Administration	$423,539	$1,158,642	$127,700	$232,480
201 - Human Resources Management	$611,864	$1,110,697	$417,180	$514,048
649 - Medical Instrument Technician	$619,012	$1,037,213	$525,072	$692,443
301 - Miscellaneous Administration and Program	$759,403	$964,733	$654,080	$729,872
ALL OTHER OCCUPATIONS	$10,758,529	$14,545,377	$9,139,816	$10,350,065
Grand Total -	$139,021,031	$164,777,015	$127,705,255	$133,751,358

Question 4a: **To what degree were pay incentive determinations made at the local level or nationally?**

VA Response: VHA's approach to using pay flexibilities such as recruitment, relocation and retention incentives has provided VISNs, through delegated authorities, with the discretion and flexibility to be prepositioned to appropriately use pay authorities and flexibilities specific to the COVID-19 response locally. The market conditions and COVID-19 penetration has varied considerably across the Nation and within the communities where VHA has facilities, resulting in some needing a temporary surge in staffing support, and others being asked to provide staff to support other regions. Therefore, maximizing flexibility for individual VISN leaders to make the appropriate decisions related to the authorization of retention incentives in their respective labor market area is key.

Question 5: **There continue to be a number of nonclinical positions identified by VA Office of the Inspector General as a critical need. Housekeeping Aide is one of these positions. Housekeepers play a vital role in preventing the spread of disease during the pandemic. What is the turnover rate for housekeepers at VA over the past five years?**

VA Response: Turnover rates for HKAs have averaged 18% from 2015 to 2019, with the highest rate at 21.6% in 2019 and lowest at 15.6% in 2016. So far in FY 2020, the turnover rate for this occupation is just below the rate at this time last year. While turnover for this occupation is higher than for other occupations in VHA, the Hire Right,

Hire Fast (HRHF) model has ensured that vacancy rates for this occupation remain below the turnover rate by proactively hiring for expected turnover and keeping a ready supply of HKAs in the pipeline however turnover for this occupation still remains a significant challenge for staffing..

Question 5a: **What steps has VA taken to fill this critical need over that time period?**

VA Response: The recruitment of HKAs continues to be a key focus and has resulted in a policy change as well as a Nation-wide hiring initiative for VHA. To provide greater flexibility to hire managers and streamline the process of reassigning and promoting current employees into restricted positions (HKAs), the VA Policy on internal movement of non-preference eligibles was revised. On May 2, 2019, a policy revision to VA Handbook 5005 was published pertaining to appointments and effecting position changes for employees in positions restricted to preference eligibles. The changes incorporated statutory exceptions that allow for the placement of non-preference eligibles into restricted positions and eliminated a previous policy requirement to obtain Office of Human Resources Management (now OCHCO) approval prior to effecting these actions.

Question 5b: **In July 2019, at a Homeland Security and Governmental Affairs subcommittee hearing, VA said it was considering and evaluating a legislative proposal that would allow for Housekeeping Aides to be appointed under 38 USC 7401(3) authority governing hybrid-covered occupations, which would allow greater flexibility in the candidates who are initially considered. What is the status of that action?**

VA Response: VA is preparing a legislative proposal that focuses on changes to T5 rather than T38. Currently, section 3310 of T5, United States Code, and subpart D of Part 330 of T5, Code of Federal Regulations, restrict HKA positions to preference eligible Veterans with limited exceptions when preference eligible Veterans are not available. VA and VHA have collaborated on a legislative proposal to remove the preference eligible restriction on HKA positions so Veterans preference is adjudicated in the same manner as it is for other T5-covered occupations. Removing this restriction would grant more flexibility to the hiring managers on the front end of the hiring process and potentially garner more applicants and improve the caliber of employee hired into those positions.

Question 5c: **Are there other initiatives you are considering to improve hiring and retention of housekeeping aides?**

VA Response: VHA's Workforce Management and Consulting Office, in partnership with VA Environmental Programs Service, recently launched a strategic recruitment and retention initiative for the HKA occupation. The Integrated Project Team, comprised of

subject matter experts from both organizations, will examine the challenges historically associated with recruitment and retention of HKAs and will develop progressive and multi-faceted plans to identify relevant talent pools, develop candidate pipelines, enhance recruitment and retention incentives and improve our ability to compete for this talent in the private sector marketplace. The success of the HRHF model will allow VA to recruit and expeditiously onboard HKAs at the most challenged locations.

VHA's Nation-wide hiring initiative, HRHF, is aimed specifically at HKAs. The HRHF initiative is a focused and collaborative recruitment effort that emphasizes efficiency, shared best practices and tracking. HRHF was previously completed for the Medical Support Assistant occupation with a highly-successful implementation focused on reducing time-to-hire and vacancy rates. The model focuses on the best practices of utilizing open continuous announcements internally; holding job fairs to hire quickly; building vetted applicant supply files; over hiring; and posting vacancies through the Delegated Examining Unit (DEU). The DEU provides T5 competitive examining for VHA. Delegated examining authority is an authority OPM delegates to agencies to fill competitive Civil Service jobs through a competitive process open to all U.S. citizens, including current Federal employees.

The pilot phase of HRHF launched on November 11, 2018, with implementation in June 2019 to all facilities across VHA and with full implementation in December 2019. The "Hire Right" aspect of the initiative focuses on making good selections (using best practices – structured interview questions, setting job expectations, holding job fairs, onboarding, etc.) that will mitigate the regrettable losses and "quick-quits." Since HRHF for HKAs has been implemented, vacancy rates across VHA have decreased.

