



CONGRESSIONAL TESTIMONY

STATEMENT BY

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BEFORE

HOUSE COMMITTEE ON VETERANS’ AFFAIRS

ON

“BUILDING A BETTER VA: ADDRESSING HEALTHCARE WORKFORCE RECRUITMENT AND
RETENTION CHALLENGES”

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

Thank you for inviting the American Federation of Government Employees to participate in today's Committee Hearing, "Building a Better VA: Addressing Healthcare Workforce Recruitment and Retention Challenges." I am Mary Jean "MJ" Burke, and I am the First Executive Vice President of AFGE's National Veterans Affairs Council, representing 283,000 AFGE VA employees across the Veterans' Health Administration (VHA), Veterans Benefits Administration (VBA), and the National Cemetery Administration (NCA). I also am a practicing physical therapist at the Indianapolis VA in Indiana. AFGE and its National Veterans Affairs Council are pleased to provide our views and recommendations on VA staffing, recruitment, and retention, including Human Resources (HR) Management, Market Pay Surveys, and HR SMART.

Overview: The state of VHA human resources management

AFGE has expressed concerns for many years about VHA's inability to properly utilize the many tools provided by Congress to improve clinical workforce recruitment and retention. VHA has failed to comply with pay laws and policies designed to make clinician pay competitive with local markets. For example, among Title 38 positions, registered nurse (RN) third party locality pay surveys, and more recently, physician assistant (PA) third party locality surveys, are often not conducted properly, completed on a timely basis, or implemented properly. Ever since the three-tier physician/dentist pay law was enacted nearly two decades ago (which now also applies to podiatrists), there has been widespread manager noncompliance with processes for

setting market pay and performance. Special pay authorities for Hybrid Title 38 positions have also been widely underutilized.

Similarly, Congress regularly looks to creating new hiring authorities to address clinical recruitment and retention. Here too, the problem has not been the lack of hiring authority, but rather the underutilization of the direct hire authority that VHA already possesses to recruit more physicians, RNs, PAs and other Title 38 clinicians.

The success of VHA human resources practices has varied widely across facilities. A number of factors have led to better outcomes, including experienced managers, good labor-management relationships, and an adequate number of trained and experienced HR specialists. When management and labor representatives of front-line clinicians collaborate, it allows the processes for hiring, setting compensation, implementing new leave policies, addressing workplace safety, and many other HR issues to be carried out in a transparent manner with checks and balances. When management and HR specialists understand the law and policies that improve recruitment and retention – and have a willingness to work with labor representatives to apply them evenly and properly – turnover is lower and work morale is higher.

Sadly, in recent years the state of VHA HR management has declined significantly as a result of a number of dramatic changes. VHA's HR reorganization, centralization of HR functions from the facility to the VISN level, and depersonalization of core HR functions into a faceless technology-driven process have severely diminished the effectiveness of VHA recruitment and retention practices.

Management's growing reluctance to work with its union partners or include them in recruitment and retention efforts has led to further frustration and failure, and this problem grew even worse during the COVID-19 pandemic emergency when managers invoked the pandemic as an excuse to further marginalize their unions and ignore the requirements of their collective bargaining agreements.

VHA's transition to a technology driven HR environment devoid of face-to-face interaction has also damaged workplace morale. Too often, employees and their labor representatives feel that this data driven environment is used as a form of harassment and surveillance in order to protect managers and the agency's reputation, rather than to serve the best interests of veterans and front-line employees. Let me be clear, everyone in their career will make some mistakes, but coaching, kindness and correcting behavior is the key, not agency investigations lasting longer than three months. This type of environment that many facilities are reporting is not conducive to retaining scarce medical personnel.

Similarly, when VHA overuses data metrics in an effort to increase clinician productivity, it further drives hard-to-recruit personnel into the private sector. Specialty physicians and other high-priced clinicians want to work at the VA to serve its unique patient population while having an adequate work-life balance. If these clinicians were motivated solely by income, they would choose the more high-pressured private sector environment. Clinicians exit the VA quickly when they start to lose the advantages of working at the VA and have already utilized the VA for its training.

VA nursing is currently experiencing similar strains. VA shifts and days off have become less predictable. Nursing supervisors often lack the hands-on experience to understand the experiences and needs of front-line nurses. Speaking up can result in subtle retaliation in the form of a bad schedule and denials of requests for days off. The recent culture shift appears to reward some manager positions, prioritizing loyalty over the necessary blend of clinical skills and administrative coaching abilities.

VA's leave policies during the pandemic harmed morale and jeopardized worker safety by forcing front-line staff to use their own earned leave instead of weather and safety leave when necessitated by COVID-19. Despite their preference to work with veterans, nurses will leave for the private sector where they can get predictable schedules and get paid full-time for three 12-hour days.

The effects of chronic personnel shortages at VA medical facilities around the country cannot be overstated. Whether they arose from broken HR practices, or from intentional short staffing, or both, they have set the VA as the employer of choice back "a step."

Chronic short-staffing has also hurt veterans by sending VHA further down the path of privatization. Instead of fixing recruitment and retention problems through better training, better performance management, and more funding for competitive pay, short-staffing is used to justify sending more veterans outside the VA for costly, fragmented, and unspecialized care. VHA's own surveys of healthcare experiences demonstrate, year after year, that the higher the veteran service connection, the more reliant and motivated veterans are to use the VA over the private sector. Why is this? Because we are the best and we need to remain the best. That is

why we are adamantly opposed to the AIR Commission recommendations that vastly shrink VHA capacity. If implemented, these recommendations will set veterans up for more costly, fragmented and unspecialized care.

