CRITICAL IMPACT: HOW BARRIERS TO HIRING AT VA AFFECT PATIENT CARE AND ACCESS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

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C O N T E N T S

WEDNESDAY, SEPTEMBER 18, 2019

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COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
Washington, DC.

The committee met, pursuant to notice, at 2:13 p.m., in room 210, House Visitors Center, Hon. Mark Takano (chairman of the committee) presiding.

Present: Representatives Takano, Brownley, Rice, Lamb, Levin, Brindisi, Pappas, Luria, Lee, Cunningham, Cisneros, Peterson, Sablan, Allred, Underwood, Roe, Bilirakis, Bost, Dunn, Banks, Watkins, Roy, and Steube.

OPENING STATEMENT OF MARK TAKANO, CHAIRMAN

The CHAIRMAN. Good afternoon. I now call the hearing to order. Today's hearing will be the first of several discussions this committee and its subcommittees will hold on how the Department of Veterans Affairs is addressing long-standing staffing challenges.

Data reported last month indicates that there were more than 49,000 vacant positions across VA. Forty nine thousand, that is an astounding number, but there is more to it than just a number. And I want to look behind that number and understand what that number really means and how staff vacancies impact VA's ability to meet its mission.

I am concerned that, if VA's vacancy rate continues to balloon unchecked, we will have no choice but to continue to send increasing numbers of veterans into the community for care, and community providers aren't ready to care for increasing numbers of veterans, according to a Rand Corporation study last year.

This is the wrong path for VA and it is most assuredly the wrong path for veterans.

First, we need to understand the scope of VA's staffing challenges. The MISSION Act required VA to report quarterly data on staffing and vacancies; however, VA's Office of Inspector General has found numerous problems with how VA reported those numbers over the first year. VA's data overstated the number of vacant positions for some medical facilities by as much as 20 percent and understated vacancies at other facilities by as much as 8 percent.

Instead of reporting vacancies by occupation, as the law required, VA published its vacancy data as occupational groups.

Finally, VA only posted the most recent quarter's data on its public face and website.

We still have no idea where the critical needs really were or whether VA has made progress in filling critical vacancies. I am told that VA has attempted to correct these deficiencies since the IG published its report.

Now, second, we also need to know what actions VA has taken to address long-standing staffing challenges and the extent to which VA has made full use of numerous new authorities Congress authorized in recent years. VA was given direct-hire authority to be able to bring on staff in areas of greatest need; however, data shows that VA is not using this authority to the fullest extent. For instance, in 2018, VA only hired 38 police officers under direct-hire authority, a rate far below than the pace of attrition. We need to understand why VA is struggling to use this and other tools Congress has provided.

Now, third, while there is always concern with shortages among clinical staff, the ability to meet the highest standard of care to our veterans relies on more than just having the right number of physicians, nurses, and pharmacists. We also need qualified and well-trained housekeepers, IT technicians, human resources staff, and all of the other occupations that help VA achieve its mission of delivering high-quality and timely care.

There are numerous identified barriers and challenges associated with hiring and retaining these staff, but we also need to hold VA accountable for identifying and implementing solutions. It is not enough to say that something is a barrier; we need to understand the extent of the problem, as well as develop an actionable and accountable plan to fix it.

Fourth, leadership and governance in human capital has been a challenge. This is a common refrain in much of VA's operations. There has been a string of acting and interim leadership responsible for managing human capital for VA and the Veterans Health Administration since 2016.

Now, I am very pleased to have Mr. Sitterly and Ms. Bonjorni here today. Welcome. I hope that VA will take the opportunity to address some long-standing recommendations from the IG and the Government Accountability Office. As we all know, it is hard to institute change when no one is responsible and no one is accountable.

Fifth, there are thousands of dedicated VA employees doing their best every day to ensure that veterans have a positive experience and that they get the very best care and resources. I have had the privilege of meeting with some of these dedicated public servants and I thank them for all that they do.

I also know that these same staff are overwhelmed and, while they have done more with less, at some point less is not enough. VA's mission also means doing the very best for its employees. GAO has reported on the need for training, performance management, and other improvements to ensure that VA can retain a highly qualified workforce.

I hope to hear about progress on the recommendations from today's witnesses and what VA is doing to increase morale in the Department.

Sixth, it is the concerning effects these vacancies have on the success or failure of billions of dollars' worth of technology modernization projects at VA. These projects have the potential to improve health care and benefits delivery, but they will also have major impacts on staff productivity. Those impacts will likely be more acutely felt at VA's facilities and in programs that are already understaffed. This is a particular concern for the Electronic Health Record Modernization project, as front-line staff members will have to be peeled away to complete countless hours of training, and some staff members will be removed from service for a month or more to act as super-users to help train and support other staff.

Now, these are essential activities, but there are questions about how VA will be able to manage these complex IT implementations and training, and yet still meet its primary mission while not being fully staffed. There needs to be greater transparency into VA's staffing plan for these IT programs and I hope to hear about that today.

It is my hope over the course of this hearing to gain a better understand of progress that has been made, barriers that remain, and what VA proposes to do next.

Further, if VA really needs additional tools to address these challenges, I hope you will speak up. Please tell us if you need more resources.

These challenges are not insurmountable. The committee is here to work with VA as a partner to ensure VA can meet these challenges now and in the future. To do that, we need transparency from VA, so we can have an open and honest dialog about the resource needs of the Department and how VA intends to use those resources to provide the highest level of service to our Nation's veterans.

I thank the witnesses for being here and I look forward to their testimony.

The CHAIRMAN. Dr. Roe, you are recognized for 5 minutes to give your opening statement.

OPENING STATEMENT OF DAVID P. ROE, RANKING MEMBER

Mr. Roe. Thank you, Mr. Chairman. And I think it was great that one of the constituents drove 2 and a half hours, but I have been in California traffic, that might not have been more than four or five miles.

[Laughter.]

Mr. ROE. They went through a great effort to get there.

The CHAIRMAN. Yes, they did.

Mr. ROE. One of the committee's longstanding priorities has been addressing recruitment and retention across the Department of Veterans Affairs. We have acted many times over the last several years to help VA hire the staff that it needs to provide high-quality care and timely benefits for our Nation's veterans. Because of those efforts, there is good news to share.

While many headlines have been written about the number of vacancies that exist within VA, VA's workforce has grown by approximately 2 to 5 percent every year for the last 5 years. In fact, VA has more than 100,000 additional employees than when I came to Congress just a decade ago.

In that time, VA has consistently maintained a turnover rate of about 9.5 percent or less, well outperforming both other large cabinet-level agencies, which average 11 percent turnover rate, and the private sector health care industry, which averages a turnover rate between 20 and 30 percent. Since the 2014 access and accountability crisis, VA has increased the number of annual appointments in VA facilities by a whopping five million visits. That leads to real-world consequences for veterans who rely on VA for care and benefits that they need to support themselves and their families; consequences such as better access to care, better patient satisfaction scores, quality ratings, and less time waiting for appointments, for disability claims to be processed and for appears to be heard.

We should all be proud of those statistics; however, serious recruitment and retention challenges remain for the Department. The Association of American Medical Colleges projects that the United States will have a shortfall of more than 120,000 physicians by 2030. Given the approximately 90 percent of VA's workforce is aligned under the Veterans Health Administration in support of the VA health care system, that will undoubtedly have significant consequences for VA, coupled with the numerous complexities inherent in VA's multiple and often-contradictory hiring authorities, and the burdensome and outdated Federal hiring practices that VA must abide by.

That means that we must remain vigilant about helping VA to improve its ability to efficiently and effectively recruit and retain top-notch talent to serve our veterans. That includes continuing to provide the Department with the additional authorities it needs to attract prospective employees in an increasingly competitive labor market and to keep the hardworking employees already at their jobs at VA.

It also means ensuring that VA utilizes the authorities that have been given to them to their fullest extent, as the chairman mentioned, which is something I would like to discuss in more detail today, to address its needs and fill gaps in care and services. It further includes touting not only the problems that VA is facing, but also the many benefits that are part of a VA career, the most important of which is the honor and privilege of caring for the men and women who have served.

As chairman and now ranking member of this committee, I have had the unique pleasure of traveling across the country, from Long Island to Los Angeles and many points in between, to visit VA facilities and meet with veterans. While poor-performing and outliers certainly exist, and they should be held accountable, they are being held accountability thanks to the passage of the Accountability and Whistleblower Protection Act last Congress. I have been impressed everywhere I go by the professionalism and the dedication of the vast majority of VA workforce, many of whom are veterans themselves. And I want to end my comments this afternoon by thanking all of them for the good work they do and the valuable services they provide for our heroes.

I look forward to our discussion this afternoon. I thank the witnesses and the audience members for being here.

With that, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Dr. Roe.

Now I would like to welcome the witnesses on our first panel, first and only panel. First we have Dr. Daniel R. Sitterly, Assistant Secretary for Human Resources and Administration/Operations, Security, and Preparedness, from the U.S. Department of Veterans Affairs. Welcome, Dr. Sitterly.

Accompanied by Ms. Jessica Bonjorni, Acting Assistant Deputy Under Secretary for Health for Workforce Service, also for the Veterans Health Administration. Welcome, Ms. Bonjorni.

We also have with us Mr. John D. Oswalt, Deputy Chief Information Officer for Information Technology Resources Management from Veterans Admimistration.

We also have with us Mr. Michael Missal, Inspector General, VA Office of Inspector General. Welcome, General Missal.

We have, finally, Mr. Robert Goldenkoff, Director of Strategic Issues, the U.S. Government Accountability Office. Welcome, Mr. Goldenkoff.

We will begin with Mr. Sitterly. I will recognize you for 5 minutes for your opening statement.

STATEMENT OF DANIEL R. SITTERLY

Mr. SITTERLY. Thank you, Mr. Chairman. I probably shouldn't start my comments correcting the chairman, but I am not a doctor. I admire all of the doctors in the VA that do great work. Mister is fine. Thank you, sir.

The CHAIRMAN. My apologies.

Mr. SITTERLY. That is quite all right, sir.

The CHAIRMAN. Mr. Sitterly.

Mr. SITTERLY. Yes. Chairman Takano, Ranking Member Roe, and members of the committee, thank you for the opportunity to discuss the Department of Veterans Affairs' views on ways to modernize and the hiring process, and also to retain our ability to be a competitive employer in the health care and information technology industries.

As a 34-year veteran of the United States Air Force myself, I have both a personal and a professional interest in ensuring we get this right at the VA. And today just happens to be the 72nd birthday of the United States Air Force, so happy birthday, U.S. Air Force.

As the operator of the largest integrated health care delivery system in America, the VA successfully attracts and retains high-quality talent, and VA's overall workforce continues to grow. This growth, 81 percent in clinical occupations, directly responds to an increased demand for services based on improved access to care, reduced wait times, improved quality, enhanced veterans' satisfaction, and overall mission growth. VA appreciates the work Congress has done to provide the flexibilities to support the recruitment and the retention of talent to care for our Nation's veterans.

That said, VA still contends with challenges presented by the complexities of multiple pay and personnel authorities. As health care demand has increased and shortages of health care and IT workers grow, private sector employers are quick to adjust to the changes in local labor markets, and modify starting salaries and total compensation packages to attract top talent. While VA recruits employees and applicants who are willing to accept lower

compensation to be part of an organization with such a noble mission, VA faces challenges in our ability to attract and then to retain quality health care and information technology professionals.

Despite challenges, VA employs a variety of tools to attract and retain quality talent. Those tools include a powerful mission of service to veterans and their families, a robust training pipeline for the majority of our Nation's physicians, strong employee engagement, direct-hiring authorities, as you mentioned, and strategic workforce planning for hard-to-fill occupations and medical center directors. VA strategically allocates monetary incentives to close skill gaps and to provide greater flexibility in the recruitment, relocation, and retention of highly qualified VA professionals. In Fiscal Year 2018, VA spent more than $50 million on these incentives.

VA has also joined efforts with the Department of Defense to recruit transitioning servicemembers. We launched a direct marketing campaign to target medical professions in the military and IT professionals currently transitioning out of the military. VA has also partnered with the Department of Defense to hire military spouses through the Military Spouse Employment Partnership. We made significant progress in filling senior medical center director positions through a vigorous national recruitment strategy.

Outcomes show that the VA is on the right track. Veterans are receiving the same or better care at VA medical centers than patients at private sector hospitals. For instance, veterans who are admitted for heart attacks, severe chronic lung disease, heart failure, and pneumonia have a greater chance of survival beyond 30 days after discharge from a VA hospital than non-VA hospitals.

According to a study in the Journal of American Medical Association, VA average wait times are shorter than those in the private sector for primary care. VA reached a telehealth milestone, achieving more than one million video telehealth visits last year.

Just this week, J.D. Power ranked the VA number 1 in the Nation for customer service satisfaction for mail order pharmacies. At the same time, almost 90 percent of the 3.3 million veterans surveyed said they trust VA outpatient medical services.

As one of the top 10 large Federal agencies, VA continues to enhance employee engagement. In April, the Secretary approved VA's first-ever employee engagement enterprise-wide plan, which emphasizes the principles of servant leadership. As I like to say, happy, engaged, empowered, innovative employees make for a positive veteran experience, and it also helps mightily with retention.

We appreciate Congress' continued support to a high-quality workforce that provides the best possible care and benefits to veterans.

The competition for talent in the health care and IT industries is increasingly competitive. Shortages abound around the Nation for both physicians and nurses, and they are projected to increase, and competition for IT talent is tight. Private hospitals use innovative and progressive solutions to address recruitment and retention challenges, and we in the VA must be creative in our approach to human capital. We want to be leaders or be very fast followers of the best human capital practices in the Federal Government and in the health care and IT space.

We look forward to working with this committee on opportunities to enhance VA's ability to attract top talent. My colleagues and I are prepared to respond to any questions you may have.

Thank you.

[THE PREPARED STATEMENT OF DANIEL R. SITTERLY APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Sitterly.

Now I would like to recognize our Inspector General, Mr. Missal.

STATEMENT OF MICHAEL MISSAL

Mr. MISSAL. Thank you. Chairman Takano, Ranking Member Roe, and members of the committee, I appreciate the opportunity to discuss the Office of Inspector General's oversight of staffing issues with the Veterans Health Administration. In response to our congressional mandate, the OIG has examined and reported on staffing issues with VHA for the past 4 consecutive years. Our 2019 report is expected to be released by September 30th.

We also encounter staffing issues in connection with other work we conduct of VHA programs and processes. We have issued a number of reports with examples of areas where staffing shortages impacted the delivery of care, including at the Loma Linda, Memphis, and Northport Medical Centers. Although VHA has made some improvements, it continues to face a number of challenges in addressing its significant staffing needs. VA has experienced chronic health care professional shortages since at least 2015. The Department must enhance its ability to maintain a robust workforce in an increasingly competitive recruitment environment and with anticipated health care worker shortages in several practice areas. VA health care remains in sharp demand even as community care options are expanded.

Since January 2015, the OIG has reported on VHA clinical staffing shortages as required by the 2014 Choice Act. Our 2018 report was the first report that included facility-specific data reported by leaders at 140 VA medical centers. It was also the first report to include non-clinical positions, such as human resources, police, and custodial personnel. These non-clinical occupations affect the ability of VHA facilities to provide quality and timely patient care in a safe and clean environment.

The facility-specific results underscore how different the clinical and non-clinical needs are from one medical facility to another. We have therefore consistently recommended that VA develop and implement a staffing model that identifies and prioritizes staffing needs at the national level, while allowing flexibility at the facility level.

The data in our 2018 report showed that 138 of the 140 facilities listed the medical officer occupational series as experiencing a shortage, with psychiatry and primary care being the most frequently reported. Of the 140 facilities, 108 listed the nurse occupational series as experiencing a shortage, with practical nurse and staff nurse as the most frequently reported.

Within non-clinical occupations, we found that human resources management and police occupations were among the most often cited as shortages. Our 2019 staffing report will have similar findings.

Challenges to meeting staffing goals were also identified in our 2018 staffing report. Responses from medical center directors identified three frequently cited hiring challenges: first, lack of qualified applicants; second, non-competitive salaries; and, third, high staff turnover.

Last year's MISSION Act created a mandate for VA to report annually on the steps taken to achieve full staffing capacity and any additional funds needed to achieve that mark. It also required VA to publish staffing and vacancy information, and update that information quarterly.

The MISSION Act directed the OIG to report on how VA can improve its publication of this data. The first required OIG report found VA to be in partial compliance with MISSION Act Section 505's requirements.

Generally, the OIG found that VA reported its current personnel levels and time-to-hire data as prescribed. However, staff vacancies were tracked in categories that were too broad to be meaningful and gains and losses were not tracked according to the law. OIG staff also found the information to not be transparent, because VA did not disclose that medical facility vacancy numbers were overstated.

The OIG has made oversight of VA leadership and workforce management a priority. Although VA has taken important steps, for sustained improvement additional fundamental changes are needed.

Mr. Chairman, this concludes my statement. I am happy to answer any questions that you or other members of the committee may have.

[THE PREPARED STATEMENT OF MICHAEL MISSAL APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Inspector General Missal.

I now recognize Mr. Goldenkoff from the GAO for 5 minutes.

STATEMENT OF ROBERT GOLDENKOFF

Mr. GOLDENKOFF. Thank you. Chairman Takano, Ranking Member Roe, and members of the committee, thank you for the opportunity to participate in today's hearing on VA's ability to recruit and retain a high-performing workforce.

As you know, VA operates one of the largest health care delivery systems in the Nation, and provides billions of dollars in benefits and services to veterans and their families. As a result, a top-notch workforce is crucial to VA's mission. Nevertheless, over the past two decades, we and others have found that VA and its components face serious and long-standing human capital management challenges that are impeding its ability to meet the needs of our Nation's veterans.

In my remarks today, I will focus first on the various human capital management challenges facing VA and its components; second, the recommendations that GAO has made to address those challenges; and, third, how these challenges are related to a broader set of Government-wide human capital problems that need to be addressed.

The bottom line is that while both VA-specific and Government-wide human capital issues are hampering VA from acquiring and retaining the talent it needs to fulfill its mission, VA can take and

in some cases is already taking a number of steps to strengthen its human capital management efforts.

With respect to VA staffing challenges, we have found them to be systemic, long-standing, and harmful to VA's mission. For example, in May 2019, we reported that leadership turnover impeded VA's ability to address a number of operational issues that we identified such as managing acquisitions, managing risk, and improving veterans' health care.

Additionally, we found that VHA's medical centers have large staffing shortages in such positions as physicians, registered nurses, physician assistants, psychologists, physical therapists, as well as human resource specialists and assistants.

And while effective succession planning can help VA ensure it has a pipeline of talent to meet current and future mission requirements, in a forthcoming report we will note that VA has not produced a Department-wide succession plan since 2009 due to leadership turnover. This could be particularly problematic as agency-wide around 30 percent of VA employees who were on board as of September 30th, 2017 will become eligible to retire by 2022.

Of the hundreds of recommendations that GAO has made over the years aimed at improving the performance and accountability of VA, beginning in 2012, we designated 40 of these recommendations as priorities. Twelve of the recommendations are aimed at strengthening VA's human capital management efforts. To date, VA has addressed six of the recommendations, but still needs to take action on the others, such as developing a process to accurately count all physicians providing care at VA medical centers and developing a modern and effective performance management system.

Beyond these specific recommendations, VA can use key talent management strategies that we identified for acquiring, incentivizing, and engaging employees, and thus be more competitive in a tight labor market.

As one example, while Federal agencies may struggle to offer competitive pay in certain labor markets, they can leverage existing incentives that appeal to a worker's desire for schedules and locations that provide work-life balance. Likewise, improved performance management, professional development opportunities, and involving employees in decisions that affect them could lead to higher levels of employee engagement and retention.

Some of the challenges that VA is facing are part of a larger set of human capital issues affecting government as a whole. Structural issues impede the ability of agencies to recruit, retain, and develop workers, and these include outmoded position classification and pay systems, ineffective recruiting and hiring processes, and challenges in dealing with poor performers.

In closing, while VA faces a number of staffing challenges, the future is not dismal, and there are a number of steps that VA can take within existing authorities and flexibilities to better address these challenges.

Chairman Takano and Ranking Member Roe, I would be pleased to respond to any questions that you may have at this time.

[THE PREPARED STATEMENT OF ROBERT GOLDENKOFF APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Goldenkoff.

At this point, I will begin the questioning, recognizing myself for 5 minutes. I would like to begin with Mr. Sitterly and Ms. Bonjorni regarding housekeeping staff, recruiting and retention of housekeeping staff.

This past June, the IG published a report that substantiated concerns I raised in early 2018 about facility cleanliness and infection control at the VA Loma Linda Health Care System. Low pay and staff turnover among housekeeping staff were among the root causes the IG identified as contributing to the lack of cleanliness inside the medical center. When I visited the facility in early July to followup on the IG recommendations, there were 45 vacant housekeeping positions out of the roughly 150 authorized positions.

In March 2019, Loma Linda requested special pay rates for its housekeeping staff and I am told that these must be approved at the department level.

What is the status of that request, if you have that information, and have you approved these special pay rates for housekeepers at Loma Linda?

Mr. SITTERLY. Mr. Chairman, let me start by answering the question, then I'll let Ms. Bonjorni address Loma Linda specifically. But one of the challenges that we have and we are working very closely with OPM is delegations of the authorities to allow us in the Department to make the changes for special salary rates and hiring re-employed annuitants in some of those. Right now, the position is that we have to go to OPM to provide the data on any occupational series, including housekeepers, to show that the local wages are not where they should be according to the pay tables that we use.

