

**MORE THAN JUST FILLING VACANCIES: A CLOSER
LOOK AT VA HIRING AUTHORITIES, RECRUIT-
ING, AND RETENTION**

HEARING

BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
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MORE THAN JUST FILLING VACANCIES: A CLOSER LOOK AT VA HIRING AUTHORITIES, RECRUITING, AND RETENTION

Thursday, June 21, 2018

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

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Neal Dunn presiding.

Present: Representatives Dunn, Bilirakis, Higgins, Mast, Roe, Brownley, Takano, Kuster, O'Rourke, and Correa.

OPENING STATEMENT OF NEAL DUNN, CHAIRMAN

Mr. DUNN. This meeting will come to order. Thank you. Good afternoon, good morning. Thank you all for joining us today as we take a closer look at the staffing across the Department of Veterans Affairs and the health care system. Just last week the Inspector General released a fourth annual VA staffing shortage report, and for the first time the report included a staffing shortage information about each VA medical center. It also included information on shortages for clinical and non-clinical positions in recognition of the fact that many VA facilities struggle to hire custodians, and police officers, and human resource professionals, just as much as they struggle to hire doctors and nurses.

To no one's surprise, the report found a wide variety of staffing needs on the ground. It also found persistent challenges to improve staffing, due primarily to a lack of qualified applications, and an inability to compete with the private sector, and some high turnover problems. The consequence of VA's failure to address these challenges are almost unparalleled as the VA cannot function on any level without high performing, appropriately staffed facilities.

Last summer, the Committee passed the VA Choice and Quality Employment Act of 2017 which contained 14 provisions to improve the VA's ability to hire clinicians and support staff. The VA Mission Act which was signed into law just three weeks ago included an additional 11 provisions to further improve the VA's ability to attract those professionals to our medical facilities.

During today's hearing, I want to examine how well the authorities that we have provided to the VA, how well those are working from last summer, and the additional authorities that we provided this summer, also what further actions need to be taken to over-

come the Department's considerable barriers to better recruitment and retention.

I am grateful to all of our witnesses for being with us this morning to discuss this important issue, and I do want to note that the American Federation of Government Employees was invited also to testified today and initially accepted that invitation, ultimately declined. I believe that hearing the perspective of the employee union would have been valuable to today's conversation. I regret that they were unable to send a representative here today.

With that, I yield to Ranking Member Brownley for any opening statement that she may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Mr. Chairman, and thank you for holding this hearing on VHA's efforts to recruit, hire, and retain quality staff in both clinical and non-clinical positions.

Nearly a year ago, this Congress passed the VA Choice and Quality Employment Act which provided the VA with even more tools to aid medical center directors as they attempt to hire quality employees. However, neither these tools nor previously authorized hiring authorities have been coupled with the resources and leadership necessary to ensure the mission is actually carried out.

For instance, GAO found that VHA has failed to execute a comprehensive review of the authorities granted to it over the years. The failure to complete this review means that when this Committee discusses these incentives, such as increased salary caps or expanded physician training opportunities, we have no clue what actually works and what doesn't. When we are talking about an agency responsible for translating limited tax dollars into the unlimited commitment that this country owes veterans, every dollar counts. So efficiency, effectiveness, and transparency are paramount.

As this Committee considers the staffing shortages of VHA today, it would be irresponsible to ignore VA's vacant executive suite. It has been nearly five weeks since the President announced his nominee for Secretary of VA. However, it took until yesterday to formally submit this nomination to the Senate. It has been 16 months since VA had a permanent Under Secretary of Health. There are no less than nine deputies Under Secretary and assistant deputy Under Secretary positions without permanent appointees.

How can VA be expected to deliver timely, quality health care to over nine million veterans when this administration refuses to prioritize the need for stable, qualified, fully vetted leaders within the agency? How can we truly expect VHA to prioritize recruitment, hiring, and retention efforts at the local level when this administration and President Trump show no desire to do the same? This administration needs to lead by example, and that means putting the leadership in place who will get the job done.