Market Pay Surveys

We urge the Committee to address a number of problems with RN and PA third-party locality pay surveys. The problem in most locations is not too few surveys but how and when the surveys are conducted and what is being done with the survey data. For many years, medical centers typically had about five locality schedules to set clinical staff compensation. Now they likely have five times that many, e.g. one each for nurses in intensive care units (ICU), critical care, operating rooms (OR), post-anesthesia care (PACU), assistant managers, head nurses and program managers.

These third-party RN locality pay surveys are triggered by turnover rates, resignations due to dissatisfaction with pay, or other criteria set by the facility director. There is a good likelihood that personnel are going to leave even with a good survey process because resultant pay adjustments are made too late. Management frequently says it does not have the budget to stay competitive with employers of physicians, RNs, and PAs in the local market. In the second half of 2021, VHA lost many physicians and inpatient nurses because it did not act quickly enough to make needed pay adjustments. Recently, one of our AFGE local unions investigated and found out that 24 out of 27 market pay surveys for PAs supported much higher pay in the local market for corresponding positions but management still did not implement the survey results.

Even though VHA cannot be a market pay leader by law, pay processes can be used far more effectively, starting with the restoration of labor-management collaboration. Labor has not been a part of the market pay conversation at VHA for the past five years even though we have a long track record of bringing value to the process. Labor is critical to providing oversight of management compliance with policy related to job matches, ensuring that the correct positions are on each pay table, understanding the data that supported that decision, and ensuring that no conflict of interest is involved.

It is important that the union become part of the process again, at least as observers, to allow us to access valuable HR metrics, as well as validate what agency data is/was being used and collected on turnover, vacancy posting time, and verify corresponding positions from third parties. Position management was put in VA policy to allow the union to be aware of the process. Instead, now the locality data is posted on a centralized compensation share point, and we have no idea how it was collected, or when management requested it from the VISN. This forces the union to have to request this data after the fact, often after further stalling from the agency, and when it is already too late to provide meaningful input.

VHA HR Reorganization: A Failed Experiment

Centralization of core HR functions to the VISN level has caused widespread frustration among managers and front-line employees alike, and ultimately veterans have suffered from medical centers' weakened ability to bring new clinicians on board in a timely manner. Managers have complained about the extremely cumbersome, fully automated processes required to get positions approved and complete the hiring process once a qualified applicant is identified.

Centralization has further shut labor out of the recruitment and retention process, losing the many benefits of labor-management collaboration that once existed through participation in position-management committees.

AFGE commends VHA for conducting pilots to reverse this harmful decentralization and bring HR actions back to the facility level. Our locals in VISN 10 found the three recent Ohio pilots to be very successful and were pleased to learn that in VISN 10, their concerns were heard and that all medical centers will resume doing their own hiring.

At the same time, we have also heard about a very troubling hiring policy being implemented at several VISNs. Reports that are yet to be confirmed by VHA indicate that if a new clinician is not brought on board within 180 days, the position is no longer available to fill, and the hiring official must begin the process all over again.

HR SMART:

VHA's transition to HR Smart has further depersonalized the HR process, leaving labor further marginalized from the facility's efforts to recruit and retain clinicians. We are now forced to go to the USA Jobs website or file an unfair labor practice complaint to obtain information about active recruiting, organizational charts, and which positions have been funded and approved.

When the union is marginalized, it becomes much easier for management to balance its budget on the backs of the front-line workforce, and ultimately is a disservice to the veterans who then receive care in short-staffed units or face delays because of closed inpatient beds.

HR SMART has been a frustrating and less effective HR system. When we had paper organizational charts, we could visualize how many positions were supposed to be present; now we have no such access.

AFGE Recommendations:

As already stated, we commend VHA for conducting decentralization pilot projects and we hope the Committee will encourage VHA to fully reverse the VISN centralization of HR functions.

Compensation for front-line RNs and PAs should be improved through several avenues. We need a new law or policy to make it easier for front-line RNs and PAs to view third-party local pay surveys. This would put these clinicians on track to receive pay adjustments and reach the new salaries authorized by the recently enacted RAISE Act and specifically help more front-line RNs and PAs to secure needed pay adjustments. Managers should also provide union representatives with the same training on the locality pay survey process that managers receive.

We need more accountability in compensation and HR processes. In addition, proficiency awards for nurses need to be restored. Many proficiency waivers were issued during the pandemic.

We wish to commend Chairwoman Brownley and Congresswoman Miller-Meeks for their bill, H.R. 3693, the “VA Continuing Professional Education (CPE) Modernization Act” which would increase the eligibility for VA clinicians to receive to CPE, increase the reimbursement amount, and adjust the amount for inflation. AFGE thanks the seven bipartisan members of the House

Veterans' Affairs Committee who have sponsored or co-sponsored this legislation, and urges the committee to pass this legislation, or an amended version of it during this Congress.

Scholarship and loan assistance programs need to be available to more new hires and current employees trying to grow their VHA careers.

Changes to law or policy are needed to improve labor's access to recruitment and retention information, specifically which positions and the types of recruitment efforts are being made. We also need staffing information, such as access to information about nursing hours per patient day; we should not have to file a grievance to get this critical information.

Finally, we want to again thank Chairman Takano for leading the charge on H.R. 1948, the "VA Employee Fairness Act." If enacted, this bill would drastically help with recruitment and retention, particularly by allowing covered clinicians the ability to grieve a paycheck that was calculated incorrectly or fight retaliatory managers with routine issues when it comes to scheduling. We hope that this bill that will address these obvious problems is considered by the full House this year.

Thank you for giving me the opportunity to testify at today's hearing. I look forward to answering any questions you may have.