Yes, we are working on that specific request for Loma Linda with OPM, but every time there is a rate change we have to go back and do that. And so, as I mentioned, we are working very closely with OPM and they are very receptive to giving us delegations to allow those special salary rates.

The CHAIRMAN. Ms. Bonjorni, do you have something to add to this at all?

Ms. BONJORNI. Yes, just that we are also working to improve our recruitment abilities for housekeeping aides using the flexibilities we created for medical support assistant hiring under Hire Right/Hire Fast approach, where we have hiring fairs and have a standing register of applicants to come through the process.

The CHAIRMAN. Do you recommend any change in authorities for you in order to make this less cumbersome? Because this is a common refrain across the country. I am asking every medical facility I go to and they all indicate they have issues with housecleaning staff.

Mr. SITTERLY. I don't know that it requires legislation. It is a Title 5 under CFR. It may be an interpretation or it may be the statute, but the more authorities that we have in the Department that we don't have to go to OPM for, the more flexible that we can be. That is not just for housekeepers, that is for everything. I will give you an example. At the senior executive level, we have to go to OPM to get the standards approved by other Government agencies——

The CHAIRMAN. Well, can you tell me how many locations you have approved special pay rates for housekeeping staff? If you don't have that information, you can get back to me with it.

Mr. SITTERLY. Yes, I don't have that information with me, Mr. Chairman.

The CHAIRMAN. I understand that the wages for VA housekeeping staff are set through the Federal prevailing rate system through OPM, which may not adequately account for differences in pay between custodial staff working in a health care environment versus staff working in an office environment. To what extent has VA studied whether reclassification for this occupation is needed?

Mr. SITTERLY. We have studied it and we agree it is needed.

The CHAIRMAN. OK. Also, an interesting proposal that I heard from the Brooklyn VA recently, pay rates are part of the issue, but really the set-aside for veterans is—they are not proposing to get rid of the set-aside, but maybe if we have a system in place where if they could show they have done due diligence in trying to recruit veterans for the set-aside that that requirement after that point may become more flexible, so they can hire from the general population more easily. What do you think about that?

Mr. SITTERLY. We have 120 different hiring authorities, I would like very much to work with you and this committee and others to streamline those authorities to something simpler than that. We have 60 different pay tables in the VA that every time we make a change to a local salary we have to update the IT systems to be able to accommodate that.

I would be willing to work with you to have a simpler H.R. system in the VA and across the Federal Government.

The CHAIRMAN. All right, thank you very much. My time is up. I am going to recognize Dr. Roe for 5 minutes.

Mr. ROE. Mr. Chairman, I am going to wait until the end. I will need to be here for the whole hearing, so I am going to wait to ask questions until it is over, just so the other members may have somewhere they need to be.

The CHAIRMAN. All right. Thank you, Dr. Roe. I should have done that.

All right, go ahead, Dr. Dunn.

Mr. DUNN. Thank you very much, Mr. Chairman.

Mr. Sitterly, Secretary Sitterly, the committee has received reports and they are confirmed by the VA's Office of Labor-Management Relations and General Counsel, that VA employees are offered $100 cash during new employment orientation to join AFGE on the spot. Are you aware of this practice and what is your opinion of this practice that appears to be a handout or a bribe to get new employees to join the union?

Mr. SITTERLY. Dr. Dunn, I have heard of that, I have not verified that, my opinion is our employees ought to be making their own decisions.

Mr. DUNN. You are the Assistant Secretary for HR, so that is kind of in your wheelhouse to know what is going on there?

Mr. SITTERLY. Yes, sir, it is. That was just recently brought to my attention as well. My opinion is that our employees ought to be able to decide on their own.

Mr. DUNN. I look forward to hearing back from you.

Mr. SITTERLY. Yes, sir.

Mr. DUNN. Also, Secretary Sitterly, what, if any, is there a practical reason for the provision in the current collective bargaining agreement with AFGE that only allows an employee to leave the union and stop paying dues in a very narrow window of time each year that is unannounced and has automatic re-enrollment if they miss that, is there a practical reason for that?

Mr. SITTERLY. Doctor, not that I am aware of, and that collective bargaining agreement is currently under negotiations.

Mr. DUNN. I am so glad to hear that. It does seem to fly in the face of choice for your employees.

Once again, Secretary Sitterly, can you please provide an update on the VA's efforts to implement the President's executive order to ensure that clinicians who are hired to care for veteran patients are focused on patient care and not spending any significant percentage of their time on—their official time on union activities?

Mr. SITTERLY. Sir, you asked the question about physicians, which are under Title 38, so we have different authorities which are not covered under the executive order for Title 38 employees. So we have repudiated that time already and we are waiting for the courts to decide on the other three EOs.

Mr. DUNN. So does that occur to—does that apply then to the other group, the Title 5?

Mr. SITTERLY. No, sir, that does not. We are waiting for the courts to make a decision on those executive orders.

Mr. DUNN. So, hypothetically, how much money would it save the taxpayers if we did have full implementation of that executive order? You would have clinicians that were doing clinical work or you wouldn't have to hire so many clinicians in that case, I assume there is some savings, have we calculated that number?

Mr. SITTERLY. We have done some sort of back-of-the-envelope math on that, Dr. Dunn. So——

Mr. DUNN. You have——

Mr. SITTERLY.—it is several millions of dollars.

Mr. DUNN. Several million, excellent.

Finally, let me say I am fully in support of Dr. Stone's efforts to prohibit smoking in the VA medical facility campuses. It is clearly aligned with best medical practices, it aligns the VA with the rest of the health care footing in the country. However, I understand that there is still debate in these same negotiations that are going on right now and the union is continuing to push for the VA to provide smoking areas on VA campuses for the employees. Can you give us an update on the VA negotiations with the unions on that front?

Mr. SITTERLY. I cannot give you an update on the negotiations, sir, but we have implemented no smoking across our medical campuses currently.

Mr. DUNN. So it is currently the rule that there is no smoking on the VA campuses?

Mr. SITTERLY. Yes, sir that is correct.

Mr. DUNN. That is good. That is a lot like all the hospitals that I ever worked in.

I appreciate your time. Thank you very much, General, for the service to our VAs, they certainly deserve our very best efforts.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Dr. Dunn.

I now recognize Ms. Brownley for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chair. Thank you all for being here and, Mr. Sitterly, you have been with the VA now for maybe 9 months or so?

Mr. SITTERLY. Yes, ma'am, that is correct.

Ms. BROWNLEY. And you came from the Air Force?

Mr. SITTERLY. I did.

Ms. BROWNLEY. No previous jobs with the VA other than this one. When you arrived, can you just explain to me or describe to me your assessment of the Department, where you thought where immediate improvements have been, and then talk a little bit about some of your successes in your short tenure.

Mr. SITTERLY. Yes, ma'am. Thank you for the question, I appreciate that. I think that my immediate assessment was I was shocked to find out how many folks, how many veterans were enrolling in the VA today, despite the fact that we have the smallest military that we have had since World War II, with the exception of the last couple of years where the end strength has increased. So my immediate question was, why do we have so many people enrolling?

The answer is that access standards are better than they have been, care standards are high, people want to come to the VA now to receive their care, present company included. When I retired several years ago now, I didn't have a disability or I didn't apply for a disability, so there was no reason for me to be at the VA. Since I have been at the VA, they have some wonderful services for me, for veterans, outreach, that I was not aware of. And so that was my fist ah-ha moment is that we need to do outreach and we are doing, under the leadership of Dr. Linda Davis, a tremendous job outreaching to our veterans who we haven't had enrolled in our facilities before.

Ms. BROWNLEY. I was thinking more along the lines——

Mr. SITTERLY. Yes, ma'am.

Ms. BROWNLEY.—of HR.

Mr. SITTERLY. OK. The thing that sort of shocked me and the thing that Secretary Wilkie asked me to look at as my No. 1 priority, and the thing that best addresses the reports of the IG and of the GAO, is that we don't have a manpower position management model by which to assess our current vacancies. I have been engaged for the last 9 months and the chairman asked, who is accountable for this, and I will tell you, ma'am, I am accountable for this, in putting together a position management system in which we can track the vacancies across the VA.

When we talk about 50,000 vacancies, we have to qualify that number many different ways to assure that we know what we are talking about. For instance, with a 9.5 percent turnover rate across, let's just use 400,000 employees for simple math, that is about 9500 positions that we have turnover every year times four and, if it takes 90 days to hire, that is 10,000 vacancies or so that will always be vacant because of the turnover rates that we have.

When we look at the growth of the VA, 2 to 5 percent, as Dr. Roe indicated, 100,000 people in a decade. Over the last 5 years,

we have gone from 315,000 to 387,000 and, if Congress approves the President's budget this time, we will be to 393,000. So we continue to grow our capacity, our capability in all of the services that we provide our veterans, it is growing exponentially every day——

Ms. BROWNLEY. But we can't count the number vacancies we have?

Mr. SITTERLY. We started by looking at our as-is by facility when we started this journey just before I got here. We have an IT system that we have to get on track to allow us to put the right data——

Ms. BROWNLEY. Just—and I understand there is a lot to get——

Mr. SITTERLY. Yes, ma'am.

Ms. BROWNLEY.—to improve upon these things, but just the real problem from your perspective, first 9 months, is we have no way of counting the number of vacancies?

Mr. SITTERLY. We have no way of verifying the exact requirements and then keeping a person tied to a position versus a person tied to a personnel system. And so it is my responsibility and I will put into place business rules where 6,000 H.R. professionals across the VA have certain things they can change in a position and certain things that they can't. And I——

Ms. BROWNLEY. OK, thanks.

Mr. SITTERLY. Yes, ma'am.

Ms. BROWNLEY. I have limited time. So I just want to ask either Mr. Missal or Mr. Goldenkoff, I am not sure which one of you can answer this, but I know in the Inspector General report you talked about there are portions—there were reporting mechanisms required within the MISSION Act, you talked about the fact that that was partially executed or executed in a way that was in larger categories, so therefore you couldn't kind of get the exact count; am I correct on that?

Mr. MISSAL. That is correct.

Ms. BROWNLEY. OK. So there was something that was required in the MISSION Act to address this issue that you are raising, but yet the VA is not doing that.

So my time has run out, but, you know, I would certainly like to have an answer.

The CHAIRMAN. Is Mr. Bilirakis here?

The CHAIRMAN. Mr. Steube.

Mr. STEUBE. Thank you, Mr. Chair.

Mr. Secretary, I represent—just to kind of orient you, I represent Southwest Florida, I have nine counties in Southwest Florida, and one of the clinics that I have in my district is in Port Charlotte. We have had limited and overwhelmed doctors seeing too many patients at the Port Charlotte clinic in my district. The veterans who go to this clinic rarely see the same doctor twice, many are referred to nurse practitioners instead of seeing a doctor. They are also letting go of employees that should not have been let go with an already short staff.

I have one veteran in my district who just got out of a private hospital and was told to see a cardiologist within a week. The VA hospital cannot provide him with a referral to see a cardiologist without him seeing a VA doctor first. The soonest he would see

that doctor was after 30 days, which I know falls within the time lines, but I don't view that as acceptable.

Bay Pines, to give you an idea, most of the people in my district, including myself, who get services through the VA go to Bay Pines, Bay Pines is 2 hours from Charlotte County. It is an hour and a half, hour and 45 from my house. If veterans in my district who live in Hardee, Desoto, Highlands, or Okeechobee, they are having to also drive, that is another probably 45 minutes, so you are probably talking 3, three and a half hours to get to Bay Pines.

Like I said, the VA hospital couldn't provide him with a referral within the time line and, because Bay Pines is 2 hours away from his home, he called an ambulance, went to the closest ER down the street. It turns out it was a life-or-death matter and he could not have waited the 30 days.

This is a situation for many of the veterans in my district, it is a situation that I have faced personally. The clinic that I am assigned to is in Manatee County, which is not in my district, but it happens to be the closest clinic to my residence, and same scenario. I need a hernia repair. You go to a doc, you see your primary care guy, which, you know, maybe you can get in within a 30-day period of time to see your primary care guy, which it may be the same guy you saw a year ago, probably not, to then get a referral to go to Bay Pines, which is then going to take you another 30 to 60 days to get somebody that you don't know who you are going to see for the first time.

This is a situation that I have personally experienced, many veterans in my district have experienced. We have a very large veteran population in my district. It is Florida, everybody likes to come and retire to Florida, especially Southwest Florida, so we have a very large veteran population. The clinic in Port Charlotte is understaffed, which is the one in my district. What do you suggest to these veterans in critical conditions do in the meantime and is there any plans to fully staff at least the Charlotte clinic?

Mr. SITTERLY. Thank you for your service. I am not familiar with the staffing issues that you have there, and I am also not the expert on MISSION Act and the decision support tools and community service opportunities that our veterans have, but I would gladly like to visit there with you to talk about the staffing issues that we have and to get our arms around exactly what it is that we need to do to take care of our veterans.

Mr. STEUBE. How soon would you be able to meet to discuss these issues?

Mr. SITTERLY. The week after next.

Mr. STEUBE. I have a staff person here, she will followup with your office, because I was supposed to meet with Secretary Wilkie, was it next—tomorrow, and he canceled, to discuss these issues and many others. So if——

Mr. SITTERLY. I am happy to come over and talk——

Mr. STEUBE.—I could meet with you——

Mr. SITTERLY.—yes, sir.

Mr. STEUBE.—in a reasonable amount of time, I would like to do that.

Mr. SITTERLY. I am going to visit some facilities next week and I would be happy to come over when I get back and meet with you, and Ms. Bonjorni as well.

Mr. STEUBE. Yes. I mean, I can't speak for other rural districts, but my district is considerably rural. I go from—if anybody is familiar with Florida, I go from almost one coast to the other, and so it is a real challenge for those in Southwest Florida because your closest hospital is Bay Pines. So that, obviously, with the timeframes and the referrals that are necessary to see a specialist, causes lots of challenges for the veterans in my district.

I will have my staff today reach out to yours and hopefully we can arrange that.

Mr. SITTERLY. I am happy to do that, sir.

Mr. STEUBE. All right, thank you.

Mr. SITTERLY. Thank you.

The CHAIRMAN. The gentleman yields back.

We now have Miss Rice—are you here? She is not here.

Mr. Brindisi? Ms. Luria?

Ms. Luria, you are recognized for 5 minutes.

Ms. LURIA. Well, thank you for being here today as part of the panel. I represent a large portion of Hampton Roads, which has a very large veterans concentration, and I have had the opportunity three times this year to visit the Hampton VA Medical Center. And I have heard each time from different groups, both from employees and from leadership and management, we are now on the third director since I have been in office less than a year. One moved to Richmond, then we had an interim director, and starting just, I believe, yesterday the new director was installed. So I look forward to sitting down with him and going over some of my concerns. But what I hear each time is the length and the complexity of the hiring process.

And each time that I have heard this I have tried to get at what is the reason that it takes so long. And one thing that is highlighted is the fact that the process must recertify the person's credentials every time, back to their degree, to their licensing, to their medical board certification, which I understand it is very important to confirm these things before employing an individual, but I also understand that this happens even if the person is already employed with the VA at a different VA medical center and then moves to the Hampton VA, even if the person is already employed as a physician or a nurse, for example, within DOD health system. And I have yet to understand if this is a statutory requirement or if it is just within the VA policy for hiring that this is required, even if the person is already employed by the Government, doing the same job with the same credentials.

Do you have any insight onto that and how we can help smooth and quicken that process?

Ms. BONJORNI. Sure, I am happy to try to address your question, Congresswoman.

It is not statutory that we have to re-credential people as they move across facilities, it is not even policy right now. So if that is occurring, then we will move to correct that. It has historically been happening. Unfortunately, right now there is not a direct

linkage between the DOD system and the VA system that we use to track credentialing, so we have some opportunities there.

Ms. LURIA. OK, we are limited on time. So I would love a followup, and specifically a followup with regards to the new director at the Hampton VA Medical Center to understand if just within their practices locally they have been doing something that is actually hampering the time line to hire people.

And then also I serve on the Mil-Per subcommittee as well, so I think that we have a good relationship between the VA and DOD policies, if there is a way to write something in that allows that streamlining, because it happens incredibly frequently within our region that people find job opportunities and move back and forth between these facilities.

I did see in the material that was presented prior to the hearing today the data about attrition or turnover. What I find is that, you know, it is taking so long to get someone on board, yet once we have them there, we are not keeping them. And statistically I wasn't aware of, you know, throughout the health care industry that there is a relatively higher turnover. In most professions it seemed that the VA nationally is below that threshold, but I do find that, you know, specifically within our VA medical center that I have had the opportunity to visit, that there are a lot of morale problems and challenges for employees, a lot of employees who feel like their concerns are not being adequately adjudicated. What do you have in mind to just improve retention? It could nationally meet a threshold that is better than the rest of the industry, but certain VA medical centers—and ours does rank in the bottom 30 in the country statistically—do you have any programs to improve that and to retain good professionals who we have already on board?

Mr. SITTERLY. Thank you for that question. Actually, you know, as you look across the entire VA enterprise, there are different issues that we have at different facilities based on where you are and it is not all monetary incentives, as you know.

One example is, in our all-employees survey we determined that for physicians who have trainees and residents, that they are more likely to stay than those that don't. We are looking at our program to make sure that we have teaching opportunities, because that will directly impact retention.

A non-monetary incentive, ma'am, since you are on the Armed Services Committee, you understand that the DOD has the very best parental leave policy in the entire Federal Government for those in uniform. For Federal employees, we get zero parental leave for Federal employees. I would like very much for the VA to be a pilot to have the same authorities that the Department of Defense has for parental leave, paid parental leave. I think with 85,000 nurses, most of whom start their careers, if they are in our intern programs, young, that would be a great incentive for retention as well.

As we look across some of our other authorities that we have, retention obviously is important to us, but the statistics you have to look a little closer at. When we look at the quit rate, we are at 3.3 percent for nurses this year and over 4 years that quit rate has been decreasing. Same thing for physicians. So when you look at

the turnover rate, a lot of those are voluntary retirements, those are voluntarily going to another facility, but our quit rates are actually extremely low and they are at a 4-year low.

So our retention, frankly, is doing well, but, again, as you go across the enterprise, it does vary greatly location to location.

The CHAIRMAN. We need to move on. Thank you.

Mr. Banks, you are recognized for 5 minutes.

Mr. BANKS. Thank you, Mr. Chairman.

Ms. Bonjorni or Mr. Sitterly, how many different hiring authorities does VHA have for Title 38 positions, meaning medical positions?

Ms. BONJORNI. Well, underneath Title 38, we have pure Title 38 for a smaller number of occupations, then we have hybrid Title 38, which has elements of Title 38 and Title 5. So two primary hiring authorities, but then we have a variety of other special authorities and carveouts within that that allow us to follow different rules.

Mr. BANKS. The answer is several?

Ms. BONJORNI. Yes.

Mr. BANKS. But there is not a specific answer, but several. Maybe you could provide the committee with a chart of what those——

Ms. BONJORNI. Sure.

Mr. BANKS.—authorities are.

Mr. Sitterly, how many of those hiring authorities do human resource officers use on a regular basis?

Mr. SITTERLY. 7306, 7401–1, 7401–3, 7405 are the four primary ones that we use on a regular basis.

I would also mention, if I may, another area that you can help us with is our market pay for medical center directors, going back to the issue that we have. Regrettably, when we look at the complexity of systems between Title 5 and Title 38, and when we add additional appointment authorities, sometimes we don't dot the Is and cross the Ts. While I have direct-hire authority for medical center directors, I can only pay them at $156,000 a year if they are not Title 38.

By fixing that, it will improve our ability to hire senior level directors at our medical centers that are other than Title 38——

Mr. BANKS. Then we also——

Mr. SITTERLY.—and then we also have hybrid Title 38——

Mr. BANKS. So follow on that line of thinking for a moment. How many Title 38 hiring authorities would you say you need in order to hire effectively?

Mr. SITTERLY. Four.

Mr. BANKS. OK. Mr. Sitterly or Mr. Oswalt, your testimony refers to an OIT vacancy rate that was historically high, but is now lower. What were the vacancy and attrition rates historically and what are they now? Mr. Oswalt.

Mr. OSWALT. Thank you for the question. Historically, it has been in the 5 to 6 percent range. I think right now it is currently approximately 8 and a half percent, so we have seen an up tick with that. I guess, given the overall aging of the workforce, that is not totally unexpected. But we have made a concerted effort over the past 18 months to broaden our recruitment net where we are

actually, right now, we are pretty much maxed out on our hiring with the available funding we have.

Mr. BANKS. OK. Mr. Oswalt as well. In today's testimony and in recent meetings with the staff, OIT gives the impression that it does not have a significant staffing problem. You seem to be saying the staffing situation is comparable to that of other chief information officer organizations at Federal agencies; would you say that is accurate?

Mr. OSWALT. Well, getting back to what Mr. Sitterly had said about our projecting the requirements versus what we have funding to hire, that would be the demarcation. I mean, if we use the staffing model now that is currently in its final stages of development, we can project that there is additional resources, IT resources needed, but given the realities of the appropriation that we have, we are at full capacity in that regard.

Mr. BANKS. OK. I understand that you have prioritized hiring for cyber-security positions. What other positions does OIT consider important and difficult to staff?

Mr. OSWALT. Anything in the information—or in the IT job series we consider to be a high priority, information security being the most critical one, but we also have enterprise architectures, and primarily I would think the next below cyber-security would be project managers.