I also ask medical facility directors and VHA frontline employees to hold strong as we do our best to hold this vacant VA accountable. I believe today's hearing is a first step towards a fully staffed VHA. However, I have concerns regarding the VA's central office

commitment to this process, a process that must include communication, data collection, and analysis, and fully supported and informed decision making.

I hope to hear today how we can ensure the VA has the focus, dedication, and resources to carry out this process. I appreciate the majority and the witnesses for their willingness to engage in today's discussion, and I thank you, and I yield back.

Mr. DUNN. Thank you very much, Ranking Member Brownley. I would like to also thank the Chairman of the overall Committee for coming in, Chairman Phil Roe. Thank you, sir.

Joining us this afternoon on our first and only panel is Max Stier, the President Chief Executive Officer of the Partnership for Public Service. Welcome.

Ms. Debra Draper, Health Care Director for the Government Accounting Office for Health. Great to have you here.

The Honorable Michael J. Missal, the VA Inspector General, and a fellow graduate of Washington and Lee University. Go General.

And also, Peter Shelby, the VA Assistant Secretary for the Office of Human Resources and Administration. And he is joined by Ms. Bonjorni, the VA Acting Assistant Deputy Under Secretary for Health for Workforce Services who was on a panel here just last week, if I remember you. So it is welcome back.

Thank you all for being here today, and Mr. Stier, we are going to begin with you, and you are now recognized for five minutes for your opening statement.

STATEMENT OF MAX STIER

Mr. STIER. Thank you very much, Mr. Chairman, Ranking Member Brownley, and the Members of the Committee. I just want to start by saying how exceptional it is that you are holding this hearing. Typically, we see legislation done, then the Committee moves on and doesn't come back to see whether it is actually working. The engagement you have had in trying to make the VA better on a bipartisan basis is really model performance in Congress in my view. So thank you for all the work that you are doing. I also want to thank the folks from VA itself who are doing really hard work and making some progress.

So I want to start by putting us in a larger context here about what is happening, and I think you have to begin, again, with the people of the agency who are the fundamental resource that the organization has to produce results, and there is a real issue here because morale at the VA is not good and it is getting worse. VHA ranks 292 out of 339 agency subcomponents that we measure in the Partnership's Best Places to Work rankings, and that number went down last year whereas the rest of government went up.

Morale is very important because it is directly related to the performance of the agency. It is related to customer experience, and much more relevant to us today, right here, it is related to retention, and there are real retention issues at the VA. Over the past six years, the VA has seen nearly a third of its medical personnel leave. That is double the attrition average of the Federal government. So again, the hiring is important, but you have got to hold on to your talent. They are intimately related, and morale is fundamental to making that work right.

And then, Ranking Member Brownley, I think you hit on a very critical issue. You have no permanent secretary, no permanent deputy secretary, no Under Secretary, and you have a lot of acting folks underneath, and no organization can work effectively, certainly not take on the really big challenges that need to be done here, without that leadership in place.

So I am going to offer nine recommendations in three buckets: oversight, short-term legislative fixes, and some long-term legislative issues that I think will make a big difference if you can get them done.

Two ideas on the oversight issue, first. Number one, back to the leadership issue. It is the most important, and we need leaders to own the actual health of the organization. In the legislation you provided last year, there is a requirement for a performance plan for political appointees. I think the new secretary should be held accountable in implementing that. You can hold them accountable by using that performance plan, and employee morale ought to be one of the core issues that is included. So I would press on that.

Secondly, I think it is very important that we look to the folks that are on this panel on the oversight side to help. They have done great work here. Two ideas that might actually help even further, one of which is that in every report that the IG and GAO does, it would be very helpful, where possible, to put promising practices in. The tendency in government is to find problems and not to find where there are bright spots that you can learn from, and I think the IG and GAO could do a lot if you asked them to find promising practices for every issue that they identify.