VHA is also pursuing special rates for HKAs where they can be supported. Special rates or schedules are authorized by OPM in individual wage areas when prevailing rates for specific types of jobs are so far above the maximum rates of regular wage schedules that agencies are seriously handicapped in recruiting and retaining qualified employees at the regular schedule rates. DoD is the lead agency for all FWS wage areas and for conducting wage surveys and setting rates of pay. VA submitted special rate requests to DoD for the New Orleans VAMC and Los Angeles VAMC. Those requests are currently being reviewed for processing by DoD Defense Civilian Personnel Advisory Service.

Question 6: **At that same HSGAC subcommittee hearing, VA stated it was considering and evaluating a legislative proposal to allow VA to sponsor U.S. Public Health Service commissioned officers as students at the Uniformed Services University of the Health Sciences (USUHS). VA would fund the officer's medical education in exchange for a commitment to serve in VA Medical Centers (VAMC) or clinics. What is the status of this proposal?**

VA Response: VA will continue to collaborate with HHS to determine how the agencies can best work together on graduate medical education and workforce issues.

Question 7: **What is VA learning from its piloting of "stay interviews" for VA Health Professional Trainees who are permanently hired at VA facilities?**

VA Response: VHA is now referring to Stay Interviews as Stay in VA Touchpoints. In FY 2020, Quarter 1, Stay in VA Touchpoints was implemented as part of the process for onboarding trainees hired through VA-TREs. The VA-TRE model promotes future forecasting of positions 3, 6, or 9 months and even 1 year prior to candidates graduating from their respective training programs. These selected candidates were nearly 1 year from completion of their respective training programs and should be onboarding by the end of FY 2020. The VA-TRE support team will work with facilities to collect the necessary data from these 30-day, 90-day Touchpoints as the candidates onboard in their new VA positions.

Question 8: **What recruitment and retention incentives regularly available in the private health sector but not at VA do you feel VA would benefit from?**

VA Response: The private health sector is able to rapidly establish many different types of incentives for staff willing to work during COVID-19, without the restrictions and requirements inherent to VA's current authorities. For example, eligible Yale New Haven Health System[1] employees received a payment equivalent to 5% of their earning associated with their total hours worked between the first pay period of 2020 through May 9, 2020. Private sector hospitals in New Orleans were able to offer nurses an additional $250.00 per 8-hour shift during COVID-19. A New York City-based hospital[2] in the private sector is giving employees who worked in, or supported, the COVID-19 front lines a $1,250 bonus. To be eligible for this bonus, employees only needed to have worked physically at a site for at least 1 week in March. For VA to offer a similar type of award or bonus, there is a requirement for a documented justification that is tied directly to a special contribution, act, service or achievement. Another example is Michigan Medicine[3] created a new special paid time off bank which provided an additional 120 hours of paid leave to nurses who care directly for COVID-19 patients. There is nothing currently in statute or policy that VHA could use to compete with such an incentive. The private sector was also able to rapidly implement temporary salary increases to retain staff without the regulatory requirements of a rating of record or type of appointment. VHA needs the ability—during declared local, state or national emergencies—to provide incentives/adjustments in real time based solely on service to VHA rather than one type of appointment, service time, likelihood of leaving Federal service and/or rating of record.

VA's existing incentive programs provide limited authority to mirror private sector incentives, as retention incentive authorizations for current employees require evidence that an employee, or group of employees, is likely to leave Federal service. Other

---

[1] https://www.beckershospitalreview.com/compensation-issues/yale-new-haven-health-employees-to-receive-covid-19-bonus-payment.html.
[2] https://www.beckershospitalreview.com/compensation-issues/newyork-presbyterian-offers-1250-bonus-to-employees-who-were-on-front-lines-in-march.html.
[3] https://www.uofmhealth.org/news/archive/202003/michigan-medicine-announces-covid-19-unit-new-paid-sick-time.

incentive programs require employees to sign service agreements which require them to complete a specified period of employment. Relocation and retention incentives can be offered to current employees, but authorization of such incentives requires the employee to have a formal rating of record on file, limiting the use of these authorities for any new hires to VA. Recruitment incentives can be authorized prior to a new employee beginning Federal service, but a minimum service period of 6 months is required, which limits the use of this authority for those new employees hired on a temporary appointment NTE 120 days.

Question 9: **Employee stakeholder groups have expressed concern that Direct Hire authority and other flexible hiring authorities under Title 38 can hinder efforts to create and maintain a diverse workforce. How does VA respond to those concerns and what practices are in place to ensure these more flexible hiring authorities do not result in a less diverse pool of qualified candidates?**

VA Response: All recruitment avenues utilized by VA adheres to general non-discriminatory processes to capitalize on the availability of persons who are best qualified to perform the work of the organization. VA does not discriminate in employment on the basis of race, color, religion, sex (including pregnancy and gender identity), national origin, political affiliation, sexual orientation, marital status, disability, genetic information, age, membership in an employee organization, retaliation, parental status, military service or other non-merit factor. VHA is committed to building a diverse, high-performing workforce that reflects all segments of society. To further ensure this commitment is maintained, VHA will perform several actions, including comparing the VHA demographic composition of the workforce to the relevant Civilian labor force.

○