Mr. BANKS. OK. How do you plan to use the direct-hire and retention pay authorities that Congress granted the VA for those positions?

Mr. OSWALT. For the cyber-security, we have been—we are in the second year of offering cyber retention pay and we have seen a considerable drop in the turnover, the attrition of these information security specialists. For direct-hire authority, we are using that, when we said earlier that we are casting a wider net, that is one of the things we are doing is we are going out with standing open announcements where there is continually a pipeline of folks coming in and applying that we are able to select from or interview based on that open and continuous announcement, and then exercise our hiring authority.

Mr. BANKS. OK, thank you very much.

I yield back.

The CHAIRMAN. The gentleman yields back. I now recognize Ms. Lee for 5 minutes.

Ms. LEE. Thank you, Mr. Chairman. Thank you all for being here.

I wanted to touch on governance within VA. It seems to be challenge with all facets of VA management, but really comes down to leadership and accountability, and human capital governance has complicated VA's decentralized management. What part of—for Mr. Sitterly—what part of VA is ultimately accountable for addressing the human capital challenges?

Mr. SITTERLY. I am.

Ms. LEE. You are? OK.

Mr. SITTERLY. Yes, ma'am.

Ms. LEE. How do you coordinate with VISNs, individual facilities?

Mr. SITTERLY. Ms. Bonjorni is the Chief Human Capital Officer for VHA, Ms. Beers for the Veterans Benefits Association, and Dr. Lisa Thomas for the National Cemetery Administration. I see those three people more than I see my family. There is not anything that we put in policy and governance that we haven't discussed, that we don't collaborate on, that we don't talk about.

Ms. LEE. Mr. Goldenkoff, I wanted to ask you, there has been some leadership turnover, and how has that—and challenges—how has that affected the VA's ability to make sustainable improvements in human capital management?

Mr. GOLDENKOFF. It has been extremely problematic. Leadership continuity is so important because, you know, if you have a plan in place, if you have a strategy in place, leaders set the tone. As long as there is that consistent turnover, a lot of that just never happens or it is just much more difficult to happen when essentially the people at the top are temporary employees.

Ms. LEE. Thank you, thank you.

I want to turn now—as you know, I am the chairwoman of the Electronic Health Record Modernization. A GAO 2018 report cited having quality, experienced program staff as a critical factor in the success of major IT acquisitions, also noted the importance of consistency and stability of government and staff in achieving these goals.

Mr. Oswalt, what specific steps has the VA and the Office of OEHRM taken in furtherance of these critical factors?

Mr. OSWALT. Well, there is a standing Integration Office in the Office of Information Technology headed up by one of our IT senior executives, who happens to be a clinician as well, so there is a constant, ongoing dialog there. The individuals who are at the initial operating capacity sites, the IOC sites, are working, what we call, shoulder-to-shoulder with the VA/VHA folks to develop the clinical workflows and to respond to their needs as our customers. In conjunction to with the EHRM staff, my staff in particular, we provide a great deal of logistical support to the EHRM folks in terms of budget space and H.R. support.

Ms. LEE. What percentage of the OIT staff is assigned or tasked with the EHRM project, do you have a percentage?

Mr. OSWALT. No, ma'am, I don't, but I will be able to get that back for you.

Ms. LEE. Can you get that for me? You know, I am just sort of—obviously, the concern with supporting your ongoing IT, as well as this enormous oncoming project and the stress that it puts on your IT personnel, and obviously with your vacancy rate as well, it is a big concern as we move into the implementation to make sure that we are moving forward to that.

Do you know what the turnover rate for your OIT personnel is and in what—do you have any idea about the turnover rate for the personnel responsible for the OEHRM?

Mr. OSWALT. No, ma'am, I don't. Given that this is within just the last 18 months, I don't think we have the metrics on that. A number of OIT employees have moved over and been hired by the EHRM staff. So, in effect, we are fully embedded with them based on the relationships that exist between people and we are backfilling the positions that, you know, were vacated by that.

So I don't have any metrics on turnover, but, again, I will be able to provide that to you.

Ms. LEE. Great. Thank you very much. My time is up.

The CHAIRMAN. The gentlelady yields back.

I now recognize Mr. Watkins for 5 minutes.

Mr. WATKINS. Thank you, Mr. Chairman. Thanks for being here.

There is a lot of discussion on the challenges that the VA and the rest of the health care community has with regards to recruiting and retaining good staff and clinical support staff, but the VA has a lot of benefits that they offer potential employees. Why should potential employees, who could be listening, or those with whom I speak with, why should they consider a career in VA? This is open to anybody.

Mr. SITTERLY. I will start. It is a noble mission taking care of America's heroes, our veterans. When you look at, beyond that, the research that our doctors get to do in our facilities, that our clinicians get to do in our facilities, they are on the cutting edge in many, many areas of making discoveries in modern medicine. The same thing can be said for all of our employees.

I don't know if you have visited a national cemetery lately, sir, but the most honorable place, they are clean, they are respectful. It is just a wonderful way to serve your country.

Mr. WATKINS. Excellent. Thank you. And then the followup to that, how can the VA better articulate these advantages of working with the VA beyond just the salary?

Ms. BONJORNI. I would say that we have a lot of great resources out there that we use in our marketing materials to candidates, when we are reaching out directly to providers to try to convince them to make the switch to come over to VA. So we offer such things as our better quality of life. They don't have to worry about spending all their time on billing and racing to get through their patients in a day, it is a much different model of care that we provide in the VA, and that attracts a lot of our providers to come work for us where they can provide more of a whole health approach rather than cranking out patients every day. Our website, VA Careers, offers a lot of information about our monetary and non-monetary benefits as well.

Mr. OSWALT. I would add, sir, that approximately 60 percent of IT employees are veterans. So, to echo what Mr. Sitterly was saying, veterans serving veterans is a belief, core belief we have.

I would think too—and this is just pure speculation on my part—that increased outreach for transitioning servicemembers is a noble and lofty goal that I think, you know—I mean, you have people who from day one are dedicated and ready to work.

Mr. WATKINS. Excellent. Thank you.

The Association of American Medical Colleges projects that the U.S. will have a shortfall of some 120,000 physicians by 2030. What can Congress do today to ensure that the VA can effectively recruit highly qualified doctors despite this shortfall?

Mr. SITTERLY. Sir, I will start with that. Give the VA the authority to provide salary support, enable us to send medical students to the Uniformed Services University. As the Department of Defense moves their Defense Health Agency model around, I think you will find, and we have spoken to the Dean of the Uniformed

Services University, that they have excess capacity and we would love to be able to grow our own doctors.

We are using some authorities that Congress gave us in the Choice in Quality Employment Act to do more scholarship programs in other facilities, we are trying to—Dr. Roe has been a coach for us in getting our own doctors to help recruit our doctors. One hundred and 20 two thousand students and residents come through VA hospitals every year. Last year, we increased the number of psychiatrists and health care providers by a net 1,000 by having a very targeted recruitment toward those students. We still have 2,000 more vacancies to go that we know of with current requirements, so we are targeting those folks as well.

Mr. WATKINS. Well, thank you very much. Thanks for being here, to the panel, thanks for what you do for our veterans and our country.

I yield back the remainder of my time.

The CHAIRMAN. The gentleman yields back.

Miss Rice, you are recognized for 5 minutes.

Miss RICE. Thank you, Mr. Chairman.

Staffing challenges have been an ongoing concern at the Northport VA Medical Center, which serves veterans in my district and throughout Long Island. Within the past 2 years, Northport faced considerable turnover in virtually all of its key administrative roles, including 4 medical center directors, 3 chiefs of staff, 3 nursing department directors, and a heads of the human resources department who all left the facility.

Last year an OIG investigation shed some light on nursing shortages at the medical center that led to quality of care issues and the highest number of vacancies continues to be for nursing staff positions.

To improve recruitment of retention of nursing staff, the facility has proposed new salary levels to address the significant pay differentials that exist between VA and private sector salaries. I just met in my district with the head of the—I guess—I don't know if he is real or acting director. It is my understanding that the new salary levels must be approved at the VISN level.

So, Mr. Sitterly, I guess this question would be for you. Can you provide any details about the approval process at the VISN level, what that entails, and how long it usually takes, and what authority do VISN leadership officials have to either effect or weigh in on facility level staffing,whether it is authorized staffing levels or the actual hiring process?

Mr. SITTERLY. I will start the conversation and ask Ms. Bonjorni to help me with her experience. But there are a couple of issues that you have brought up I would like to address. And the first one is authorizing market pay for our medical center directors themselves, depending on whether they are Title 5 or Title 38, and to allow us the flexibility to establish those market pays.

The other issues is just in general. We do market salary surveys, and then we come back and determine what is the right rate to pay the folks based on that particular market. I don't mean to sound flippant, but I would say that every VA facility is a handmade wooden shoe when it comes to the human capital dynamics of that particular area.

For instance, in San Francisco a neurosurgeon can get paid downtown close to a million dollars, 800 and some thousand. We can only pay them up to the aggregate $400,000. I can never compete with that.

When you get to more rural areas in America, the average salary is less than it is nationwide and I can't compete because when I do the survey of market data they are already getting lower pay. So I can't raise that pay above market rate.

To give us more—and your particular facility I haven't done the research on exactly. But I suspect that it is probably a high area.

Miss RICE. Yes.

Mr. SITTERLY. We don't have to have any additional authorities in order to set those pay rates. But what we have to do is continuously do the market surveys to determine what the local pay rates are, and then they have to be approved through the chain to offer those salary rates.

I will let Ms. Bonjorni add to that if she wishes.

Ms. BONJORNI. For nurse salary rates in particular, those go through the VISN, from the facility to the VISN and then from the VISN up to my office. For Northport in particular, we are working with them to make sure that those get processed in a timely fashion. We have moved to a model of having compensation managed at the network level to make sure that we are looking across the entire market and setting pay appropriately.

We do still have some challenges in that, even when we look at the market and see that we need to make a change. There are caps within statute that we cannot go over, even if the market indicates it.

Miss RICE. Well, I mean, I think we have to address this issue because I agree with you that we are not going to—the Federal Government is not going to be able to compensate people at the level that they get in the private sector. If it means us acting to raise those caps, if that is where the authorization comes from, that is what we have to do because this is not just a morale issue, although it certainly affects the morale of the employees. This is, are the veterans getting the kind of healthcare that they deserve, and the answer is in some instances, no. And it should never be because we are not paying people enough money to, you know, you to get them to come.

So, Mr. Missal, this question is for you. There has been, you know, well documented significant leadership turnover and vacancies at VA over the last few years. We see this happening not only at the facility level as I just talked about, but department-wide.

In your view, how has this affected VA's ability to make more meaningful progress toward addressing outstanding recommendations from OIG and GAO? And I think it is important to kind of frame this by mentioning a comment that the president made himself that he actually likes the flexibility that keeping people in acting positions gives him.

But we all know that that is not—first of all, I don't agree with that. I mean, you should have—they should be approved through the process and you shouldn't have an agency like the VA being constantly run by someone in an acting position.

In your opinion, how has that affected the ability to get the kind of changes that we are talking about done with people who are actual employees who are doing the grunt work?

Mr. MISSAL. I have had the privilege to be the inspector general for 3 years, 4 months and 16 days, and in that time I have served with 5 different individuals who have been the secretary——

Miss RICE. Yes.

Mr. MISSAL.—and an almost equal number for other secretaries of health and other senior positions. It is very difficult for those people, if they are in an acting position, to present their vision for what they want to do to get the respect of the staff as to following what they do, and almost as importantly, having a leadership group who work together well, who communicate because in any large organization it is not going to be 1 person or 2 people. It is going to be a number of different people who are leading. And if they don't have experience working together, it makes it that much more challenging.

Miss RICE. I think this is an issue that we—my time is up, but I think this is, you know, we need to communicate that acting positions and this kind of turnover are not helpful to the efficient running of an agency as important as the VA and helping our veterans.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. All right. Thank you, Miss Rice.

Mr. Sablan, you are recognized for 5 minutes.

Mr. SABLAN. Thank you very much, Mr. Chairman. And good afternoon, everyone.

The VA acquired HR*Smart, this new software for human resources management in 2016, and in December 2017 VA began working on a department-wide position management cleanup in HR*Smart. But according to the inspector general, VA has yet to complete this position management cleanup nearly 2 years later. Therefore, discrepancies exist between this number of full-time employee equivalents authorized at VA medical facilities and the number of positions appearing in HR*Smart.

For some facilities the IT found that HR*Smart overstated the number of positions by as much as 20 percent, while at other facilities the number of positions for were unaccounted by as much as 8 percent.

So, Mr. Sitterly and Ms. Bonjorni, why is VA's position management cleanup taking so long? Shouldn't this be finished by now?

Mr. SITTERLY. Thank you for the question, Congressman. It is a complicated answer and I will try to make it as simple as I possibly can.

But HR*Smart is our personnel data base system. We never had a manpower requirements piece of that in the system. And so the data cleanup is in the personnel actions as we went in 2016 from one system to another. When we started our manpower position management journey, we started with the as is, if you will, on what positions were currently across the VA, input them in.

Now what we are cleaning up is we have positions where let's say you have a requirement for a left-handed monkey wrench turner and a right-handed monkey wrench turner, but you can only

find two left-handed ones. So is that good enough to put into this position, yes or no.

You know, that's probably a simplistic answer, but when you start talking about specialties across the entire VA, you may have a physician's assistant that you have hired because you couldn't hire an RN, or you may have a food service worker you hired instead of an RN.

As we get to the position management across the entire VA, understanding the metric that we need to be able to assess and then to surgically input where we need recruiting, retention, and relocation bonuses, that will better help us define where those requirements are.

Mr. SABLAN. That still doesn't answer my question of why it is taking so long.

Mr. SITTERLY. So HR*Smart, sir——

Mr. SABLAN. Yes. Who——

Mr. SITTERLY.—will require——

Mr. SABLAN.—who decided to acquire this software or whatever it is?

Mr. SITTERLY. I cannot speak. That decision was made probably in 2015. It came on board in 2016. But we are adding new capability to the system every day. Not all of it is rolled out as I would like it, but we are adding the opportunity for us to track our residents and our students, and we will be able to do that soon so that we can better recruit them. We will have them in a data base system, our employee relations. So we are continuing to build out that system.

I also have to tell you that productivity standards for the VA is not something new. We have always had them, and we have about 40 percent of everybody now that meets some sort of a manpower determinant. To put the business rules in place and to get each of those positions into the IT system is what we are working on now.

Mr. SABLAN. Well, I don't think it is easy, but I think it is necessary that it must be done because, you know, you need the data to make good decisions.

Mr. SITTERLY. Yes, sir.

Mr. SABLAN. And so, Mr. Missal, does the Department's explanation seem reasonable to you, what was just answered? Should it take 2 years for VA to complete this position management cleanup?

Mr. MISSAL. It is hard for me to say since it is their system. We have reported that they need to continue to work to improve HR*Smart. We have identified some issues, and they have committed to doing so.

Mr. SABLAN. Is HR*Smart the right program, the right software for what the VA is faced with?

Mr. MISSAL. I think it can be. There are a lot of different products out there. It's their decision as to which one they want to use, which one they think is going to be the most effective for their needs.

Mr. SABLAN. So you can't say for sure?

Mr. MISSAL. I can't say for sure.

Mr. SABLAN. You think there could be maybe a better system out there? I mean, we don't want to be back here 2 years from now and still be talking about, you know, all of these issues.

Mr. MISSAL. I agree with you. IT is——

Mr. SABLAN. It's unfair to our veterans.

Mr. MISSAL.—an issue that comes up in a lot of different matters we work on.

Mr. SABLAN. All right. So let me ask one more question. Actually, my time is up, Thank you.

The CHAIRMAN. Thank you.

Mr. SABLAN. Thank you.

The CHAIRMAN. I appreciate that, Mr. Sablan.

Mr. SABLAN. Thank you very much.

The CHAIRMAN. I do.

Mr. Lamb, you have 5 minutes.

Mr. LAMB. Thank you, Mr. Chairman, and thank you to all the witnesses for being here with us. This is such an important issue. We hear about it at every VA that we visit. I just think the VA employees themselves are kind of crying out for some extra help in a lot of cases, and we want to make sure we get it to them, and for the patients, too.

I know a lot of our conversation today has probably been about doctors, and I apologize. I just came in. I wanted to talk to you about non-doctor jobs, particularly the medical technician and other types of jobs that require training cycles that are a little bit shorter and cheaper maybe from a community college or even from some non-college programs.

I know we have—in Pittsburgh there is a great program called the Manchester Craftsman Guild and there are similar programs in different places around the country that are really good at training medical technicians.

We have such a strong healthcare economy in Western Pennsylvania that those people get jobs and they are good-paying jobs, 40, 50, 60 grand a year. They are competed for actually because these programs are so good at them. But when I met with some folks there the VA wasn't really even on their radar screen. They weren't thinking of it as a destination for their students.

I was just curious, do any of the VA witnesses know, do we have formal partnership programs with kind of community organizations like this or with community colleges?

Ms. BONJORNI. Sure. Thank you for the question. And that is an important one because medical technologists are a key part of our workforce, and they are on our list of shortages.

Our national recruiters have been primarily focused on physician recruitment since that is where our focus needs to be in many cases. We also need to focus on these other occupations.

We do have relationships with many schools across the country. Our health professional trainee programs allow us to bring in folks through different local schools. It sounds like we have at least one that we haven't reached out with to partner with, and we would be happy to meet with you to figure out how to do that.

Mr. LAMB. Just so I know, where does the hiring authority exist for folks like that? Is it at the individual hospital level?

Ms. BONJORNI. Yes.

Mr. LAMB. OK.

OK, now to doctors, again, for any of the VA witnesses, since MISSION Act has increased the amount of debt repayment, I know

it has been a pretty short period of time, but do you have any data or feedback yet showing if that makes a difference or are you getting that impression?

Ms. BONJORNI. Yes. Already we have seen a significant uptick in the usage among our physicians. The average award amount has gone up significantly since the MISSION Act passed and we were given more authority.

Mr. LAMB. That's great. And did it go overall from, what, 140 to $200, was that it or——

Ms. BONJORNI. $1500, yes. And so our average award amount was around $77,000 prior to MISSION Act passing, and now it is up to 113,000—$115,000 on average.

Mr. LAMB. OK. And what commitment are we asking people to get the full reward, how many years?

Ms. BONJORNI. Well, each year that you are a part of the EDRP program, essentially it is paid in arrears. So it goes up to 5 years and it is paid out after you have completed the year.

Mr. LAMB. OK. So you have to do 5 years to get the full benefit?

Ms. BONJORNI. To get all the way to the $200,000.

Mr. LAMB. Yes. Then in this program if you leave before the 5 years are up, do you have to repay what was already given to you or——

Ms. BONJORNI. No, because it is paid in arrears. You have done the time——

Mr. LAMB. It is paid in arrears. That's good.

Ms. BONJORNI.—once you get it.

Mr. LAMB. See, when I was at the Department of Justice we had a similar thing, but if you left before the 3 years was up, you had to pay it back which I had to do when I ran for Congress.

[Laughter.]

Mr. LAMB. Yes. I like the way yours is structured. That is good for talent.

On the issue of the geographic disparities, I have visited a few VA facilities in Pennsylvania, not in my district, that have a hard time keeping and attracting mental health, especially which I know is a system-wide problem, just kind of based on where they are, a little isolated.

Has anyone talked about whether you could use loan repayment to give even an additional benefit to people that are willing to go to the areas where we really need people the most? Maine is another example I hear of a lot. Have we talked about increasing the rewards even further for those specifically targeted people?

Ms. BONJORNI. Yes. Absolutely. We have a group right now that is looking at how to enhance our trainee recruitment among physicians and health profession trainees. As part of that review they have identified we need to have a more strategic approach to putting together our compensation packages so that facilities that are in those harder to reach areas understand exactly what kind of package they should put together to offer people to come on board.

We are also focusing on recruiting those trainees and trying to find ways to match them across the country so that they can't confine positions not just where they are training, but also elsewhere. If they would like to, for example, move home to Maine or elsewhere.

Mr. LAMB. OK. Yes. Great. Thank you for that. I mean, it strikes me that with the lower cost of living in a lot of these placements, and enhanced debt repayment or enhanced salary or all 3 could combine to a really nice, you know, incentive for somebody. But we might have to put our thumb on the scales a little bit more.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you, Mr. Lamb.

Mr. Cisneros, you are recognized for 5 minutes.

Mr. CISNEROS. Thank you, Mr. Chairman. Thank you all for being here today.

The VA Office of Inspector General found that 3 frequently cited categories for reasons of VA staff shortages is due to a lack of applicants, non-competitive salaries and high staff turnover.

Mr. Missal, in your opinion what more needs to be done to address the issues of high staff turnover and retention?

Mr. MISSAL. A number of things should be done. First, I would like to emphasize that leadership at different facilities is so important. That really sets the tone of the facility. People want to work at a place where not only they feel like they are fulfilling the noble mission of VA, but that working with people who have the highest integrity. So working leadership is very important.

Also, VA has a number of different recruitment tools that they can use and they do use. And there could be opportunities for them to use them more aggressively and more effectively.

Mr. CISNEROS. One of the recommendations you provided for was to engage employees as engaged employees are more productive and less likely to leave.

Can you elaborate on that, please?