Secondly, it would be really helpful if they also found things that the VA should stop doing. One of the big challenges, and one of the reasons why implementation is so hard, is the folks at the VA are being asked to do more and more and more and more. It builds on top of each other. No one goes back and says, "Is that really important? Is that the priority?" And the cost means that the important things don't get done, and I think if you directed the VA and the oversight folks to find the things that they shouldn't be doing, the reports they should not be giving you, that would be a huge benefit.

Alright, let me move to some legislative opportunities. First, Congress should authorize market pay for medical center directors. This is the most important group in terms of performance at the VA. They are the folks that are leading the hospital centers and the VISNs, and right now they are being paid by and large under the SES system which was not designed for medical center directors. There are only about 170 of them, and if you provided market-base pay, or market-sensitive pay, for them that would be hugely important. You gave VA a direct hire authority already, but that authority is coming in even underneath the SES pay. That is a big problem. Fixing that would make a big change.

Number two, give the VA the authority to certify senior executives. We have a process right now where everything goes through OPM at the front end. It slows everything down. You need to reverse this. Allow the VA to make its own SES appointments, and then have oversight after the fact so that the process doesn't become overwhelming and then chase away a lot of candidates. That is also true around critical pay authority, and I would also advo-

cate that you codify the authority to make conditional offers to job candidates.

I am going to jump to two long-term suggestions, here. The VA staff right now in HR has to operate with three personnel systems: Title 38, Title 5, and a hybrid Title 38. That makes no sense. It is a waste of time. You should create one system for VA. That would enable them, bluntly, to do their work much better. Next, Congress should also get rid of the current classification system. I recognize that it is a big lift. It was a system that was created long ago for a world that doesn't exist anymore and the nature of work has changed. This reform should be made for all of government, but certainly here at VA.

And I am happy to talk slower and offer a few more of those ideas, but I don't want to take more than my five minutes. Thank you.

[THE PREPARED STATEMENT OF MAX STIER APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you very much, Mr. Stier. We appreciate you squeezing so much information into five minutes. I know how hard it can be.

Ms. Draper, you are now recognized for five minutes.

STATEMENT OF DEBRA A. DRAPER

Ms. DRAPER. Chairman Dunn, Ranking Member Brownley, and Members of the Subcommittee, thank you for the opportunity to be here today to discuss VA's ability to recruit, retain an onboard high-quality clinicians and support staff to care for our Nation's veterans.

Physicians provide and supervise a broad range of care, including primary and specialty care, and are vital to VA's mission of providing quality and timely health care to veterans. Factors such as VA's lengthy hiring process, a limited supply of candidates, and a highly competitive recruitment environment have resulted in physicians occupying a top spot on VA's annual list of mission-critical occupations.

Over the past two decades, we and others have expressed concern about VA's ability to ensure that it has the appropriate clinical workforce to meet the current and future needs of veterans. For example, a 2015 independent assessment found that VA may be unable to meet the projected demand for services if it doesn't increase the number of clinical staff, including physicians. In 2016, we found that physician losses steadily increased over the previous five years, due primarily to voluntary resignations and retirements.

Additionally, the Health Resources and Services Administration projects that by 2025 the national demand for physician services will exceed supply. These shortages are expected to be considerably worse in rural areas where communities struggle to attract and keep well-trained providers. This is particularly concerning given that approximately one in four VA medical centers is located in a rural community.

In October, we reported the VA's information on the number of physicians providing care at its medical centers was incomplete because it lacked data on the number of contract physicians and only

had limited data on the number of physician trainees, two types of physicians that augment the care provided by VA employed physicians. As a result, the VA does not know how many physicians it has, impeding not only its ability to determine current needs, but also to appropriately plan for the future.

In our October report, we recommended that VA implement a systematic process to count all of its physicians which would result in complete and accurate information. VA did not concur with this recommendation and recently reiterated its nonconcurrence. Although VA has implemented a new personnel database, HRsmart, that could help provide an accurate count, it does not plan to use the system to track physicians it does not directly employ. This is despite VA officials acknowledging that their workforce planning processes do not include data on all physicians. We continue to believe that it is imperative for VA to have an accurate count of all of its physicians.