Mr. MISSAL. Sure. It goes back to my previous answer, which is if employees feel that they own the mission, that they are part of helping veterans get the services and benefits that they so richly earn and deserve, then they are going to feel more committed to their job. If they feel like the job is not meeting those goals, then it is going to be much harder for them to want to stay.

Mr. CISNEROS. Thank you.

Now the VA cannot accomplish this mission without dedicated people behind it. For at least 2 decades the Government Accountability Office has documented how the VA has fallen short with its management of human capital. In 2019, GAO provided 8 priority recommendations to VA for addressing human capital, which includes accurate counting of positions, assessing the effectiveness of recruitment, developing effective performance management systems, and addressing retaliation.

Mr. Goldenkoff, for those outstanding priority recommendations what has been the VA's progress in implementing solutions?

Mr. GOLDENKOFF. Well, it has been mixed. VA certainly recognizes and has embraced most of those recommendations. And we have been working with them on a regular basis to share some leading practices with them. But it has been taking time.

For example, in the area of performance management systems, we would like to see more progress because that is so important to the transformation of the whole organization. It often starts with the performance management system, what you hold people accountable for.

It is taking steps in the right direction. We are encouraged by that. It was interesting to hear about the engagement plan at the enterprise level. That can address some of these issues. You just mentioned the importance of engagement.

We will continue to work with them.

Mr. CISNEROS. There has also been significant human capital leadership turnover at the VA over the last few years, including at VHA.

In your view, how has this affected VA's ability to make significant strides in addressing outstanding recommendations?

Mr. GOLDENKOFF. It has been an absolute impediment. What we have seen, both at VA and at all Federal agencies, is a direct connection between the human resource staff and the leadership within the human resource function and the mission side of the agency.

Within the human resource area we found 2 significant issues. One was just a lack of internal control procedures that are so important to execute the human resource function. But then also in the capacity of the human resource specialists, there were shortcomings there as well. It's a perfect storm of problems there is a lot of the human resources offices not fully staffed. So that increases the workload. That creates burnout and engagement problems which increases turnover, which increases workload. And so you can see it is a non-virtuous cycle.

It is so important to start with the human resource office because what they do is so important to everything else that the agency does.

Mr. CISNEROS. Thank you all for your testimony today.

I yield back the balance of my time.

The CHAIRMAN. Dr. Roe, I recognize you for 5 minutes.

Mr. ROE. Thank you.

Mr. Sitterly, I was having a really good day today until you mentioned the birthday of the Air Force and I realized I was older than the Air Force.

[Laughter.]

Mr. ROE. It messed up my whole day.

Mr. SITTERLY. Sorry, Doctor.

Mr. ROE. A couple of things.

One, the VA is out competing in a market across the country for very skilled people. There is a hospital in my region that has 100 openings right now. Every single police officer, I mean police chief and sheriff I have talked to in my district cannot find enough people to work in the police area, in law enforcement.

The challenge you face is a nationwide challenge, both in and outside the VA. And I think you all in H.R. are in a unique position, one of the most important positions that is unrecognized in the VA to recruit these talented people. You have an incredible challenge in front of you to do that.

As it was mentioned, Mr. Watkins has some great advantages. One, the physician management, we talked about it yesterday in the office, may be changing how the loan scholarships like the DOD uses to recruit doctors have a very effective to do. 80 percent of us at some point in our career go through a VA, spend some time at a VA hospital during our medical training. So you have a chance

to interact and show them that the VA, how this would be a great place to work.

We mentioned our local hospital system, in the last 2 years of nursing school, paid the tuition, books and fees, and a small stipend. We were able to retain nurses. They stopped that program and low and behold we didn't have enough nurses.

Those things are huge for young people now because of the student loan debt that they are facing across the country, $1.6 trillion in student loan debt.

We have advantages. And there are obviously some challenges. Geographic were mentioned. I think you mentioned some things that we are absolutely going to look at. The DOD paid family leave, and that is for young families that are raising children. I know I was—you know, matter of fact, we mentioned this yesterday in this office, but I volunteered my wife to be the one that stayed home with the kids. I go to work because that was a lot easier than taking care of babies.

We mentioned some successes. What I would like for you all to do, and I want to just any of you take this question. If you had a magic wand, what would you do right now to streamline the hiring practices to make your job easier? What can we do to help is what I am asking?

Mr. Missal, any of you all can jump on that and take it.

Mr. SITTERLY. I guess I will start that, Dr. Roe.

I would ask Congress to do a little less in terms of additional authorities for hiring. I spent 43 years doing H.R. work and I never seen as complex an H.R. system as I see facing us right now, not just in the VA, across the entire Federal Government. There are 120 that we can count specific appointment authorities. And several people come under more than one authority. Veterans have 6 different appointment authorities, for instance.

And I think the best characteristic or the best talent an H.R. specialist has to have is a law degree. It is so complex. It is very difficult.

Thank you to this Congress. You asked us to stand up an H.R. academy and we did that in Baltimore. I attended it personally where we did nurse pay setting. It took me an entire day to learn how to do one nurse pay setting. It is very, very complex.

So I would ask that we work together, sir, to simplify. We are working with OPM as well to simplify all of the authorities that we have.

Mr. ROE. Well, we don't know those. And so we have to have you all to help us with that because I think we could help not only the VA, that's what our committee is, but we could help a lot of other agencies if we could do just that. But we need your expertise to tell us where the road blocks are.

Mr. MISSAL. Yes, sir.

Mr. ROE. Before we go, because we haven't got time to go through all that today. But, I mean, that is maybe a round table that we do to get this hammered down so we can make your job more efficient and easier.

The Choice Act we passed in 2014 increased the number of GME slots, about 1,500 positions, for primary care, mental health and others.

Do you know how many of those have been created, how many of those 1,500 slots are out there available now?

Ms. BONJORNI. Right now it just over 1,300, so we have about 200 to go.

Mr. ROE. And so we are close. That is very good. And how do you decide where they are positioned, where they are located?

Ms. BONJORNI. Well, I believe the language in the law did ask us to try to move those toward more rural areas.

Mr. ROE. Yes.

Ms. BONJORNI. And so that has been a bit of the delay in getting them up and running because it requires us to create the infrastructure to get out to those rural areas. So we look at where the most need is.

Mr. ROE. And which states have had the most GME positions? I hope it is Tennessee.

[Laughter.]

Ms. BONJORNI. I can't answer that one off the top of my head, sir.

Mr. ROE. OK. And I guess the last question on this very quickly is just most of these are probably with pre-existing programs that already had GME slots, or were these programs that did not have any GME slots and it started? That is much harder.

Ms. BONJORNI. It is. And our academic affiliate office has worked to create a grant program to actually help build out that infrastructure in the places where they don't have programs.

Mr. ROE. So if we could get that, Mr. Chairman. I know you are interested in that——

The CHAIRMAN. Yes.

Mr. ROE.—because that was one of your great ideas in 2014. So if we could get all that sort of compiled up, we would like to see that.

Thank you, all. My time is expired. I yield back.

Mr. CHAIRMAN. Dr. Roe, and I am especially also interested in that, the idea. We have been talking offline here about the, is it USU?

Mr. MISSAL. Yes, sir, that's correct. USU. Uniformed Services University.

The CHAIRMAN. Uniformed services, they have capacity there. I am intrigued with that idea as well. That is wonderful.

Well, I would like to thank the witnesses for their appearances and their testimony today. Thank you all for what you do for our country and for our veterans.

All members will have 5 legislative days to revise and extend their remarks, and include extraneous material.

Again, thank you for appearing before us today. This hearing is now adjourned.

[Whereupon, at 3:51 p.m., the committee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

PREPARED STATEMENT OF DANIEL SITTERLY

Chairman Takano, Ranking Member Roe, and Members of the Committee. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) ability to be a competitive employer in the health care and information technology industries, including any impacts of rising labor costs, provider pay structure, and the impact of previous hiring and retention related efforts. I am joined today by Ms. Jessica Bonjorni, the Acting Assistant Deputy Undersecretary for Health for Workforce Services, Veterans Health Administration (VHA), and Mr. John Oswalt, the Deputy Chief Information Officer for Information Technology Resource Management, Office of Information Technology (OIT).

COMPETITIVE EMPLOYER IN THE HEALTH CARE INDUSTRY

As the operator of the largest integrated health care delivery system in America, VA successfully attracts and retains high quality talent and VA's overall workforce has consistently grown by approximately two to 5 percent annually over the last 5 years. This growth is responsive to an increased demand for services, which is the result of improved access, reduced wait times, improved quality, enhanced Veteran satisfaction, and overall mission growth. As of June 30, 2019, VA has 386,000 employees with over 89 percent of VA employees serving in VHA. Most of the additional staffing capacity needed in VA in the past 5 years has been in clinical occupations, which accounts for 81 percent of overall growth in VA. VA has consistently maintained turnover rates at or below 9.5 percent for the past decade, which is low when compared with other large Cabinet-level agencies that average 11 percent (as published by the Office of Personnel Management's (OPM), FedScope), or with health care industry turnover rates of 20–30 percent (per the United States (U.S.) Bureau of Labor Statistics). VA has also ranked quite favorably on the list of Best Places to Work in the Federal Government, as compiled by the Partnership for Public Service, reflecting improvements in employee engagement.

Despite the foregoing successes in staffing growth, the ability for VA to remain competitive for some occupations is challenged by compensation inflexibilities faced in the Federal pay system. For example, the San Francisco medical center is in one of the highest cost-of-living markets. Highly specialized surgeons in that market average nearly eight hundred thousand dollars in compensation, while VA is capped at about 50 percent of that rate. Statutory limits on total compensation mean that VA must spend considerably more to contract out critical healthcare services such as cardiothoracic surgery and interventional radiology, as a lower cost alternative.

IMPACTS OF THE RISING LABOR COSTS

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. However, VA still contends with ongoing pay challenges presented by the limitations of multiple pay systems and compounded by rising labor costs. While VA utilizes many incentives available under statute to recruit and retain talent successfully, these incentives provide only a short-term solution. In many situations, existing flexibilities are insufficient to support a strategic approach to attracting and retaining talent. Incentives do not necessarily eliminate salary disparities with competing employers and therefore, do not address long-term gaps in pay. As the demand for healthcare providers continues to outstrip supply (BLS Healthcare Occupation Outlook; American Association of Medical Colleges report, 2019), private sector employers are nimble enough to adjust quickly to changes in local labor markets by modifying starting salaries and total compensation packages, as needed, to attract top talent. Meanwhile, VHA and other Federal employers are restricted by Federal statutes and regulations regarding the establishment of pay rates, and often require years of pay disparities to exist before lengthy processes can respond to market changes. This leaves Federal agencies at a disadvantage when

competing for talented employees. While VA has employees and applicants who are willing to accept a lower salary to be part of an organization with such an important mission, VHA faces increasing challenges in its ability to attract or retain quality health care professionals when the salary gap continues to increase.

The General Schedule (GS) is the predominant pay scale for Federal employees and is based on the level of difficulty, responsibility, and qualifications required for the position. By law, GS base rates are adjusted annually based on average increases in private sector salaries as measured by the Employment Cost Index, except as otherwise provided under a Presidential alternative plan. Annual locality pay adjustments for GS employees are also provided by law but are subject to a Presidential alternative plan. As part of the Fiscal Year (FY) 2020 budget, the President has proposed that no increases in GS base rates or locality rates be made in January 2020. The Administration supports reforming the GS pay system so that it is more performance-based and so pay levels and adjustments are targeted to address occupation-specific pay disparities. As a first step, the Administration has proposed legislative changes that would slow the frequency of GS longevity-based step increases and make funding available to provide targeted performance-based pay increases for mission-critical occupations. To request Special Salary Rates or adjustments to these scales, VA must prepare comprehensive documentation on market conditions and submit the request to OPM, which coordinates special rate requests with other agencies employing the same type of employees, for approval. The Federal Wage System (FWS) is a uniform pay-setting structure that covers Federal blue-collar hourly employees. OPM oversees this pay system, with the support of the Department of Defense (DoD), which has responsibility for conducting wage surveys and coordinating special rate requests. These existing pay systems do not meet the fluid and dynamic nature of today's market. VHA's volume of positions to hire is tremendous, reaching more than 45,000 new hires in Fiscal Year 2018 to replace workers due to turnover and grow the workforce to meet Veteran demand. As of the end of the third quarter Fiscal Year 2019, VHA has more than 28,000 new hires for the year and hiring for Fiscal Year 2019 has continued to outpace separations. The constant need for new hiring due to mission growth and turnover is reflected in more than 43,000 VHA vacancies. As a result, it is necessary for the pay structure to support VHA's ability to hire qualified candidates as quickly as possible to support access to care for Veterans.

In addition to the limited flexibility in establishing new locality areas and the overall pay structure, the GS pay system and the FWS require the use of antiquated rules and formulas that do not provide for market driven pay-setting latitude. Most GS employees are entitled to locality pay, which is a geographic-based percentage rate that reflects pay levels for non-Federal workers in certain geographic areas as determined by surveys the U.S. Bureau of Labor Statistics conducts. Those localities that do not fall under a specified locality pay schedule are placed on the Rest of United States (RUS) schedule covering all other localities not otherwise having a specified schedule. VHA facilities serve multiple local labor markets, to include heavily populated cities, suburban towns, and low populated rural areas. Many of these areas receive locality pay under the RUS schedule because they do not meet the criteria: for a separate locality pay area; as an area of application to a locality pay area by being adjacent to the metropolitan statistical area; or as a combined statistical area comprising the basic locality pay area and having 2,500 or more GS employees. VHA facilities in smaller counties and rural towns generally offer salaries significantly lower than the local labor market because they do not have enough GS employees to be considered for their own locality pay schedule. It is important to also note that, wherever VA facilities are located, there is a need for a robust and fully capable IT workforce. OIT faces some of the same challenges VHA does to include outdated position classification guidance that inhibits OIT's ability to attract and retain top tier IT talent in highly competitive job markets.

PROVIDER PAY STRUCTURE

VHA currently functions under multiple personnel systems (title 38, Hybrid title 38, and title 5), each with multiple pay systems that contain distinctive variations and complexities. VHA hires health care providers under title 38 and associated health professionals under Hybrid title 38 (i.e., employees are covered under title 38 for appointment, advancement, and some pay structures, but for all other purposes are covered under title 5). Both authorities allow the Secretary of VA broad flexibility in setting pay based on both the individual's qualifications and conditions in the local market. VHA hires non-clinical employees under Government-wide title 5 authorities, with pay set under the GS and FWS.

VHA needs the ability to offer competitive salaries to recruit and retain employees in various occupations that have much higher rates of pay in the private sector, particularly in larger cities and rural areas. VHA is in the process of developing a comprehensive legislative package that would provide additional flexibilities for its workforce.

IMPACT AND SUCCESS OF PREVIOUS HIRING AND RETENTION RELATED EFFORTS

Despite the above challenges, VA employs a variety of tools to attract and retain quality talent. Those tools include direct hiring authorities, recruitment and retention flexibilities, hiring initiatives, improved employee engagement, workforce planning, targeted recruitment of Servicemembers transitioning from DoD, national recruitment programs for hard-to-fill occupations and specialties, and strategies for filling medical center director positions.

VA has successfully used direct hire authority for more than 71 percent Cyber Security / Information Security (Cyber / IT) of its hiring actions for 12 months, ending June 2019.

The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 authorized or expanded several programs intended to recruit and retain health care providers in VHA, to include an increase in the maximum amount of student loan debt that may be reimbursed under the VHA Education Debt Reduction Program (EDRP); authorizing designated scholarships for physicians and dentists under the VA Health Professional Scholarship Program (HPSP); establishing the VA specialty education loan repayment program to incentivize VHA employees to pursue education and training in medical specialties for which VA determines there is a shortage; and establishing a pilot program for the Veterans Healing Veterans Medical Access and Scholarship program.

The new OIT Office of Human Capital Management developed and implemented a robust Recruitment and Talent Acquisition Strategy to reduce the time to hire, attract, and brand OIT as an employer of choice. OIT has simultaneously created a first-ever comprehensive staffing model that identifies all existing workload drivers and associated workforce profiles giving OIT the necessary analytical tools to determine actual staffing requirements as they emerge alongside new technologies.

During this past fiscal year, OIT rolled out many new and expanded recruitment and talent acquisition strategies to include: resume mining via USAJOBS; gaining access to critical talent identification platforms like LinkedIn; providing opportunities for students, recent graduates, Presidential Management Fellows, military spouses; and offering noncompetitive appointments designed to attract disabled Veterans and non-Veterans. OIT continues to educate hiring managers on the vast number of recruitment and hiring flexibilities available to them.

VA strategically allocates recruitment, retention, and relocation (3R) incentives to close skills gaps and provide greater flexibility in the recruitment, relocation, and retention of highly qualified VA professionals. In Fiscal Year 2018, VA spent $52.4 million on 3R incentives. Of that total, $41.2 million (78.6 percent) was directed toward VHA shortage occupations (i.e., the 10 clinical and 8 non-clinical occupations identified by facilities as shortage occupations via the VHA workforce planning cycle).

For the second year in a row, OIT has offered Cyber-Retention pay incentives to IT specialists, which has been beneficial in keeping prized cyber talent within VA.

VA uses EDRP to secure health care providers in specific, difficult to fill positions for up to 5 years by providing student loan payment reimbursements. Positions eligible for EDRP are prioritized based on local recruitment and retention requirements to meet specific staffing needs. In Fiscal Year 2018, VA spent $44 million on EDRP. Section 302 of the MISSION Act enhanced EDRP by increasing the maximum award amount from $120,000 to $200,000, not to exceed $40,000 per year. Additionally, section 306 ensures clinical staff working at Vet Centers are eligible to participate in EDRP.

During Fiscal Year 2018, VA awarded 1,071 new scholarships in the Employee Incentive Scholarship Program and supported 3,133 employees actively participating in the educational phase of their scholarship with funding totaling $29 million. The top five scholarship-funded occupations were: Registered Nurse, Licensed Practical/Vocational Nurse, Social Worker, Physical Therapist, and Medical Technologist/Medical Records Technician. The VA Learning Opportunity Residency program allows nursing, pharmacy, and medical technology students who have completed their junior year in an accredited clinical program to gain valuable clinical experience at a VA health care facility for up to 800 hours, with pay. From Fiscal Year 2015 through Fiscal Year 2018, VA funded 339 student salaries for nurses, pharmacists, and medical technology students for a total of $4.2 million. VA also awarded $5.2

million for new and continuing awards to 201 nursing, physical therapy, and physician assistant participants in the 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 such personnel for VA and the U.S.

Targeted hiring initiatives have proven to be an extremely effective way of hiring talent where it is needed most. In 2017, VA introduced a Mental Health Hiring Initiative, committing to hiring 1,000 new mental health providers by June 30, 2019, as part of VA's No. 1 clinical priority to eliminate Veteran suicide. By January 31, 2019, VA surpassed its goal by hiring 3,956 mental health providers resulting in a net gain of 1,045 additional mental health providers. This initiative included VA's inaugural virtual trainee hiring fair where 85 facilities participated to connect, match, and place interested candidates into mental health positions across VHA. Through the trainee hiring fair, 74 mental health trainees accepted job offers at a matched location after completion of their training. This initiative laid the groundwork for a permanent trainee hiring capability in VHA.

Hire Right Hire Fast (HRHF) is a hiring model initiated in 2017 for the medical support assistance occupation. The goal for HRHF was to reduce the time it takes to hire and fill open positions within this occupation. This was achieved by developing applicant registers and implementing specific actions integral to hiring success. This program drove time-to-hire to under 60 days (formerly 180 days) and reduced open positions to 9.4 percent. Based on the preliminary results, HRHF will also be extended to the Housekeeping Aid occupation. The HRHF model was found to be most impactful in occupations that exhibit few requirements to entry (e.g., no licenses, no certifications, etc.); high loss rates; and large onboard full-time employee equivalent requirements.

VHA's Workforce Planning Cycle places direct emphasis on optimizing VA's most vulnerable professions. During this process, VHA identifies staffing shortage occupations; assists with current and future workforce planning efforts and challenges; and conducts other workforce planning activities. In response to requirements in the VA Choice and Quality Employment Act of 2017, the workforce planning cycle was redesigned to provide a structured, data-driven approach for identifying clinical and non-clinical shortage occupations at the health care system level. Each year, VHA publishes a staffing shortage report that identifies the results from the Workforce Planning Cycle. During the Fiscal Year 202018 cycle, recruitment challenges were selected as the primary drivers for 64 percent of the shortage occupations and specialties, while the remaining 36 percent were primarily associated with retention challenges. The most commonly cited root causes for shortage occupations included competition with other health care employers and a limited supply of candidates. The most commonly cited strategies to address staffing challenges included non-competitive hiring flexibilities and utilization of recruitment and retention incentives.

As a subset of the military to civilian transition, DoD and VA have combined efforts to recruit transitioning Servicemembers into vacant positions within VA. In a 2015 study of over 8,500 Veterans, active duty Servicemembers, National Guard and Reserve members, and military dependents, 55 percent of the participants identified "finding a job" as their most significant transition challenge. The goal of this effort is to create an additional candidate pipeline for entry level job opportunities. Beginning in Fiscal Year 2018, VHA launched a direct marketing campaign to target military medical professionals currently enrolled in the transition process for recruitment into VHA employment. VHA uses the VA-DoD Identity Repository data to identify Servicemembers, their discharge date, and their military occupational specialty or specialty codes. In Fiscal Year 2018, VHA's total Veteran hires increased by 36 percent, totaling over 17,000. VA is also partnering with DoD to support hiring military spouses for mission-critical and hard to fill positions. Military spouses represent a robust pipeline of talent for health care and science, technology, engineering, and mathematics occupations nationwide. Through the Military Spouse Employment Partnership, VA will have direct access to points of contact at military installations where we are able to share job opportunities and access resumes of qualified candidates for noncompetitive employment.