Also in October, we reported that although VA provides its medical centers with some guidance on how to determine the number of physicians and support staff it needs, there is insufficient guidance for the medical and surgical specialties. As a result, medical center officials told us that they are often unsure if their staffing is adequate.

We recommended the VA issue guidance to its medical centers on determining appropriate physician staffing levels and VA concurred. VA recently told us it has taken steps to address this recommendation. For example, it established a work group to develop a staffing model for specialty care. VA anticipates that the work—will issue guidance in December.

Additionally in October, we found that VA uses a number of strategies to recruit and retain physicians, but has not evaluated them to determine their effectiveness. These strategies include, for example, a national physician training program and financial incentives. We recommended that VA conduct a comprehensive evaluation of its physician recruitment and retention efforts, and establish an ongoing monitoring program, and establish a system-wide process to share information about physician trainees to help fill vacancies across medical centers.

VA concurred with our recommendations and has taken steps to address them. For example, VA recently told us that they are in the process of completing a review of its physician recruitment and retention incentives, including an effort to evaluate and recommend a systematic approach for allocating resources, such as those for their education debt reduction program. This review is expected to be completed later this year.

In conclusion, our October report identified a number of weaknesses with regards to VA's ability to recruit, retain an onboard high-quality physicians, and we made a number of recommendations. It is critical for VA to fully implement all of our recommendations to ensure its ability to attract and retain physicians, particularly given the continuing growth and demand for VA health care, an increasingly competitive recruitment environment, and looming shortages.

Mr. Chairman, this concludes my opening remarks. I would be happy to answer any questions.

[THE PREPARED STATEMENT OF DEBRA DRAPER APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you very much, Ms. Draper. We now yield to Inspector General Missal five minutes.

STATEMENT OF MICHAEL J. MISSAL

Mr. MISSAL. Chairman Dunn, Ranking Member Brownley, Chairman Roe, and other Members of the Subcommittee, thank you for the opportunity to discuss my office's recent report, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages for Fiscal Year 2018*.

Although this is the fifth OIG report on staffing shortages within VA's health care system, it is the first report that includes facility specific data reported by leaders at 140 VA medical centers. Since January 2015, the OIG has reported on VA clinical staffing shortages as required by the Veterans Access Choice and Accountability Act of 2014. In our prior reports, we recommended that VHA develop and implement staffing models for critical occupations. We recognize that VHA has implemented staffing models in specific areas, such as primary care and in-patient nursing. However, operational staffing models that comprehensively cover critical occupations are still needed.

The VA Choice and Quality Employment Act of 2017 expanded the reporting requirements to include both clinical and non-clinical positions, as well as requiring information for each VA medical center. Consequently, the OIG conducted a facility-specific survey to determine current local staffing levels and identify shortages. The OIG requested that VA medical center directors designate and rank each occupation for which there is a shortage at their facility. This shortage information should assist VHA in determining how to best meet facility-specific needs and improve the quality of health care.

Recent OIG reports have demonstrated the importance of including non-clinical positions in our reports of staffing shortages. For example, in our March 2018 report, critical deficiencies at the Washington D.C. VA Medical Center, we detail how excessive vacancies in key departments can impact patient care. In that report, we found an inadequately staffed human resources function that contributed to key vacancies throughout the facility, including shortages in logistics, prosthetic ordering, sterile processing, and environmental management services.

In our 2018 survey, 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. Our analysis showed that 138 of 140 facilities listed the medical officer occupational series as experiencing a shortage, with psychiatry and primary care positions 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. With non-clinical occupations, the OIG found that human resources management and police occupations were among the most often cited as shortages.

The results of our survey demonstrate that although there are clusters of commonalities, there is also wide variability and occupational shortages reported by individual medical centers. This is

critically important to recognize because facilities have distinct staffing needs that must be considered. For example, a rural facility that specializes in the treatment of mental health will need to be staffed differently than an urban facility that provides a broad array of services.

The report also identified challenges to meeting staffing goals. The three most frequently cited challenges were lack of qualified applicants, non-competitive salaries, and high staff turnover.

Our 2018 report repeats the OIG's previous calls for VHA to develop a new staffing model that identifies and prioritizes staffing needs at the national level, while supporting flexibility at the facility level, to ensure taxpayer dollars are invested in delivering the highest quality care to veterans. VA's focus on developing a comprehensive staffing model will lead to more efficient hiring practices, and result in fewer recruitment challenges, and an increased capacity to serve veterans' needs.

In conclusion, for VA to meet its mission of providing high quality health care to veterans, VA must have a better understanding of each facility's staffing needs. Our 2018 report should provide prompt and meaningful discussions at both the local and national levels about how to implement, support, and oversee staffing in VA medical centers.

Mr. Chairman, this concludes my statement. I would be pleased to answer any questions that you or other Members of the Committee may have. Thank you.

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

Mr. DUNN. Thank you very much, Mr. Missal. Assistant Secretary Shelby, we now recognize you for five minutes.

STATEMENT OF PETER SHELBY

Mr. SHELBY. Thank you, sir. Morning Chairman Dunn, Ranking Member Brownley, Chairman Roe, and distinguished Members of the Committee. Thank you for this opportunity to discuss staffing at the Department of Veterans Affairs. I am accompanied by Ms. Jessica Bonjorni, our acting Assistant Deputy Under Secretary for Health.

The Department of Veterans Affairs, and I personally as a 24-year veteran of the Marine Corps, appreciate your steadfast commitment to America's veterans with your recent passage of several legislative acts, including the VA Mission Act and last year's VA Choice and Quality Employment Act. These bills enable the department's comprehensive efforts to recruit, develop, and retain the high-quality professionals who provide health care, benefits assistance, and memorial services to our veterans.

Last week, the Office of Inspector General released its report on VHA occupational staffing shortages. Their findings are consistent with prior annual reviews of VHA staffing, with physicians and nurses topping the list. For the first time, non-clinical shortages were also identified, which consist of HR specialists, police officers, and custodial staff.

VA continues to develop strategies to address shortages in these critical areas. Every occupation is critical to our ability to success-

fully deliver the highest quality care to our veterans. Inclusion of non-clinical positions in the GAO study is recognition of this reality.

Strong HR is paramount to VA's ability to serve our veterans. The complexity of VA's three personnel system exacerbates our inability to fill HR vacancies and meet critical requirements. The only non-clinical occupation consistently in VHA's top mission-critical occupations, year after year, is HR. Despite this challenge, our HR capabilities and services continue to improve.

Last year's GAO report on VHA human capital provided numerous recommendations to clarify lines of authority and provide comprehensive training and competency assessments to improve HR services. We are implementing these and many other changes to address our customers' needs. I am committed to exploring every option, technology, and innovation to develop and sustain highly effective human resources capabilities across the Department of Veterans Affairs.

VA appreciates the legislative support of this Committee. Enhanced accountability and hiring authorities help us deliver critical recruitment and staffing services to sustain a vast department. VA is the second largest Federal agency with over 380,000 employees distributed across all 50 states and all U.S. territories. The scope and scale make vacancies numbers often quoted in the media seem very high. Taken in context, VA's vacancy and turnover rates are very low. We fluctuate between nine and ten percent, which compares very favorably with the private sector. Since March 2018, we have filled more than 16,000 vacancies and increased our end strength by nearly 3,000.

To meet key performance indicators, VA, like Kaiser, Cleveland Clinic, and DoD, approach staffing holistically by addressing the entire employee life cycle; recruitment, onboarding, development, and retention. Our staffing strategy targets one key performance indication: How well we meet the needs of the veterans we serve. Staffing issues in certain areas of our health care system impede our ability to provide optimal care to veterans. We are working diligently to correct those issues and continuously strive to improve.

Recent events in some of our health care facilities raised concerns about VA staffing capabilities, and our processes for assessing and monitoring adequate staffing levels. Congress, GAO, and OIG have provided recommendations to improve staffing and to proactively identify occupational shortages.