The VHA National Recruitment Program (NRP) provides a small in-house team of skilled professional recruiters employing private sector best practices to the Agency's most critical clinical and executive positions. The VHA-NRP works directly with VHA's Office of Rural Health, other national program offices, Veterans Integrated Service Network Directors, VA Medical Center (VAMC) Directors, clinical leadership, and local VAMC Facility Recruitment Liaisons to develop a comprehensive, client-centered recruitment strategy that addresses both current and future critical needs.

VHA has made significant progress in efficiently filling medical center director (MCD) positions through the implementation of a vigorous national recruitment

strategy which includes using existing legal authorities to fill MCD positions and leveraging critical pay authority to adjust the rate of pay up to $201,900 (as of January 2019) for 39 Complexity Level 1A MCD positions. In addition, the Agency has adopted a 120-day time-to-fill standard for MCD positions. The result has been a significant reduction in the MCD opening positions from as high as 25 percent in Fiscal Year 2015 to 11 percent in Fiscal Year 2018.

The historically high vacancy rate in OIT resulted from an increase in attrition rates due to retirements, transfers, and losses to other Federal agencies in highly competitive job markets. As mentioned above, OIT has expanded its recruitment efforts beyond the normal USAJOBS announcement and has been very successful in reducing its vacancy rate. One area where OIT has made great strides is hiring from outside of OIT. While developing and promoting existing staff is a key component of any human capital strategy, internal hiring creates a new vacancy elsewhere in the organization. By encouraging hiring managers to consider a wider catchment area outside of OIT to fill positions, OIT has increased its net number of new hires lowering the overall vacancy rate.

Improved outcomes show that VA is on the right track and that Veterans are being well served. Recent studies have reported that Veterans are receiving the same or better care at VAMCs as patients at private sector hospitals. Since 2014, the number of annual appointments for VA care is up by almost 5.0 million, with more than 58 million appointments scheduled in VA facilities last Fiscal Year and 1.5 million extra appointments expected by the end of this fiscal year. According to a study in the Journal of the American Medical Association, VA average wait times are shorter than those in the private sector for primary care, as well as two out of three specialty care areas. VA recently reached a telehealth milestone, achieving more than 1 million video telehealth visits in Fiscal Year 2018, a 19 percent increase in video telehealth visits over the prior year. This technology gives Veterans access to the timely, quality care they deserve, without having to travel great distances to a VA facility. As published in a March 2019 article in the Annals of Internal Medicine, Veterans who choose VA for their health care have a greater chance of survival beyond 30 days after hospital discharge, if they were admitted for heart attacks, severe chronic lung disease, heart failure and pneumonia as compared with non-VA hospitals.

In the second quarter of Fiscal Year 2019, 87.6 percent of 3.3 million Veterans surveyed said they trust VHA outpatient services, with an overwhelming majority (92.1 percent) of VAMCs improving in that trust score from fall of 2017. In December 2018, the Partnership for Public Service released its Best Places to Work in the Federal Government rankings where VA ranked sixth out of large Federal agencies. As one of the top ten large agencies to work for in the Federal Government, VA continues to enhance employee engagement, focusing on multiple touchpoints to receive employee feedback. VA's Employee Engagement Council periodically meets to address and implement solutions. In April, the Secretary approved VA's first ever Employee Engagement Enterprise-Wide Plan which emphasizes principles of servant leadership. Leaders at all levels seek feedback year-round, in person and online, to ensure the Agency continues making progress. High employee engagement at VA will positively impact the customer service Veterans receive daily.

In summary, VA is very appreciative of the numerous recruitment and retention authorities granted by Congress to help support a high-quality workforce providing the best possible care to Veterans. However, the competition for talent in the health care industry is increasingly competitive. Shortages of physicians and nurses abound nationwide. Medical schools and private hospitals are implementing innovative and progressive solutions to address these deficits both in the short and long term. Our ever-expanding reliance on IT to accomplish VA's mission requires us to remain competitive in the IT job market and adopt new ways of thinking about recruitment and retention of IT talent.

VHA has fallen significantly behind private sector health care recruitment and compensation practices, which are aggressive and effective at targeting an array of new employees from entry levels to experienced professional staff. VHA has struggled with staying competitive and being an employer of choice with the limitations placed on the Agency under the current pay systems and with the increased demands to hire additional staff quickly to meet patient needs and support our Veterans. Additionally, to position ourselves for success we must have the right level of IT and support. Mission success depends on IT success. We look forward to working with this Committee on opportunities to enhance VA's ability to attract top talent. This concludes my testimony. My colleagues and I are prepared to respond to any questions you may have.

PREPARED STATEMENT OF MICHAEL J. MISSAL

Chairman Takano, Ranking Member Roe, and members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of how ongoing recruitment and hiring challenges within the Department of Veterans Affairs (VA) can affect patient access to quality care. The mission of the OIG is to oversee the efficiency and effectiveness of VA's programs and operations through independent audits, inspections, reviews, and investigations. In response to Congressional mandate, the OIG has examined and reported on staffing concerns within the Veterans Health Administration (VHA) for the past four consecutive years (with the 2019 report expected to be released by September 30), and has raised issues with shortages or related issues whenever appropriate in the context of its other routine examinations of programs and processes. While it has made some significant strides, VHA continues to face a number of challenges to reaching full staffing.

This statement focuses on the barriers and challenges the OIG has identified in VA's efforts to recruit and retain a highly qualified workforce that delivers health care to millions of veterans. The OIG also acknowledges areas in which VA has made some laudable progress. The OIG has identified frequent changes (and lapses) in leadership and workforce issues as major management challenges for VA and consistently found staffing shortages as a root cause for many of the problems in veterans' care and access identified in oversight reports. VA's inability to adequately recruit, onboard, and retain clinicians and support staff, particularly within specific service areas, reflects problems with competitive pay, field-wide shortages with some professions or positions, leadership and climate, planning, and other factors. Efforts to remediate these problems are hampered by VA's inability to maintain accurate medical facility vacancy numbers.

VA has experienced chronic healthcare professional shortages since at least 2015. It is critical for VA to move forward with developing staffing models calculated from defined requirements based on accurate data and implementing OIG recommendations related to hiring and retention. VA must enhance its ability to maintain a full workforce given the demand for VA health care, even as community care options are expanded. This is particularly important given an increasingly competitive recruitment environment and anticipated healthcare worker shortages in several practice areas. The OIG reports highlighted in this statement provide stakeholders with examples of areas where the results of OIG reviews found instances of staffing shortages impacting the delivery of care.

CONGRESSIONALLY MANDATED STAFFING REPORTS

Congress has passed at least three laws since 2014 requiring a periodic accounting of vacancies within VHA, all of which have related OIG reporting requirements on VA's occupational shortages.[1]

OIG DETERMINATION OF VETERANS HEALTH ADMINISTRATION'S OCCUPATIONAL STAFFING SHORTAGES FOR FISCAL YEAR 2018

Since January 2015, the OIG has reported on VHA clinical staffing shortages as required by the Veterans Access, Choice, and Accountability Act of 2014 (PL 113–146).[2] Although the 2018 report was the fifth OIG report on staffing shortages within VHA, it was the first report that included facility-specific data reported by leaders at 140 VA medical centers.[3] Users can examine the particular self-reported needs of an individual facility as opposed to only national data. It was also the first report to include nonclinical positions (such as human resources, police, and custodial personnel) as required by the VA Choice and Quality Employment Act of 2017 (PL 115–46).[4] These nonclinical occupations ultimately affect the ability of VHA facilities to provide quality and timely patient care in a safe and clean environment.

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[1] Veterans Access, Choice, and Accountability Act of 2014, Section 301; VA Choice and Quality Employment Act of 2017, Section 201; and VA MISSION Act of 2018, Section 505.

[2] OIG Determination of Veterans Health Administration's Occupational Staffing Shortages reports were previously published on September 27, 2017; September 26, 2016; September 1, 2015; and January 30, 2015.

[3] OIG Determination of Veterans Health Administration's Occupational Staffing Shortages for Fiscal Year 2018, June 14, 2018.

[4] VHA's own rankings in previous reports included Human Resources Officer as a position with shortages, but because the statute had excluded administrative positions, OIG did not include Human Resources Officer in the ranking methodology.

The facility-specific results underscore for readers how variable the clinical and nonclinical needs are from one medical facility to another.

Medical center directors most commonly cited the need for medical officers and nurses, which is consistent with the OIG's four previous VHA staffing reports. The data showed that 138 of 140 facilities listed the medical officer occupational series (or a related VHA assignment code) as experiencing a shortage, with the psychiatry and primary care positions being the most frequently reported. Of the 140 facilities, 108 listed the nurse occupational series (or a related VHA assignment code) as experiencing a shortage, with practical nurse and staff nurse as the most frequently reported. Within nonclinical occupations, the OIG found that human resources management and police occupations were among the most often cited as shortages.

These results demonstrated that there are some clear commonalities, but the results also revealed wide variability in occupational shortages reported by individual medical centers. This was critically important to recognize because facilities have distinct staffing needs that must be considered in light of the facility's mission and its local resources. For example, a rural facility specializing in treating mental health needs may be staffed differently than an urban facility providing a broad array of services. Moreover, the rural facility may have a much smaller pool of qualified behavioral health professionals from which to recruit than VA facilities in urban areas.

The OIG's 2018 report also identified challenges to meeting staffing goals. Although hiring has increased, in 4 years of publishing the determination of VHA occupational shortages, the OIG has repeatedly noted the relatively long onboarding process and difficulty in finding suitable candidates. Medical center directors were able to use free text to explain the reasons for shortages, which varied significantly. OIG staffs' thematic analysis of the responses resulted in three frequently cited categories: (1) lack of qualified applicants, (2) noncompetitive salaries, and (3) high staff turnover.[5] Facilities reported recruitment challenges because of tough competition for quality healthcare professionals, and were using various recruitment tools such as special salary rates; recruitment, relocation, and retention incentives; and the education debt reduction program. The noncompetitive salaries were noted as a particular issue with recruitment of nonclinical staff, such as police officers. The survey responses noted that high turnover amongst high-performing staff had follow-on impacts as remaining staff became burned out from working overtime to cover existing vacancies. Additionally, facilities noted that both OPM classification appeal downgrade decisions and outdated OPM classifications affected their ability to offer competitive salaries and advancement opportunities within the organization, resulting in VHA being a less competitive employer for new staff and less likely to retain highly skilled staff. An additional challenge for managers is navigating the recruiting and on-boarding process. In a separate OIG report, one manager described the recruitment process at their facility as being "exquisitely problematic."[6]

VA'S CORRECTIVE ACTIONS

Staffing for future needs requires hiring in anticipation of future losses, as well as ongoing and projected changes in clinical demand, staffing productivity, and allocation of personnel. The OIG recognizes that VHA has made progress in implemented staffing models in specific areas such as primary care and inpatient nursing. However, operational staffing models that comprehensively cover other critical occupations are still needed. Well-developed predictive staffing models would allow VHA to better assess and implement effective measures to address staffing shortage concerns. It is not enough, for example, to address doctor and nurse positions if the staffing model also does not provide for staff to schedule those providers' appointments, handle lab capacity for their testing, for sterile processing staff to clean their instruments, or the custodial staff to clean additional rooms.

The Fiscal Year 2018 report's recommendations repeat the OIG's previous calls for VHA to develop additional comprehensive staffing models that address national needs, while supporting flexibility at the facility level. This approach would help ensure taxpayer dollars are invested in delivering the highest quality of care to veterans as promptly as possible. These staffing models, however, cannot be completed without accurate data. As detailed below, in a recent report examining VA's self-reported staffing data, the OIG found that VA and some of its medical facilities were unable to provide accurate data on the numbers of vacancies. Focusing on

[5] The thematic analysis categories were developed after reading all the responses. Responses that fell outside of the developed categories were classified as "other."

[6] Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center Augusta, Georgia, November 2, 2017.

serving the individual and aggregate needs of veterans in different geographic areas and using that understanding to develop comprehensive staffing models will help VA achieve more efficient and targeted hiring and retention practices. Both of the Fiscal Year 2018 report's recommendations are open as of September 18, 2019, despite the Executive in Charge for VHA providing a target date for completion of May 2019. The recommendations call on VHA to refine and formalize its position categories for clinical and non-clinical staff across all facilities.

In September 2017, the OIG made the following four recommendations to the Acting Under Secretary for Health in the Fiscal Year 2017 report.

1. We recommended that the Acting Under Secretary for Health ensure that the Veterans Health Administration implements staffing models for critical need occupations. VA's self-determined Targeted Completion Date: September 2018.

2. We recommended that the Acting Under Secretary for Health review the Veterans Health Administration report on regrettable losses and implement effective measures to reduce such losses. Closed on August 2, 2018.

3. We recommended that the Acting Under Secretary for Health continue incorporating data that predict changes in veteran demand for health care into its staffing model. VA's self-determined Targeted Completion Date: September 2018.

4. We recommended that the Acting Under Secretary for Health continue assessing the Veterans Health Administration's resources and expertise in developing staffing models and determine whether exploration of external options to develop the above staffing model is necessary. VA's self-determined Targeted Completion Date: June 2018.

VHA has provided information on the progress they have made in addressing the recommendations, and OIG staff will continue to review VHA's future work.

STAFFING AND VACANCY REPORTING UNDER THE MISSION ACT OF 2018

The OIG now reports on how VA can improve its administration of a website that publishes staffing and vacancy information in accordance with the MISSION Act.[7] Specifically, Section 505 of the MISSION Act requires VA to publish by departmental component, such as the Veterans Benefits Administration, National Cemetery Administration, and staff offices, or by medical facility for VHA, the following information:

- The number of current personnel
- The number of employment gains and losses processed during the previous quarter
- The number of staff vacancies by occupation
- The percentage of new staff who were hired within the Office of Personnel Management's (OPM) time-to-hire target of 80 days

The MISSION Act also requires VA to report annually on the steps taken to achieve full staffing capacity and any additional funds needed to achieve that mark. The first required OIG report assessing how VA is meeting this mandate found VA to be in partial compliance with the Section 505 requirements of the MISSION Act.[8] Generally, OIG found that VA reported its current personnel levels and time-to-hire data as prescribed. However, the staff vacancy, as well as the gains and losses, used alternative aggregation methods and were not sufficiently transparent for stakeholders to use the information reliably to track VA's progress toward meeting its full staffing capacity.

VACANCY INFORMATION LACKED DETAIL

Section 505 of the MISSION Act requires that VA publish the number of vacancies by occupation.[9] Instead, in each quarterly release, VA presented its vacancy data by occupational groups and job families, which are broad categories covering a set of related job functions. Most of the reported vacancies were generalized under the Medical, Hospital, Dental, and Public Health Group, referred to as the 0600-occupational group. However, this group includes clinical positions, such as doctors,

[7] Under the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 or VA MISSION Act of 2018, VA's Office of HR&A coordinates the quarterly retrieval, aggregation, validation, and publication of the data (PL 115–182).

[8] Staffing and Vacancy Reporting under the MISSION Act of 2018, June 25, 2019.

[9] In implementing 5 U.S.C. § 51, OPM identified 676 occupational series (or occupations) divided into 59 occupational groups and job families as of September 2018.

nurses, and pharmacists, as well as nonclinical positions in medical records administration, housekeeping management, and consumer safety. The lack of specificity is significant because, as currently reported by VA, vacancy numbers for the 0600-occupational group do not sufficiently identify position-specific staffing needs in VHA. For example, VA reported in November 2018 that the North Florida/South Georgia Veterans Health System had approximately 347 full-time equivalent (FTE) vacancies within the 0600-occupational group. That number is too broad to provide meaningful insight on specific vacancies, such as nurses versus physicians. VA's Office of Human Resources and Administration (HR&A) staff stated they did not list vacancies by series because it would reduce the readability of the report and because they lacked enough staff to break down the data by series. While these concerns may have merit, the OIG maintains that reporting the data by specific job or position would improve the value to VA and the public.

GAINS AND LOSSES NOT REPORTED AS REQUIRED

The MISSION Act requires VA to publish the number of employment gains and losses that were processed during the quarter preceding the data's publication date. However, VA did not follow these specifications and, instead, published data on all actions that took place during all four quarters of Fiscal Year 2018, instead of only the fourth quarter as required. VA maintained that a report covering a single quarter would not capture losses that were initiated but not processed until after the quarter concluded. However, the MISSION Act does not require a complete accounting of all gains and losses, only those that were processed during the quarter. VA should adjust this methodology to ensure that data are reported in compliance with the MISSION Act.

PUBLISHED STAFFING AND VACANCY DATA LACKED TRANSPARENCY

The OIG team identified opportunities for VA to improve the administration of posted personnel data by clearly articulating any caveats or context required to understand published figures. For example, VA did not disclose in their Section 505 staffing reports that it was aware the medical facility vacancy numbers were overstated. HR&A and VHA officials told the OIG team that inconsistencies and how the human resources software, H.R. Smart, was used created problems in counting vacant positions. Since December 2017, VA has been undergoing a process to correct this issue. Nevertheless, to improve the value and utility of the data, VA should inform the public of any known facility-level inaccuracies.

HR Smart is a position-based software, which means records are tied to the particular job position—not to the individual filling that position. The position, once established, exists regardless of whether it is filled. VA policy requires human resources staff to reuse an existing HR Smart position when an employee leaves a job. However, the OIG team was informed that human resources staff were creating new positions in HR Smart after employees left without deleting the existing job position, which was inflating the vacancy numbers to show two vacancies for the facility's single position—the original slot and the newly created position.

From October to November 2018, VHA's calculations for the discrepancy between the number of FTE in H.R. Smart and the authorized FTE level grew from 1 percent to 2.4 percent nationwide. In December 3, 2018, an internal VHA memo indicated some individual VA medical facilities had H.R. Smart position counts that were overstated by as much as 20.7 percent or understated by as much as 8.1 percent.[10]

Any variance between H.R. Smart and the authorized FTE for each location means that VA cannot precisely report on vacancies by facility as the MISSION Act requires. Also, VA medical facilities risk reporting vacancy numbers that do not accurately reflect their needs. VA's three administrations recognized that their position counts were inaccurate and began efforts to correct these figures before the initial release in August 2018. In general, this involved reconciling approved organizational charts with FTE counts in H.R. Smart. As of February 2019, the efforts to clean up H.R. Smart position counts and correct VA vacancy numbers were ongoing.

At the time the OIG published its report, VA's public website did not maintain each iteration of its published data, which further undermined its value as it limited the public's ability to compare data over time. For example, on November 14, 2018, and again on February 15, 2019, VA released the quarterly staffing and vacancy information, but replaced the prior publication rather than posting it as an additional release. Initially, VA staff claimed that historical releases were not maintained due

[10] OIG staff did not receive definitive explanations from VA regarding the causes of understated position counts.

to concern that data could be manipulated. For comparison, VA proposed that it has maintained its annual budget submission for public use dating back to Fiscal Year 2008, and preserved public reports detailing veteran population and expenditures for compensation and pension benefits, medical care, construction, and readjustment and vocational rehabilitation for each State, congressional district, and municipality dating back to Fiscal Year 1996. Subsequently, VA changed its position and is presently maintaining historical data.

VA ESTABLISHED A METHODOLOGY FOR DATA REPORTING, BUT ADDITIONAL IMPROVEMENTS ARE NEEDED

The OIG report identified several errors in VA's reported data that should be corrected to ensure accurate representation to the public. VA misreported time-to-hire information in two instances. VA's website incorrectly reported figures in November 2018 as pertaining to the fourth quarter of Fiscal Year 2018 only, when in fact it represented time-to-hire data for all of Fiscal Year 2018. Similar mislabeling occurred in February 2019, when VA's time-to-hire data noted that several occupational groups and Senior Executive Service positions were excluded.[11] These occupational groups support critical, mission-oriented work for the department. While HR&A leaders explained the exclusions were in error, VA should have verified that labels were accurate. In order to boost stakeholder trust in the validity of the data, VA's methodology needed to be updated to include quality control steps to verify the accuracy of its data labeling.

VA lacked a documented methodology for implementing the MISSION Act's requirements until February 7, 2019.[12] The methodology VA established in February described how to compile the information supporting the MISSION Act's four requirements. The guidance ensures the work is not dependent on a single individual, allows for consistency across quarterly reporting, and provides an opportunity for VA to review each step of the process.

The OIG team noted that VA did alter its method for sharing data with its different administrations and staff offices to improve the accuracy of internal quality assurance checks.

RECOMMENDATIONS

In May 2019, the OIG made the following five recommendations to the Assistant Secretary for HR&A to improve the administration of VA's staffing and vacancy reporting. VA concurred with the recommendations and provided acceptable implementation plans.

1. Ensure VA vacancy data are reported by occupation as required by Section 505(a)(1)(C) of the MISSION Act. Targeted Completion Date: VA's self-determined Before publishing Fiscal Year 2020 Quarter 1 MISSION Act Report, which will occur in February 2020.

2. Make certain that VA staffing gains and losses data are reported by quarter as required by Section 505(a)(1)(B) of the MISSION Act. VA's self-determined Targeted Completion Date: Before publishing Fiscal Year 202019 Quarter 3 MISSION Act Report, which will occur in August 2019.