VA has established a manpower management office, and we have upgraded our HR system of record to enhance our talent acquisition capabilities. VHA has developed new staffing models. They now benchmark access, quality, and staffing against similar health care systems, and they can identify facilities at risk of critical staffing shortfalls. These efforts, combined with longstanding clinical staffing models, and non-clinical models being developed, validated, and refined, will provide VA's holistic staffing capability.

VA is also making progress in implementing provisions of the VA Choice and Quality Employment Act of 2017. The Accountability Act provided direct higher authority to fill medical center and network director positions. However, it does not include authority to provide pay commensurate with other senior executives.

In conclusion, we thank Congress for your continued support of the Department of Veterans Affairs. We serve and honor the men and women who have served this country, America's veterans. I personally welcome every opportunity to engage the Committee in dialogue and explore how we best work together to meet the needs of our veterans.

Mr. Chairman, Jessica and I are prepared to answer any questions you and Members of the Committee may have.

[THE PREPARED STATEMENT OF PETER SHELBY APPEARS IN THE APPENDIX]

Mr. DUNN. Thank you very much, Mr. Shelby. We will turn to the question portion of the panel, and I am going to ask the panelists if you can keep your answers, sort of, succinct. I know that is hard sometimes, but we are constrained by time. So appreciate your efforts on behalf of that.

I will now yield myself five minutes for questions and begin, if I may, with Inspector General Missal.

We have pretty—the same recommendations year after year, at least since 2015. I am going to ask you, you know, it feels like we are stuck. Are we stuck, and if we are not stuck—well, if we are stuck, why? Where?

Mr. MISSAL. We agree with you that we have been making the same recommendation on a staffing model, first to develop, then to implement. That still hasn't been closed out by us. We believe VA is making progress on it, but not as quickly as we would like.

Mr. DUNN. So on the implementation, the model is there?

Mr. MISSAL. Implementation, right. They do have some staffing models, as I said, in primary care and some nursing positions, but they need a comprehensive staffing model, so they really understand where they need positions, how to spend the dollars, and how to budget.

Mr. DUNN. Do you think that is the biggest barrier? The VA, is that the biggest barrier to meeting staffing shortages, is the lack of implementation of model, or is it shortage of—

Mr. DUNN [continued]. —adequate personnel?

Mr. MISSAL. That is a significant issue. If they can get a staffing model where they really understand what they need. I think that goes a long way towards improving the staffing.—

Mr. DUNN. So that is a start. All right.

Mr. Shelby, thank you for your service. How many vacancies—let's see—no, how—you said this. This is great, you addressed the vacancy rate is not that different from other large health care systems, but it—clearly, we have shortages. So I am guessing, that is all specialty specific. Does it match up to the gaps we have in the staffing models?

Mr. SHELBY. Yes, sir. What is critically important to focus on is our critical shortfalls. Overall vacancy rate doesn't tell me where we are not meeting the needs of veterans. Focusing on critical shortfalls does, and noted in the IG, you saw a great difference in the types of shortages they have across. We have several that are common, and they will parallel the private sector health care. All right? There is a shortage of psychiatrists across—

Mr. DUNN. Across the Nation.

Mr. SHELBY [continued]. —the Nation. So we compete for that limited—

Mr. DUNN. I remember, we are always looking for nurses. That is—so, a great, great profession.

Let me—do you have any direct authority over the HR functions at VA?

Mr. SHELBY. Yes, sir. You have full authority over all HR functions at the VA.

Mr. DUNN. Okay. So, this sort of sounds like HR is in your wheelhouse to implement these models that we have talked about: can you give us any good news here?

Mr. SHELBY. We have—in the past, it has been three or four different HR organizations, very decentralized. We are consolidating that into a single HR authority. We work as a single executive HR team now and we are figuring out how to consolidate official and effective HR.

If I have 182 people doing a single HR function and divide them over 182 organizations, any one of those that goes on vacation, that particular facility loses 100 percent of their capability. If I start consolidating those capabilities into regional support centers, they meet the needs.