3. Annotate limitations clearly within the staffing and vacancy data to improve transparency and usability of the data, to include changes from H.R. Smart data-cleansing efforts. VA's self-determined Targeted Completion Date: Before publishing Fiscal Year 202019 Quarter 3 MISSION Act Report, which will occur in August 2019.

4. Ensure that the staffing and vacancy reporting website maintains historical information on the data elements required by the MISSION Act. VA's self-determined Targeted Completion Date: Before publishing Fiscal Year 202019 Quarter 3 MISSION Act Report, which will occur in August 2019.

5. Update the methodology for collecting and reporting on VA staffing and vacancy data to ensure consistency in future quarters. VA's self-determined Targeted Completion Date: Before publishing Fiscal Year 2019 Q3 MISSION Act Report, which will occur in August 2019.

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[11] The excluded 0600-occupational family includes physicians and nurses, who would be providing direct care to veterans. The excluded 0900-occupational family includes veterans claims examiners and veterans service representatives, who would be processing veterans' benefits. The excluded 4754-occupational series is for cemetery caretakers, who would be providing burial for veterans and maintaining the cemeteries.

[12] VA did not have a documented methodology for the initial two postings of staffing and vacancy data in August and November 2018. VA's process to aggregate data was undocumented and the responsibility rested with one HR&A data analyst. HR&A staff told the OIG team that standardized processes were necessary for staffing and vacancy collection.

VA has begun implementing the changes in Recommendations 1, 2, and 4, but all recommendations remain open. OIG staff will monitor VA's progress until all proposed actions are complete.

PRIOR REPORTS IDENTIFYING STAFFING-RELATED PROBLEMS

Each year, the OIG provides Congress with an update summarizing the most serious management and performance challenges identified by OIG work as well as an assessment of VA's progress in addressing them.[13] These challenges are aligned with the OIG's six areas of focus outlined in its strategic plan: (1) leadership and workforce investment, (2) healthcare delivery, (3) benefits delivery, (4) financial management, (5) procurement practices, and (6) information management.

The following OIG reports are highlighted to demonstrate how OIG staff have identified staffing and workforce concerns over the past several years that can affect the quality and timeliness of patient care. In particular, these reports highlight how shortages of non-clinical personnel, such as human resources, logistics, scheduling, and custodial, can have impacts in the timeliness of care delivered across VA medical facilities.

Health Care Inspection: Evaluation of System-Wide Clinical, Supervisory, and Administrative Practice, Oklahoma City VA Health Care System, Oklahoma. In early 2016, the OIG became aware of concerns regarding clinical and administrative operations at the system, subsequently expanding to other provider-related issues.[14] The report describes how underlying causes for shortcomings within multiple program areas, processes, and operations were, in part, the result of leadership turnover and vacancies at multiple levels, most notably the medical director position, prior to May 2016. System data indicated that full-time employee-equivalent staff levels were often below authorized levels, despite the use of incentives and direct-hire authorities. At the same time, the system experienced serious front-line patient care staffing shortages, particularly in primary care, mental health, specialty care, nursing, and non-VA care coordination, which has clinical and non-clinical components. The system director took action on the OIG recommendation, including establishing a process to automatically recruit for clinical and medical support assistant positions.

Critical Deficiencies at the Washington DC VA Medical Center. In March 2017, the OIG received a confidential complaint and additional subsequent allegations that the medical center had equipment and supply issues that could be putting patients at risk for harm. The OIG conducted an inspection, issuing an interim report in April 2017, and a final report in March 2018.[15] The final report provided findings in four areas: (1) risk of harm to patients, (2) hospital service deficiencies affecting patient care, (3) lack of financial controls, and (4) failures in leadership. These deficiencies spanned many years, impacting the core medical center functions that healthcare providers need to effectively provide quality care. In particular, the report detailed the failure to inventory and to ensure supplies and equipment reached patient care areas when needed. An inadequately staffed human resources function contributed to key vacancies throughout that facility, including shortages in logistics, prosthetics ordering, sterile processing, and environmental management services. The OIG made 40 recommendations, to which VA concurred. While VA provided detailed action plans on how the recommendations would be implemented and identified progress made, of the 40 recommendations, 9 are still open as of September 18, 2019. One open recommendation calls on the VISN 5 Director to ensure the timely completion of hiring actions at the facility until staffing deficiencies in the Logistics Service and Sterile Processing Service are fully resolved.

Delays in Processing Community-Based Patient Care at the Orlando VA Medical Center, Florida. In January 2018, the OIG initiated a healthcare inspection of the medical center at the request of Congressman Bill Posey. The allegations included that a patient died while experiencing a delay in obtaining approval for aortic valve surgery outside VA.[16] It was additionally alleged that the facility failed to timely approve, process, and coordinate non-VA care coordination (NVCC) consults, and these delays were causing adverse clinical outcomes. The OIG substantiated delays in the processing of other thoracic surgery NVCC consults entered during a 10-month period in 2017 related to an increase in the number of consults and limited

[13] U.S. Department of Veterans Affairs Office of Inspector General Management and Performance Challenges, November 2018.

[14] Health Care Inspection: Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA Health Care System, November 2, 2017.

[15] Interim Summary Report, April 17, 2017; Critical Deficiencies at the Washington DC VA Medical Center, March 7, 2018.

[16] Delays in Processing Community-Based Patient Care at the Orlando VA Medical Center, February 20, 2019.

staff available to process consults. However, the OIG did not identify adverse clinical outcomes associated with the delays. The OIG concluded the absence of a fully implemented tool to assist with care coordination increased the possibility of disruptions in the care coordination for the NVCC patients. The OIG made six recommendations, including that the medical center director conduct a review of Integrated Health Services workload demand and available staff, and takes appropriate action to ensure staffing allows for consults to be acted upon within VHA timeliness standards. All recommendations are now closed.

Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center, New York. Following allegations from several sources, the OIG conducted a healthcare inspection to assess long-term care nurse staffing and quality of care issues in the Community Living Centers (CLC).[17] Among other findings in the September 2018 report, OIG staff substantiated that nursing leaders were aware of staffing shortages; administrative registered nurses provided CLC nursing care; facility leaders pressured CLC managers to accept admissions despite inadequate staffing. The OIG was unable to substantiate that the use of float staff and overtime placed residents at a higher risk for adverse events. The OIG found the facility failed to use alternative staffing. There was also a delay in filling vacant positions and a lack of approval for increased staff. Also, overtime funding exceeded the cost of filling vacant positions. The OIG made three recommendations related to CLC nurse staffing and recruitment, alternative staffing, and overtime management. The recommendations related to nurse staffing and overtime management remain open.

Review of Environment of Care, Infection Control Practices, Provider Availability, and Leadership VA Loma Linda Healthcare System, California. In March 2018, the OIG conducted an inspection at the request of Congressmen Pete Aguilar and Mark Takano related to a series of concerns regarding the environment of care (EOC), infection control (including Legionella), care provider availability, leadership responsiveness, and the dental clinic at the VA Loma Linda Healthcare System.[18] The OIG substantiated many of the identified concerns related to inconsistent levels of cleanliness and repair through the EOC, including the dental clinic, as well as inadequate staff training and ineffective facility leader corrective actions. OIG also found high staff turnover, necessitating contracting for cleaning work and borrowing staff from other VA medical facilities. The OIG found inconsistent water temperatures to deter Legionella and in the notification of water testing results. The Sterile Processing Service's storage room was not consistently within temperature and humidity parameters, and the facility's healthcare-associated infection rates underperformed VHA's national averages. There were high hospitalist and mental health staff vacancy rates and recruiting challenges. The OIG made 14 recommendations regarding staff recruitment, EOC, infection control, Legionella inhibition, training, and documentation. OIG staff will monitor VA's progress until all proposed actions are complete.

Pathology Processing Delays at the Memphis VA Medical Center, Tennessee. In July 2018, the OIG initiated a healthcare inspection at the medical center following allegations of patient harm and death due to delays in processing laboratory specimens and reporting pathology results in the Pathology and Laboratory Medicine Service (P&LMS).[19] The OIG learned of delays in processing the reports, and found that in 2018, nearly 40 percent of P&LMS positions were vacant, and recruitment incentives for these critical staff vacancies were not being used. The OIG also found that Veterans Integrated Service Network (VISN) and national P&LMS leaders were aware of the vacancies but took no mitigating action. Facility leaders cited lengthy recruiting processes and lower pay leading to continued vacancies, as well as limited promotional opportunities leading to retention challenges. Additionally, turnover among human resources staff impacted P&LMS hiring efforts. The OIG made a recommendation to the VISN director to ensure that the medical center director and leadership team properly assess staffing needs in pathology and laboratory services and develop plans to recruit and retain those staff. The VISN director concurred with the recommendation, with a projected completion date of September

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[17] Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center, September 18, 2018. That same day, the OIG released two other reports regarding allegations of poor quality of care at the CLC: Alleged Poor Quality of Care in a Community Living Center at the Northport VA Medical Center and Alleged Quality of Care Issues in the Community Living Centers, Northport VA Medical Center.

[18] Review of Environment of Care, Infection Control Practices, Provider Availability, and Leadership VA Loma Linda Healthcare System, June 18, 2019.

[19] Pathology Processing Delays at the Memphis VA Medical Center, Tennessee, August 27, 2019.

27, 2019. OIG staff will monitor VA's progress until all proposed actions are complete.

Although these are just a few examples, it should be clear that staffing deficiencies occur throughout VHA with far-reaching implications. Last month, the OIG reported how staffing shortages have created extensive backlogs in scanning electronic health records from community providers with the potential to undermine coordinated patient care and well-reasoned medical decisions.[20]

CONCLUSION

The OIG has prioritized oversight of VA leadership and workforce management, particularly adequate staffing by qualified professionals—recognizing that deficiencies in these areas are the root cause for many issues identified during OIG oversight reviews. Although VA has made important improvements, additional fundamental changes are needed for significant and sustained improvement, such as accurately tracking VHA's vacancy numbers; considering the implications for support staff and other team members in staffing models for particular positions; reliable and transparent reporting; recruiting and retention oversight that includes consideration of both individual facility and veterans' needs within a community; and strong and consistent leadership to create a stable and welcoming environment. To more efficiently utilize its resources, VHA must identify needed staff positions based upon comprehensive staffing models that are completely implemented.

The OIG thanks Congress for its commitment to ensuring VA has the resources to provide veterans with timely access to quality care that can be provided by caring and qualified staff.

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

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[20] Health Information Management Medical Documentation Backlog, August 21, 2019.

United States Government Accountability Office

Testimony

Before the Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
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Wednesday, September 18, 2019

VETERANS AFFAIRS

Sustained Leadership Attention Needed to Address Long-Standing Workforce Problems

Statement of Robert Goldenkoff,
Director, Strategic Issues

GAO-19-720T

September 18, 2019

VETERANS AFFAIRS

Sustained Leadership Attention Needed to Address Long-Standing Workforce Problems

GAO Highlights

Highlights of GAO-19-720T, a testimony before the Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

VA operates one of the largest health care delivery systems in the nation and provides billions of dollars in benefits and services to veterans and their families. However, VA faces serious and long-standing problems with management challenges and veterans' access to health care and disability benefits. These issues contributed to GAO's decision to list several areas involving VA on GAO's High-Risk List, including managing acquisitions, managing risk and improving veterans' health care, and improving and modernizing VA's disability programs.

This testimony discusses (1) human capital challenges facing VA and its components, (2) GAO recommendations addressing some of those challenges, and (3) how those challenges are related to a broader set of government-wide human capital problems.

This testimony is based on GAO's work on VA issued since 2017, as well as GAO's work on government-wide strategic human capital management issued since July 2014. To conduct these studies, GAO reviewed key agency documents and government-wide employment data and interviewed knowledgeable agency officials and managers, as well as subject matter specialists.

What GAO Recommends

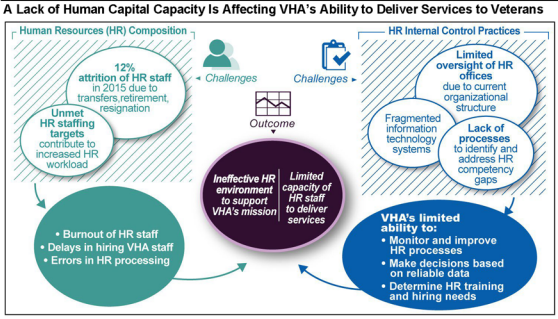
GAO has designated 40 of its prior recommendations to VA as priorities for implementation. Twelve of these priority recommendations are aimed at strengthening VA's human capital management efforts. To date, VA has implemented six of these priority recommendations, but needs to take additional action on the other six. GAO will continue to monitor VA's progress in implementing these recommendations.

View GAO-19-720T. For more information, contact Robert Goldenkoff, (202) 512-2757, GoldenkoffR@gao.gov.

What GAO Found

Serious human capital shortfalls are undermining the Department of Veterans Affairs' (VA) ability to provide veterans with quality and timely services. Over the past two decades, GAO has identified major challenges with VA human capital practices. For example, in March 2019, GAO found large staffing shortages, including physicians and registered nurses, at the Veterans Health Administration's (VHA) 172 medical centers. In December 2016, GAO found that high attrition, increased workload, and burnout among VHA's human resources (HR) staff, along with ineffective internal controls to support its HR operations, have impeded VHA's ability to serve the nation's veterans (see figure).

A Lack of Human Capital Capacity Is Affecting VHA's Ability to Deliver Services to Veterans



Source: GAO analysis of Veterans Health Administration (VHA) data. | GAO-19- 720T

Continued leadership attention to addressing GAO's recommendations could help VA better execute its mission. GAO has made numerous recommendations to VA, 40 of which were designated as priorities because they could significantly improve VA's operations. Twelve of the 40 were aimed at strengthening VA's human capital management efforts. Of these, six have been addressed. However, VA still needs to take additional actions on the other six, such as developing a modern and effective performance management system. Beyond these priority recommendations, VA can use key talent management strategies that GAO has identified for acquiring, incentivizing, and engaging employees and thus be more competitive for a high-performing workforce in a tight labor market.

Some of the challenges facing VA are part of a larger set of human capital issues affecting government as a whole. Although Congress, the Office of Personnel Management, and individual agencies have made improvements in recent years, human capital management in general remains a high-risk area because of mission-critical skills gaps within the federal workforce. Structural issues impede the ability of agencies to recruit, retain, and develop workers, including outmoded position classification and pay systems, ineffective recruiting and hiring processes, and challenges in dealing with poor performers.

United States Government Accountability Office

Chairman Takano, Ranking Member Roe, and Members of the Committee:

Thank you for the opportunity to participate in today's hearing on the Department of Veterans Affairs' (VA) ability to recruit and retain talented employees and thus ensure quality medical care and other services for our nation's veterans. VA operates one of the largest health care delivery systems in the nation and provides billions of dollars per year in benefits and services to veterans and their families. However, the department and two of its components, the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA), face serious and long-standing problems with management challenges and problems with veterans' access to care and disability compensation benefits.[1] In multiple reports, we have found that mission-critical skills gaps and a lack of effective strategic human capital management have limited VA's ability to carry out its vital mission to serve and honor America's veterans.[2]

VA needs a strong workforce to provide quality and timely care to veterans, but over the past two decades, we and others have expressed concern about certain VA human capital practices. In February 2015, we added managing risks and improving veterans' health care to our list of federal high-risk areas.[3] Since then, VA has made some progress in ensuring its resources are being used cost-effectively and efficiently to improve veterans' timely access to health care and to ensure the quality and safety of that care.

My remarks today focus on (1) some of the key human capital management challenges facing VA and its components—especially at its

[1]We highlight these issues in more detail in our High-Risk List. This list focuses attention on government operations that are most vulnerable to fraud, waste, abuse, or mismanagement, or in need of transformation. The high-risk areas involving VA include managing acquisitions, managing risk and improving veterans' health care, managing disability claim workloads, and updating eligibility criteria for disability benefits. See GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*, GAO-19-157SP (Washington, D.C.: Mar. 6, 2019).

[2]See, for example, GAO-19-157SP; GAO, *Veterans Affairs: Sustained Leadership Needed to Address High-Risk Issues*, GAO-19-571T (Washington, D.C.: May 22, 2019); *Veterans Health Administration: Actions Needed to Better Recruit and Retain Clinical and Administrative Staff*, GAO-17-475T (Washington, D.C.: Mar. 22, 2017); and *Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges*, GAO-17-30 (Washington, D.C.: Dec. 23, 2016).

[3]GAO-19-157SP.

largest component, VHA—and the impact those challenges are having on VA's essential mission; (2) specific recommendations and talent management strategies we have identified in our prior work that VA can leverage to recruit and retain a high-performing workforce in a highly competitive labor market; and (3) how a number of the human capital challenges that VA is facing are part of a broader set of government-wide human capital problems that are also jeopardizing the missions of other federal agencies.

The bottom line is that both VA-specific human capital and government-wide structural issues are hampering VA from acquiring and retaining the talent it needs to fill vacancies and serve veterans. VA-specific human capital issues include such difficulties as recruiting and retaining clinical and human resources (HR) staff at VHA. Government-wide structural issues include a federal personnel system that is, in many ways, unable to meet the requirements of today's federal work and workforce.

Nevertheless, VA can take, and in some cases is already taking, a number of steps to strengthen its human capital management efforts but more work is needed. VA will need continued leadership attention and strong congressional oversight. Other steps will be required within VA to fully implement our open recommendations and mitigate any newly emerging problems.

This testimony is based on our recent work on VA issued since 2017, as well as our work on government-wide strategic human capital management issued between July 2014 and July 2019. For the VA studies, among other things, we reviewed key agency documents and interviewed knowledgeable agency officials and managers in headquarters as well as in several medical facilities across the country.[4] For the government-wide human capital work, among other things, we reviewed government-wide employment data and interviewed officials from the Office of Personnel Management (OPM) and subject matter specialists from think tanks, academia, government employee unions,

[4]See for example, GAO, *Priority Open Recommendations: Department of Veterans Affairs,* GAO-19-358SP (Washington, D.C.: Mar. 28, 2019) and GAO-17-475T.

and other areas.[5] Our reports provide further details on our scope and methodology.

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

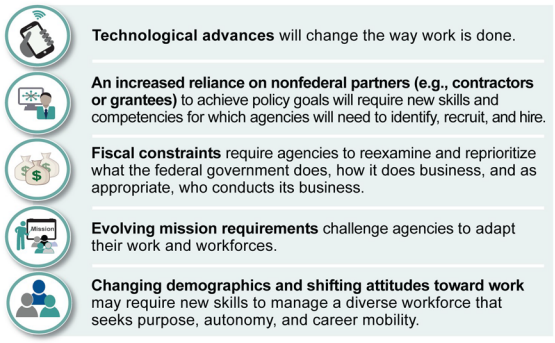
At VA, and indeed at all federal agencies, strategic human capital management plays a critical role in maximizing the government's performance and assuring its accountability to Congress and the nation as a whole. As we have long reported, there is a direct link between the effectiveness of an agency's personnel management efforts and its ability to carry out its mission. Addressing challenges in areas such as disaster response, homeland security, economic stability, and numerous other complex and evolving issues requires a skilled federal workforce able to work seamlessly with other agencies, levels of government, and nongovernmental entities.

In our March 2019 report, we identified key trends in agency operations and attitudes toward work that are affecting how federal work is done and, consequently the skills and competencies that workers will need to accomplish agency missions.[6] Agencies will need to apply appropriate talent management strategies that are adapted to these trends to recruit, develop, and retain a high-performing workforce and better meet their missions (see fig. 1).

[5]See for example, GAO, *Human Capital: Improving Federal Recruiting and Hiring Efforts*, GAO-19-696T (Washington, D.C.: July 30, 2019); *Priority Open Recommendations: Office of Personnel Management*, GAO-19-322SP (Washington, D.C.: Apr. 3, 2019); GAO-19-157SP; *Federal Workforce: Key Talent Management Strategies for Agencies to Better Meet Their Missions*, GAO-19-181 (Washington, D.C.: Mar. 28, 2019); *Federal Workforce: Lessons Learned for Engaging Millennials and Other Age Groups*, GAO-16-880T (Washington, D.C.: Sept. 29, 2016); and *Federal Workforce: Human Capital Management Challenges and the Path to Reform*, GAO-14-723T (Washington, D.C.: July 15, 2014).

[6]GAO-19-181.

Figure 1: Key Trends Affecting Federal Work



Source: GAO analysis. I GAO-19-720T

Note: We identified trends based on our review of literature, expert interviews, and analysis of data from the Office of Personnel Management, Bureau of Labor Statistics, and the Federal Procurement Data System – Next Generation.

Staffing Challenges at VA Are Systemic, Long-Standing, and Undermining Its Mission

Over the past two decades, we and others have expressed concern about certain human capital practices at VA and its components. For example, in November 2018, VA's Office of Inspector General identified leadership and workforce investment as a major management challenge.[7] The Inspector General noted that the root cause for many of the issues it identified at VA was poor and unstable leadership as well as staffing shortages. Similarly, in May 2019, we reported that leadership turnover impeded VA's ability to address a number of management challenges we identified such as managing acquisitions, managing risk, and improving veterans' health care.[8]

[7]Department of Veterans Affairs Office of the Inspector General, *Inspector General's Management and Performance Challenges* (Washington, D.C.: Nov. 28, 2018).

[8]GAO-19-571T.

At VHA, we found that serious human capital shortfalls are undermining its ability to meet the health care needs of veterans. Key examples from our prior work include the following:

- In March 2019, we reported that VHA's 172 medical centers have large staffing shortages, including physicians, registered nurses, physician assistants, psychologists, and physical therapists, as well as HR specialists and assistants.[9]
- As of December 2018, VA reported an overall vacancy rate of 11 percent at VHA medical facilities, including vacancies of over 24,000 medical and dental positions and around 900 HR positions.[10]
- In July 2016, we found that losses in VHA's five clinical occupations with the largest staffing shortages, including physicians, registered nurses, and psychologists, increased from about 5,900 employees in fiscal year 2011 to about 7,700 in fiscal year 2015. Voluntary resignations and retirements were the primary drivers. VHA's exit survey indicated that advancement issues or dissatisfaction with certain aspects of the work, such as concerns about management and obstacles to getting the work done, were commonly cited as the primary reasons people left.[11]
- In December 2016, we found that several problems combined to impede VHA's ability to improve delivery of health care services to veterans. These problems include high attrition (often involving transfers to other federal agencies), increased workload, and burnout among VHA's HR staff. Another issue is a lack of effective internal control practices to support HR operations such as information systems that meet operational needs (see fig. 2).[12]

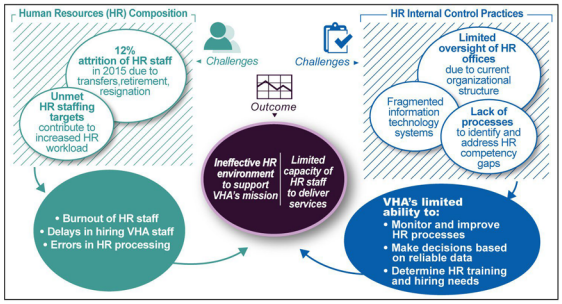
[9]GAO-19-157SP.

[10]GAO-19-571T.

[11]GAO, *Veterans Health Administration: Personnel Data Show Losses Increased for Clinical Occupations from Fiscal Year 2011 through 2015, Driven by Voluntary Resignations and Retirements*, GAO-16-666R (Washington, D.C.: July 29, 2016).

[12]GAO-17-30.

Figure 2: A Lack of Human Capital Capacity Is Affecting VHA's Ability to Deliver Services to Veterans



Source: GAO analysis of Veterans Health Administration (VHA) data. | GAO-19- 720T

In our preliminary findings in a forthcoming report on the extent to which succession planning policies and procedures at VA and its components are consistent with key leading practices, we have identified several concerns.[13] For example, according to VA officials, the agency has not produced a department-wide succession plan since 2009 due to leadership turnover. Department-wide, around 30 percent of VA employees on board as of September 30, 2017, will become eligible to retire in the next 5 years.

Effective succession planning can help VA ensure it has a pipeline of talent to meet current and future mission requirements. In our prior work, we noted that effective succession planning is more than filling existing vacancies with people that have the same occupational skills and competencies. Rather, succession planning focuses on current and future needs and develops pools of high-potential staff to meet the organization's mission over the long term.[14]

[13]We expect to release this report in October 2019.

[14]GAO, *Human Capital: Selected Agencies Have Opportunities to Enhance Existing Succession Planning and Management Efforts*, GAO-05-585 (Washington, D.C.: June 30, 2005).

Continued Leadership Attention to Implementing Our Prior Recommendations and Other Talent Management Strategies Could Help VA Better Serve Veterans

We have designated 40 of our prior recommendations to VA as priority recommendations because, upon implementation, they may have an especially significant impact on VA's operations. Twelve of these priority recommendations are aimed at strengthening VA's human capital management efforts and will help address VA's challenges in such areas as recruiting and retaining doctors and nurses, performance management, and employee misconduct. To date, VA has implemented six of these priority recommendations, but needs to take additional action on the other six. While VA agreed or partially agreed with and is taking steps to implement five of these remaining priority recommendations, it disagreed with one related to developing a process to accurately count all physicians at each VA medical center because it does not believe this affects its ability to assess workload. Nevertheless, we continue to believe that VHA needs a systematic process to identify all physicians working at VA medical centers as part of the agency's efforts to monitor and assess workload.[15] The six unimplemented priority recommendations are for VA to

1. develop a process to accurately count all physicians providing care at each VA medical center (recommended in 2017),
2. develop a modern and effective performance management system in which VA managers make meaningful distinctions in employees' performance ratings (recommended in 2016),
3. ensure that ratings-based performance awards are administered in a manner that is consistent with leading practices (recommended in 2016),
4. develop a plan to implement a modern information technology system to support employee performance management processes (recommended in 2016),
5. collect complete and reliable misconduct and associated disciplinary action data (recommended in 2018), and
6. ensure that employees who report wrongdoing are treated fairly and protected against retaliation (recommended in 2018).

We will continue to monitor VA's progress in implementing these and our other open recommendations.

[15]GAO, *Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies*, GAO-18-124 (Washington, D.C.: Oct. 19, 2017).

Beyond these specific recommendations, VA and other agencies can use talent management strategies to better compete for critical positions in a tight labor market and to help meet agency missions. In our prior work we noted that while these strategies are not an exhaustive list, collectively they suggest basic steps that agencies can take within existing authorities to address the demographic and technological trends affecting work that are discussed earlier in this statement.[16] These strategies include:

- **Align human capital strategy with current and future mission requirements.** With shifting attitudes toward work, technological advances, and increased reliance on nonfederal partners, agencies need to identify the knowledge and skills necessary to respond to current and future demands. Key practices include identifying and assessing existing skills, competencies, and skills gaps.
- **Acquire and assign talent.** To ensure agencies have the talent capacity to address evolving mission requirements and negative perceptions of federal work (e.g., that it is too bureaucratic), agencies can cultivate a diverse talent pipeline, highlight their respective missions, recruit early in the school year, support rotations, and assign talent where needed.
- **Incentivize and compensate employees.** While federal agencies may struggle to offer competitive pay in certain labor markets, they can leverage existing incentives that appeal to workers' desire for schedules and locations that provide work-life balance.
- **Engage employees.** Engaged employees are more productive and less likely to leave. Agencies can better ensure their workforces are engaged by managing employee performance, involving employees in decisions, and developing employees.

[16]GAO-19-181.

Strategic Human Capital Management Is at Risk Government-wide and Is Impacting Agencies' Missions

A number of the staffing challenges facing VA are actually part of a broader set of human capital issues affecting government as a whole. As we noted in our March 2019 update of government high-risk areas, the federal government faces long-standing challenges in strategically managing its workforce.[17] We first added strategic human capital management to our list of high-risk government programs and operations in 2001. Although Congress, OPM, and individual agencies have made improvements since then, strategic human capital management remains a high-risk area because mission-critical skills gaps within the federal workforce pose a high risk to the nation. Of the 34 other high-risk areas on our 2019 High-Risk List, skills gaps played a significant role in 16 of the areas, including information technology management and acquisitions, strengthening management functions at the Department of Homeland Security, and, as noted above, veterans' health care at VA.

While causes for these skills gaps related to high-risk areas vary, they often occur because of a shortfall in talent management activities such as robust workforce planning or training.[18] Additionally, the changing nature of federal work and the high percentage of employees eligible for retirement have the potential to produce gaps in leadership and institutional knowledge and could threaten to aggravate the problems created from existing skills gaps. For example, 31.6 percent of permanent federal employees who were on board as of September 30, 2017 will be eligible to retire in the next 5 years, with some agencies having particularly high levels of employees eligible to retire.

High-performing organizations have found that the full life cycle of human capital management activities needs to be fully aligned and focused on the cost-effective achievement of an organization's mission. These activities include workforce planning, recruitment, on-boarding, compensation, engagement, succession planning, and retirement programs.

Further, adding to agencies' staffing challenges is the fact that much has changed since the Civil Service Reform Act of 1978 and the Classification Act of 1949 laid the foundation of much of today's federal personnel

[17] GAO-19-157SP.

[18] GAO-19-157SP.

system.[19] Agencies' missions have evolved and employees' expectations of work and the workplace are changing. As a result, the extent to which the current and future workforce finds the government's employment policies and practices relevant is an open question.

We and others have identified several structural challenges within the federal human capital system that impede the ability of agencies to recruit, retain, and develop workers, both today and in the future.[20] For example:

- **Classification system.** The General Schedule classification system—which defines and organizes federal positions primarily to assign rates of pay—has not kept pace with the government's evolving requirements.
- **Recruiting and hiring.** Federal agencies need a hiring process that is applicant friendly and flexible while also meeting policy requirements.
- **Pay system.** Employees are compensated through an outmoded system that (1) rewards length of service rather than individual performance and contributions, and (2) automatically provides across-the-board annual pay increases, even for poor performance.
- **Performance management.** Federal agencies have faced long-standing challenges developing modern, credible, and effective employee performance management systems and dealing with poor performers.

Going forward, to help agencies effectively carry out their missions, OPM and federal agencies must take some important steps to address ongoing human capital problems. These actions include continuing to develop the capacity to measure and address existing mission-critical skills gaps and using workforce analytics to predict and mitigate future gaps.

Chairman Takano, Ranking Member Roe, and Members of the Committee, this completes my prepared statement. I would be pleased to respond to any questions you may have at this time.

[19]Civil Service Reform Act of 1978, Pub. L. No. 95-454, 92 Stat. 1111 (Oct. 13, 1978) and Classification Act of 1949, Pub. L No. 81-429, 63 Stat. 954 (Oct. 28, 1949).

[20]GAO-19-181.

If you or your staff have any questions about this testimony, please contact Robert Goldenkoff, Director, Strategic Issues, at (202) 512-2757 or GoldenkoffR@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Shirley Hwang (Assistant Director), Alexander Ray (Analyst-In-Charge), Sarah Green, Allison Gunn, and Shelby Kain.

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Additional Submissions for the Record

SUBMISSIONS FOR THE RECORD

PREPARED STATEMENT OF THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

Chairman Takano, Ranking Member Roe, and Members of the Committee,

The American Federation of Government Employees, AFL–CIO and its National Veterans Affairs Council (AFGE) appreciate the opportunity to provide our views on how hiring barriers at the Department of Veterans Affairs (VA) affect patient care and access to VA's exemplary, comprehensive and veteran-centric medical and mental health services.

AFGE represents more than 700,000 Federal and District of Columbia government employees, 260,000 of whom are dedicated VA employees. AFGE is the largest labor representative of Veterans Health Administration (VHA) providers and support personnel, and represents employees at nearly every VA medical center.

FRONT-LINE EMPLOYEES AND THEIR LABOR REPRESENTATIVES: CRITICAL "CHANGE AGENTS" FOR VHA INNOVATIONS

AFGE shares the Committee's concerns about the corrosive effect that chronic VHA short staffing has on patient care and access. We applaud the Committee's commitment to spotlight VHA staffing shortages on the eve of the rollout of the new electronic health record (EHR) that will place additional demands on staff.

During most of the past fifty years, AFGE had a front row seat at many of VHA's major information technology (IT) transformations. We are grateful to former Under Secretary of Health, Dr. Ken Kizer for providing AFGE with a meaningful seat at the table when both the first EHR and bar code medication systems were implemented in the 1970's. We feel proud of our essential role in the success of these earlier IT systems. As the primary users of these systems and recipients of training, the employees we represent must be true partners in all such endeavors.

Sadly, reports by local AFGE officers at VA medical centers indicate that the agency has made little or no effort to include the union in efforts to implement the new EHR.

Therefore, we urge the Committee and VA leadership to work with front-line employees and their labor representatives to implement and improve new technology initiatives. VA asserted in its September 16th press release that the VA Innovative Technology Advancement Lab (VITAL) Program selected "key clinical and frontline staff" for end user advanced training. We request that that Committee look into whether any labor representatives were actually among those selected. The agency description of VITAL participants aligns closely with the beneficial role that AFGE represented employees have played in the past, i.e. to "directly influence a successful EHRM introduction at their facilities by performing as 'change agents' who can capitalize on and advance the capabilities and value of EHRM's transformational innovation." (https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5314)

COMPENSATION

Provider compensation is a significant barrier to VHA's ability to recruit and retain a strong health care workforce. The VA does not fully or correctly utilize the many recruitment and retention tools enacted by Congress to make the VA competitive with pay provided by other employers in local markets. The problem is exacerbated for providers covered completely by the Title 38 personnel system, including physicians, dentists, registered nurses, physician assistants and podiatrists. Due to broad Secretary discretion over Title 38 providers, and the absence of collective bargaining rights, they cannot challenge management violations of pay laws or pay rules. This also prevents pay from being consistent among providers, causing favoritism and unequal application of pay laws that greatly undermine recruitment and retention. However, some VHA facilities have successfully applied existing pay laws to make provider pay more competitive. Therefore, the VA already has the tools it

needs to make pay competitive for VHA personnel. The root cause continues to be overly broad Secretary discretion over the pay and working conditions of Title 38 clinicians. Adequate training of managers and human resources (HR) personnel will help ensure that they make proper pay decisions and face greater accountability when they make bad pay decisions. More congressional oversight of pay setting processes and pay decisions will ensure use of best practices across all VHA facilities.

For physicians, dentists and podiatrists, Secretary discretion over their market pay has resulted in long delays in updating pay, arbitrary decisions over which comparative pay data is relevant and how much to adjust market pay. In 2004, Congress passed the physician-dentist pay law to make the process more transparent. However, in 2016, Congress eliminated the requirement that VA set market pay through compensation panels comprised of providers working in the relevant practice area. As a result, management now makes market pay decisions without any accountability or transparency and it has become much more difficult for providers to know whether they or their colleagues are receiving the proper amount of market pay. We regularly hear reports from the field that senior physicians are paid significantly less than new hires, and that many providers are making far below market rate. The adverse impact of these poor pay practices is especially felt among specialty physicians and providers in high cost of living areas.

Podiatrists were added to the physician-dentist pay system by the VA MISSION Act. AFGE has received many reports that they are widely disappointed by the market pay determinations they have received. Their frustrating experiences to date further illustrate how a lack of competency and accountability cause good pay tools to be poorly utilized. Many facilities delayed implementation of this pay change; others began implementing the fix, but miscalculated market pay and failed to take into consideration the greater pay needs of podiatrists performing rear-foot surgeries.

Broad Title 38 discretion and a lack of transparency have also limited the ability of registered nurses (RNs) and physician assistants (PAs) (who were added to the RN third party locality pay system in 2017) to challenge improper pay determinations and resulted in delays in making needed pay updates.

RNs also express frustration with the pay determinations made by the nurse professional standards boards (PSB) for new hires and RNs seeking promotions. Many front-line nurses feel that the PSB is plagued by favoritism, denying promotions to many deserving RNs. Our members express frustration that many in the position of Nurse II with extensive experience never get promoted to Nurse III. Similarly, individuals in the position of Nurse I with valuable experience never get promoted to Nurse II because they do not have 4-year degrees and the PSBs fails to properly credit their years of service with the VA.

VA physician assistants (PA) report that it is extremely difficult to be promoted beyond a GS–11, leaving their pay well below the PA pay offered outside the VA. Similarly, PA Leads also have difficulty moving from GS–13 to GS 14. The VA Choice and Quality Employment Act of 2017 required that the VA apply the RN third party locality pay process to PAs but to date, the legislation has been applied very unevenly across facilities.

As previously mentioned, the lack of full bargaining rights among Title 38 providers causes an additional barrier to receiving competitive pay. The VA's Title 38 collective bargaining rights policy, which is based on an extremely narrow reading of Section 7422 of Title 38, prohibits these providers from challenging VHA's violation of pay laws and its own policies. AFGE has fought a long battle to amend Section 7422 to eliminate the compensation exclusion and other exclusions to bargaining. We are very grateful to Chairman Takano for introducing H.R. 1133, the "VA Employee Fairness Act", which will rectify this problem. Without this change, the VA's "7422" policy will continue to undermine the pay laws Congress enacts to keep the VA provider workforce strong.

Hybrid Title 38 providers, including psychologists, social workers and pharmacists are also frustrated by the Hybrid Title 38 Professional Standards Board and the fact that special pay increases are within the discretion of the Medical Center Director. However, they can use their full collective bargaining rights and to grieve over improper applications of pay laws and policies. That is why AFGE strongly opposes efforts to move VHA psychologists from Hybrid to full Title 38 through Section 501 of S. 785, the "Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019". One of the reasons offered by proponents for this change is the ability to get higher pay for psychologists under the physician three-tier pay system. In addition to losing full bargaining rights, and the right to use the grievance and arbitration process, or Merit Systems Protection Board to challenge unfair terminations and discipline, or incorrect pay determinations, it is far from certain

whether front-line VHA psychologists would receive higher pay under the market pay system.

VA MISSION ACT VACANCY DATA

Adequate data on vacancies within the Department is crucial to fully assessing the true State of VA staffing. When Congress began the process of overhauling the CHOICE program, AFGE was adamant that language be included to provide transparency on staffing levels. As the VA MISSION Act began to develop Section 505 was added, which requires the Department to post data every quarter outlining where vacancies exist. This data is intended to provide the public with information — both at the national and facility levels. This data should be used as an indicator of how the Department is doing with hiring and retaining talented professionals to care for our veterans.

Pushing for vacancy transparency is not a new notion. When Congress passed the CHOICE Act, they included language directing the VA Office of Inspector General (OIG) to provide an annual update on the five occupations with the largest vacancy rates. Congress further amended this part of statute in 2017 with the passage of the VA Choice and Quality Employment Act, which required reporting on the top five clinical and nonclinical occupations with the largest staff shortages. Making this data publicly available is important so that patients and other stakeholders are able to fully assess the State of their local VA. Looking at wait times only does not tell the full story.

In the CHOICE-mandated reports the OIG routinely found vacancies in mental health and primary care. These two components are the bedrock of VA care, and it certainly raises red flags that the Department is routinely coming up short in these areas. What is also interesting is high number of nonclinical vacancies the Department has, for example in the June 14, 2018, OIG report occupations such as police officer, general engineer, and custodial worker were all in the top 11 (11) of positions that need to be filled.

Section 505 of the MISSION Act was intended to take this occupational data and narrow it down even further. Ideally, this language was drafted to require the department to report by facility how many vacancies exist for each occupation. On June 25, 2019, the OIG released its first report based on the new MISSION Act requirement. While the OIG did not accuse the VA of not complying with the law, they did call into question the extent of VA's reporting. According to the OIG, "VA's initial reporting of staff vacancies and employee gains and losses used alternative aggregation methods and lacked sufficient transparency to permit stakeholders to use this information to track VA's progress toward meeting full staffing capacity."

When Section 505 was included it was clear that the intent of the provision was to provide stakeholders with adequate data to assess VA hiring. We all agree that veterans have earned the world-class care and services provided by the Department, and AFGE stands ready to help the VA bring more fulltime Federal employees on board who want to make a career out of serving veterans. Instead, though, it appears that the We hope that the Committee will continue to force the VA to be transparent and put forth a serious effort to address staffing challenges.

AFGE thanks the Committee for the opportunity to share our views on VHA hiring practices and vacancy data collection. We welcome the opportunity to share the perspective of AFGE and the front-line employees we represent to ensure increased competency, accountability and transparency in management's application of all VHA pay processes. The VA's refusal to fill the nearly 50,000 positions that remain vacant is a disservice to veterans. We look forward to working with the Committee to ensure that all stakeholders have access to adequate data to assess VA hiring.

THE PREPARED STATEMENT OF THELMA ROACH-SERRY

Chairman Takano, Ranking Member Roe, and Members of the Committee, on behalf of the nearly 3,000 members of the Nurses Organization of Veterans Affairs (NOVA), I would like to thank you for the opportunity to submit testimony on today's hearing "Critical Impact: How Barriers to Hiring at VA Affect Patient Care and Access."

NOVA is a professional organization for nurses employed by the Department of Veterans Affairs (VA).

NOVA appreciates the opportunity to provide our input; as nurses who make up one third of the VA workforce, we will discuss the critical areas that affect hiring, recruitment and retention and how staffing shortages affect the delivery of care around the country.

Staffing vacancies within the Veterans Health Administration (VHA) have continued to plaque the Department and remain at over 45,000. NOVA believes that filling critical vacancies is one of the most pressing issues for VA.

Studies have shown that better care is provided when facilities have both an adequate number of nurses, and nurses that are qualified for the jobs to which they are assigned.

The number of Veterans receiving care within VHA facilities has steadily climbed from 6.8 million in Fiscal Year 2002 to 9.0 million in Fiscal Year 2015, with many who require more intensive nursing care especially those returning from Afghanistan and Iraq, and the aging population of Veterans from prior service.

The need to have an adequate and qualified nursing staff to care for those with more complex injuries led to legislation (PL 107–135) passed by Congress requiring VA to develop a nationwide policy on staffing levels for operation at all VAMCs. VA's Office of Nursing Services (ONS) oversees the implementation of the Staffing Methodology for VHA Nursing Personnel as outlined in VA Directive 2017–1351.[1]

The Directive provides a nationally standardized method of determining appropriate direct care staffing for VA nursing personnel, with nurse staffing in Patient Aligned Care Teams (PACTs) following the VHA Handbook 1101.10 (PACT). The Directive noted that staffing decisions require the use of research and non-research sources of evidence, professional judgment, critical thinking, and flexibility. While also using available evidence with staffing standards of nursing professional organizations, established VHA team staffing models and facility strategic directions to ensure safe and effective nursing care for Veterans.

Staffing needs are individualized to specific clinical settings and cannot rely solely on ranges and fixed staffing models, staff-to-patient ratios, or prescribed patient formulas. The staffing methodology described in the VA Directive requires the systematic collection of a minimum set of core data and unit-based operations assessment to support staffing decisions. Professional nursing organizations' staffing standards and recommendations, where they exist, provide the basis for the ONS-developed tools.

While the methodology uses a variety of tools to determine staffing levels within VHA, it also accounts for changes in each unit/facility to include high staff turnover and vacancies throughout the system.

Several recent reports published by the VA Office of Inspector General (VAOIG) found a significant variation in the number and types of shortages reported. According to a June 14 report, (June 14, 2018/VA OIG 18–01693–196)[2], "reasons for the shortages varied significantly and not all facilities provided a reason for each designated shortage." The number of vacancies within the Department remains high and the most commonly cited challenges to staffing fell into three categories:

- Lack of qualified applicants
- Non-competitive salary
- High staff turnover

NOVA remains concerned about the inconsistencies in how data is collected on where shortages exist. As noted in the VA OIG report mandated under the MISSION Act, Section 505, (June 25, 2019 /VA OIG 19–00266–141) the VA's vacancy data is organized by broad position categories—clinical and nonclinical—rather than specific occupations.[3] Without the required specificity, i.e. nurses, doctors and other clinical staff shortages, those using the data to identify needs to hire within facilities are spending valuable time on another step impeding the process.

Identifying shortages where patient centered care and access is affected should be a priority. Simplified data that provides information on how many nurses (at all levels), doctors, mental health providers, etc. are needed at each facility would be far more effective and transparent.

The OIG noted in its recommendations, that VA should identify specific jobs or positions so that the public can better understand its staffing needs. VA should also adjust its methodology for aggregating gains and losses to ensure that data is reported appropriately and transparently.

As nurses who provide direct patient care, having adequate staff goes hand in hand in determining access and delivering high quality health care to all Veterans.

Budgets that are sufficient in allowing VISN and Medical Center Directors to hire staff is critical. With the passage of the MISSION Act and expanded access to community care, VHA leaders must make decisions on how funding will be used and disbursed throughout its Veteran population. Medical Center Directors are constantly challenged to weigh the cost of funding staff as opposed to funding other

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[1] VHA Directive 2017–1351https://www.va.gov/vhapublications/publications.cfm?pub=1

[2] VAOIG 18–01693–196, June 14, 2018

[3] VAOIG 19–00266–141, June 25, 2019

critical needs. Funding mechanisms and congressional appropriations have not always contained priorities which consider the internal needs of the VHA system.

NOVA reminds the Committee that requiring VA to do more with less puts unnecessary pressure on leadership at VA facilities to manage funding by borrowing from one account to pay for another. We have noted in the past that we do not agree with any plan that would include diverting staff (i.e. to non-clinical VCCP administrative referrals), and other funding from clinical care needs. Adequate and appropriate funding is critical if the system is to remain competitive within the health care industry.

Recruitment and Retention remains one of NOVA's top priority goals. This includes ensuring Human Resources has sufficiently trained staff in order to review and streamline policies and procedures to improve the efficiency and speed of the hiring process; supporting competitive wages for all levels of nursing; undertaking a thorough review of downgrades, reclassification of critical positions and implementing salary surveys annually with corrective steps for all nursing staff across VA. As well as, revising the cap on nurse pay structures and RN pay schedules and reclassification of critical positions so that VA can provide acceptable salaries especially in highly competitive employment regions.

We also stand by our commitment to a more inclusive use of APRN's, NP's, and PA's within the system. Allowing health care professionals to practice to their full scope and authority will provide higher access to care for Veterans enrolled in VA, while encouraging those eligible to come into a system that provides the highest access to timely quality care.

Thank you for allowing us to submit our views today. As nurses, who are often the first face a patient sees, we are reminded that it is VA care that Veterans overwhelmingly prefer and deserve. We are committed to enhancing access and improving health care at VA and stand ready to work with this Committee and its staff on this important mission.

PREPARED STATEMENT OF KATHRYN JANSKY

INTRODUCTION

Chairman Takano, Ranking Member Roe, and Members of the Committee, thank you for the opportunity to offer this statement for the record. The American Association of Nurse Anesthetists (AANA) is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists, with membership that includes more than 53,000 CRNAs and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 45 million anesthetics to patients each year in the United States. CRNAs provide acute, chronic, and interventional pain management services. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

The House Committee on Veterans' Affairs' hearing, entitled "Critical Impact: How Barriers to Hiring at VA Affect Patient Care and Access" comes at an important time, as the largest barrier CRNAs face is not being able to practice to their full scope of education and training. On December 14, 2016, the U.S. Department of Veterans Affairs (VA) issued a final rule granting three of the four APRN specialties full practice authority, excluding CRNAs. In the final APRN rule, the VA indicated that CRNAs are highly qualified for full practice authority, but were not included with the other three APRN specialties because the VA believes there currently is not a problem with access to anesthesia care in Veterans Health Administration (VHA) facilities. Granting CRNAs full practice authority would go a long way in terms of recruitment and retention.

ASSESSMENT OF CURRENT AND FUTURE ACCESS TO ANESTHESIA CARE ISSUES

The AANA advocates on numerous issues to help improve healthcare, patient safety and practice excellence by working to increase access to healthcare, make healthcare more affordable, and improve the quality of the care available to all patients, including our Nation's veterans. The AANA supports full practice authority for CRNAs, working in Veterans Health Administration (VHA) facilities, who help care for our Nation's veterans to the full scope of their education, training and licensure to help ensure that veterans have access to the timely anesthesia and related healthcare services they deserve.

On December 14, 2016, the VA published its final rule granting full practice authority to three of the four APRN specialties, illogically excluding CRNAs from the rule "due to VA's lack of access problems in the area of anesthesiology."[1] This is an inaccurate statement that is clearly refuted by evidence, as will be illustrated below. In order to help expand veterans' access to quality anesthesia care, we urge you to do what is right for our veterans by using the evidence clearly demonstrated in this statement to reconsider this action. Permitting full practice authority for CRNAs will ensure veterans receive the full scope of timely, high-quality anesthesia and pain management care they so rightfully deserve within VHA facilities.

THE VA'S OWN STUDIES AND DATA CONFIRM AN ACCESS TO ANESTHESIA CARE ISSUE

Recent data from VA commissioned studies show a clear access to care issue in VHA facilities. We are troubled as to why these objective findings weren't considered to be sufficient evidence for granting full practice authority to CRNAs in the final rule. As you know, the VA sponsored the congressionally mandated 2015 RAND Corporation Independent Assessment of the VHA, which reported that wait times for VA care are getting longer and current VA workforce capacity may not be sufficient to provide timely care to veterans across a number of key specialties, as well as primary care.[2] The VA's Enrollee Health Care Projection Model (EHCPM), a healthcare demand projection model, forecasts a "19-percent increase in demand for VA health care services nationally from Fiscal Year 2014 to Fiscal Year 2019, due to a projected 5.1-percent increase in enrollment and the aging of enrollees."[3] The VA Independent Assessment stated that one of the most important changes in VA policy to help meet increases in demand for healthcare over the next 5 years and ensure continued access to care for veterans would be formalizing full practice authority for all APRNs, including CRNAs.

Instead, the VA has chosen to exclude CRNAs from full practice authority, which means many veterans will continue to endure dangerously long wait times for needed healthcare requiring anesthesia services. A report released by the VA in December 2016 showed there are 150 VHA facilities reporting that more than 10 percent of their appointments have a wait time of more than 30 days, meaning that veterans have to wait more than a month to get an appointment.[4]

The VA Independent Assessment reported access to care challenges due to anesthesia delays. Specifically, the VA Independent Assessment identified delays in cardiovascular surgery for lack of anesthesia support, rapidly increasing demand for procedures requiring anesthesia outside of the operating room, and slow production of colonoscopy services in comparison with the private sector.[5] This speaks to the underutilization of existing anesthesia providers such as CRNAs, who are not allowed to practice to the full scope of their education, experience, and licensure. It remains unclear why the Independent Assessment's impartial findings are not sufficient evidence to allow full practice authority for CRNAs in VHA facilities.

A logical solution to reducing or preventing delays in veterans' access to anesthesia care in VHA facilities would be to promptly allow CRNAs to practice to the full extent of their education, training, and licensure.

UNREQUIRED, UNNECESSARY CRNA SUPERVISION REDUCES ACCESS TO CARE IN VHA FACILITIES

Concerns over anesthesia delays in VHA facilities stem from the underutilization of CRNAs who are not allowed to practice to the full scope of their education, experience, and licensure, as well as anesthesiologists who spend more time supervising CRNAs than actually providing hands-on patient care, even though the VA does not require CRNAs to be supervised by anesthesiologists or by any other physicians. CRNAs are appropriately educated and trained to handle every aspect of the delivery of anesthesia services including general and regional anesthesia and acute, chronic, and interventional pain management services. Forty states plus the District of Columbia have no supervision requirement concerning nurse anesthetists in

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[1] 81 Fed. Reg. 90198. https://www.gpo.gov/fdsys/pkg/FR–2016–12–14/pdf/2016–29950.pdf

[2] RAND Health. "Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans," (2015). http://www.rand.org/content/dam/rand/pubs/research__reports/RR1100/RR1165z2/RAND__RR1165z2.pdf

[3] Ibid.

[4] Department of Veterans Affairs Report "Pending appointments and Electronic Wait List Summary — National, Facility, and Division Level Summaries Wait Time Calculated from Prefed Date" (December 2016). http://www.va.gov/HEALTH/docs/DR60__122016__Pending__and__EWL__Biweekly__Desired__Date__Division.pdf

[5] VA Independent Assessment, Appendices E — I, http://www.va.gov/opa/choiceact/documents/assessments/Assessment__B__Health__Care__Capabilities__Appendices__E-I.pdf

nurse practice acts, board of nursing rules/regulations, medical practice acts, board of medicine rules/regulations, or their generic equivalents, allowing CRNAs to practice autonomously consistent with their education, training, and licensure. (This does not take into account hospital statutes or regulations.) Furthermore, no State or Federal laws require CRNAs to be supervised by anesthesiologists. CRNA supervision leads to increased costs and reduced access to timely care, but does not lead to better healthcare outcomes as confirmed by scientific research data time and time again.

However, observations within the VHA have found that some supervising anesthesiologists prohibit CRNAs from providing regional anesthesia services to veterans undergoing certain procedures, such as orthopedic, urological, and vascular, for which regional anesthesia may be the preferred choice. Further, many of these patients suffer from multiple chronic conditions such as lung disease, obstructive sleep apnea, and obesity. In these instances, regional anesthesia services are frequently the best option. Administering large amounts of narcotics to these patients, as in general anesthesia, introduces risks beyond those of regional anesthesia care. Instead of the surgeon authorizing the CRNA to provide regional anesthesia, anesthesiologists are ordering CRNAs to administer general anesthesia which requires a higher dosage of narcotic medications and inhalational agents and puts the patient at greater risk of postoperative pulmonary problems, slower recovery times, and greater postoperative pain, and also contributes to delays in physical therapy services. All of these factors compromise the patient's ability to recover as promptly and safely as possible and leads to additional costs due to longer hospital stays.

Additional observations within the VHA find CRNAs are commonly supervised by anesthesiologists at 1:1 and 1:2 ratios not generally found in the commercial healthcare delivery marketplace, and which do not correlate with improved outcomes.[6] Because these arrangements are so costly compared with alternatives, they divert resources from VHA delivery of other priority services such as primary care, women's healthcare or mental healthcare. Anesthesia services provided by CRNAs and anesthesiologists are considered extremely safe and except in rare instances a single anesthesia provider is sufficient to administer an excellent anesthetic. CRNAs administer anesthesia in all settings working in collaboration with surgeons, anesthesiologists, and other healthcare professionals as part of the patient care team. A Lewin Group peer-reviewed economic analysis noted, "There are no circumstances examined in which a 1:1 direction model is cost effective or financially viable."[7] The Lewin Group analysis concludes that allowing CRNAs to practice to the full extent of their education and training would "both ensure patient safety and result in substantial cost savings, allowing the VHA to allocate scarce resources toward other Veteran healthcare needs."[8]

By granting full practice authority to CRNAs, the VHA would make full use of more than 900 CRNAs already practicing in VHA facilities. Many more veterans could be cared for if start times for surgical and other types of cases requiring anesthesia were no longer delayed unnecessarily while waiting for supervising anesthesiologists to become available. This would ensure that our Nation's veterans have access to essential surgical, emergency, obstetric, and pain management healthcare services without needless delays or having to travel long distances for care. It would also correspond with VA Secretary David Shulkin's May 31, 2017 address on the "State of the VA" where he remarked that the goal was to "turn the VA into the organization veterans and their families deserve, and one that America can take pride in," which includes, "reducing burdensome regulations that do not make sense and launching new tools that make it easier for veterans to engage with VA."[9]

RECRUITMENT AND RETENTION OF CRNAS WILL INCREASE PRODUCTIVITY AND EFFICIENCY

The AANA fails to understand how the VA concluded that the current anesthesia workforce is sufficient to meet the healthcare needs of veterans in the VA health system. The VA stated in their final APRN rule, "VA understands that there are difficulties hiring and retaining anesthesia providers." We agree with this statement, since a major VHA workforce evaluation published in January 2015 reported

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[6] Dulisse, op cit., http://content.healthaffairs.org/content/29/8/1469.full.pdf and Negrusa op cit., http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Scope__of__Practice__Laws__and__Anesthesia.98905.aspx

[7] Hogan op cit., http://www.aana.com/resources2/research/Documents/nec__mj__10__hogan.pdf

[8] Ibid.

[9] Secretary David Shulkin "State of the VA" Address (May 31, 2017), http://www.blogs.va.gov/VAntage/wp-content/uploads/2017/05/StateofVA__FactSheet__5–31–2017.pdf

that CRNAs have been among the VHA's most difficult to recruit specialties over four of the past 5 years.[10]

In the final APRN rule, the VA provided data on CRNAs and anesthesiologists that is inaccurate, troubling and does not justify the assertion that current staffing levels can meet the anesthesia needs of veterans. As stated in the final APRN rule, as of August 31, 2016, the VA had 940 anesthesiologists and 937 CRNAs. In addition, data from the VA's Center for Veterans Analysis and Statistics show a growth in total Veteran enrollees (6.8 million in 2002 to 9.1 million in 2014), outpatient visits (46.5 million to 92.4 million) and inpatient admissions (565,000 to 707,000) in the VA healthcare system over the last 12 years.[11] The final APRN rule also stated that the 2015 independent survey of VA general facility Chief of Staffs conducted by the RAND Corporation showed that about 38 percent reported problems recruiting or hiring advanced practice providers and 30 percent reported problems retaining advanced practice providers.[12]

Looking at these numbers alone, it is clear that the VA is suffering from APRN recruitment and retention issues. With the substantial increases in the number of veterans using the VA system for healthcare over the last 10 years, it is unclear to us how only 940 anesthesiologists and 937 CRNAs are sufficient to meet the anesthesia care needs of more than 9 million veterans across the country.

Moreover, we feel that CRNAs are being held to a different and unfair standard regarding recruitment and retention data than the other categories of APRNs who were granted full practice authority in the final APRN rule. For example, the VA states that the lack of advancement opportunities and practice autonomy were not cited as reasons for recruitment and retention challenges for CRNAs, and that it would consider future rulemaking if there's evidence linking full practice authority to CRNA recruitment and retention. However, the VA fails to show that this same linkage was established for the other APRN categories that were granted full practice authority. The final APRN rule also provides data on critical staffing shortages and states that CRNAs and physician anesthesiologists are not high on the list of hard to recruit and retain specialties. The VA again fails to present compelling data that reveals shortages in the other APRN categories or of their respective physician counterparts. Again, CRNAs are being held to a different and inconsistent set of rules than the other categories of APRNs. Also, in the VA's Economic Impact Analysis for RIN–2900-AP44, the VA reports in the description of current APRN practice a net gain of 88 CRNA FTEs as a reason to exclude them from the rule, while the VA noted a net gain of 620 NP FTEs, which is far greater than the net gain for CRNAs.[13]

The VA's final APRN rule also references current and future recruitment and retention of CRNAs, stating that it is possible resources might be available to address some of these underlying issues if efficiencies were realized as a result of advanced practice nursing authority.[14] The AANA recently surveyed its membership, which includes more than 90 percent of the Nation's nurse anesthetists, and found that over 90 percent of respondents indicated that the decision to not grant full practice authority to CRNAs would deter them from seeking employment in the VHA in the future. This chilling effect on the ability of the VHA to hire skilled CRNAs will have a lasting impact on its ability to meet the healthcare needs of veterans. Conversely, 98 percent of the survey respondents said they would be more inclined to work for the VHA if it took the appropriate steps to grant full practice authority to CRNAs.

CONCLUSION

By granting full practice authority to CRNAs, the VA would become a more desirable place for CRNAs to work. It would maximize productivity and efficiency, making full use of more than 900 CRNAs already practicing in VHA facilities and also make working in VHA facilities more attractive to future CRNAs. Allowing CRNA full practice authority in the VA would only help to increase the number of CRNAs who can provide safe, high quality and cost effective anesthesia care for our Nation's veterans. This would ensure that our Nation's veterans have access to essential sur-

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[10] VA Office of the Inspector General, OIG Determination of Veterans Health Administration's Occupational Staffing Shortages (January 30, 2015)

[11] http://www.va.gov/oig/publications/report-summary.asp?id=3276.

[12] https://www.va.gov/vetdata/Utilization.asp.

[13] 81 Fed. Reg. 90198. https://www.gpo.gov/fdsys/pkg/FR–2016–12–14/pdf/2016–29950.pdf.

[14] VA Impact Analysis for RIN 2900-APxx/WP 2013–036, Advanced Practice Registered Nurses. "APRN Gains and Losses for FY–12 to FY–16 (Source: 2015 VHA Workforce Planning Report): The number of Nurse Anesthetist gains and losses for FY–12 to FY–16: Total Gains 314 / Total Losses 226 for a net gain of 88. The number of Nurse Practitioner gains and losses for FY–12 to FY–14: Total Gains 1499 / Total Losses 879 for a net gain of 620."

gical, emergency, obstetric, and pain management healthcare services without needless delays or having to travel long distances for care.

Question and Answer for the Record

Government Accountability Office (GAO) Responses to Questions for the Record
Committee on Veterans' Affairs, U.S. House of Representatives
Full Committee Hearing
"Critical Impact: How Barriers to Hiring at VA Affect Patient Care and Access"
September 18, 2019

Rep. Levin

1. **Mr. Goldenkoff, how does VA compare to other federal agencies, in terms of creative approaches to acquiring talent, and what are some best practices elsewhere in the federal government that VA could learn from?**

Although it is difficult to accurately compare one agency's approach to acquiring talent to another given differences in mission, skills required, and other variables, we have identified several strategies from other organizations that might be useful to the Department of Veterans Affairs (VA) and augment its ongoing efforts. Our prior work has found that challenges in recruiting and retaining skilled health care providers and human resources staff at the Veterans Health Administration's (VHA) medical centers make it difficult to meet the health care needs of more than 9 million veterans. As a result, VHA's medical centers have large staffing shortages. These shortages include physicians, registered nurses, physician assistants, psychologists, physical therapists, and human resource specialists and assistants.

We are encouraged that VA has shown some improvement in employee engagement. This can improve productivity and retention, and also help make VA a more attractive employer. In its 2018 "Best Places to Work in the Federal Government" rankings, the Partnership for Public Service ranked VA's employee engagement scores as the sixth-highest out of 17 large federal agencies.[1] This marks an increase from the previous 4 years, when VA's employee engagement scores ranked in the bottom 25 percent of large federal agencies.

In March 2019, we reported on key strategies and practices for managing the current and future workforce.[2] Table 1 summarizes the actionable strategies we identified in that report. These strategies could help VA acquire and retain the talent it needs to better serve this nation's veterans.

[1]Partnership for Public Service, *Best Places to Work in the Federal Government*, accessed October 17, 2019, https://bestplacestowork.org/.

[2]GAO, *Federal Workforce: Key Talent Management Strategies for Agencies to Better Meet Their Missions,* GAO-19-181 (Washington, D.C.: Mar. 28, 2019).

Table 1: Key Strategies and Practices for Managing the Current and Future Federal Workforce

Function	Strategy	Practice
Align human capital strategy with current and future mission requirements	Set workforce goals and assess skills and competencies needed to achieve them	Identify existing skills and competencies
		Assess gaps in existing and future skills and competencies
		Monitor progress toward closing skills gaps
Acquire and assign talent	Source and recruit talent	Cultivate a diverse talent pipeline
		Highlight agency mission
		Recruit continuously and start the hiring process early in the school year
		Strategically leverage available hiring flexibilities
		Write user-friendly vacancy announcements
	Assess and screen candidates	Use relevant assessment methods and share hiring lists
		Improve the security clearance process
	Assign employees where needed	Develop a culture of agility
Incentivize and compensate employees	Leverage benefits and incentives	Increase awareness of benefits and incentives, such as work-life programs
		Tailor benefits and incentives to employees' needs
		Address barriers to telework
	Leverage existing pay authorities	Use special payment authorities strategically
Engage employees	Manage employee performance and create a "line of sight" between individual performance and organizational results	Improve selection and training of supervisors and managers
		Link agency's mission and employees' work
		Implement meaningful rewards programs
		Share innovative approaches to performance
	Involve employees in decisions	Increase support for an inclusive work environment
	Develop employees	Prioritize training for employees and managers
		Encourage details, rotations, and other mobility opportunities

Source: GAO-19-181.