Mr. DUNN. We like that. In terms of consolidations, I notice you have 19 physician recruiters for the entire system; is that roughly a correct number, 19 physician recruiters?

Mr. SHELBY. Yes.

Mr. DUNN. Yes? Okay. So, do they have a lot of staff? Each of them has staff, because—no? That is just 19 people, total, front to back.

Okay. Have you been using civilian recruitment—physician recruitment forms—vendors?

Mr. SHELBY. Yes, Jessica can speak specifically to the ones we use, but we use all resources at our disposal to meet the recruiting and staffing needs of the VA.

Mr. DUNN. So, what feedback do we get from our vendors, you go asking them for fine doctors and they come back empty-handed, what feedback are they giving us?

Mr. SHELBY. Jessica?

Ms. BONJOURNI. Sure. So, similar challenges that you might see across any health care system. I think the challenge that we have is by using those private sector recruiters, it is significantly more expensive than using the ones that we have in-house, who are extremely effective. We just need more of the in-house recruiters.

Mr. DUNN. So, I have used recruiters over the years, and I agree, it can be expensive, but I also think we can negotiate those fees. You are the largest health care system in the country. I think you can negotiate a break on that. And there is expertise involved in recruiting physicians and expertise in getting each specialty.

I think I will yield back at this point to Ms. Brownley, the Ranking Member.

Ms. BROWNLEY. Thank you, Mr. Chairman.

This Committee has heard time and time again that hiring medical center directors has had its own specific challenges and that is why vacancies remain open for long periods of time. So, I was happy when we passed the VA Choice and Quality Employment

Act, which mandated the VA to develop a plan to address hiring medical center directors.

And, recently, I became aware that there was a plan submitted. It was roughly three months late. It was four pages long and, basically, the gist of the whole report is to say that VHA will utilize the current recruitment process to select candidates. So, we asked to do a plan to overcome challenges. We got a plan that says we should just use the regular recruitment process.

So, Ms. Draper, based on your experience, what constitutes a good plan to address this issue around hiring, in a timely way, medical center directors?

Ms. DRAPER. Well, I think a lot of lessons can be learned from us on VA high-risk, but a good plan has a number of different elements. I think the very first thing that needs to be done is a root cause analysis, because there obviously was some issue with hiring medical center directors. There is some problem that either there is not enough candidates or qualified candidates or not able to retain them. So, I think understanding the issues that are leading to that issue is really critical. So, that is really a first plan in developing the first action in developing a good plan.

And there needs to be corrective actions; those need to be clearly identified. Resources need to be identified and allocated looking at timelines, looking at metrics—how are you going to measure this—and looking at what are your expected outcomes.

And one key thing is that you need to assign will accountability: who is going to be responsible for making sure that this plan is carried out?

Ms. BROWNLEY. Have you seen this plan?

Ms. DRAPER. It was on the table here, so ...

Ms. BROWNLEY. So, have you had a chance to review it a little?

Ms. DRAPER. I reviewed a really quickly. I mean, I think the thing that struck me was that they are going to continue to use the same process that they have done and to me that was a little surprising.

Ms. BROWNLEY. So, you feel that is a valid concern, that they—the plan says to just use the existing recruitment process?

Ms. DRAPER. Well, to me, if you look at the elements of a good plan, it really didn't contain many of those elements, so ...

Ms. BROWNLEY. Thank you.

Mr. Shelby, first, let me thank you for your 24 years of service with the Marine Corps. And so, you know, what is your response for that? If you think that, you know, our recruitment efforts are fully adequate, what evaluations do you have to confirm that?

Mr. SHELBY. I don't particularly think all of our recruitment efforts are fully adequate and I am working on getting more diagnostic capabilities. One of the biggest things that jumped out in the changes we made is we were way too decentralized. So, you have individual organizations trying to meet all of their needs on a local level and we have commonalities; in particular, medical center directors, nurses, certain physicians. We have raised that to a national capability, rather than a lower capability so we can target a broader audience, have targeted teams that focus on the onboarding and hiring of these critical shortfalls. And so, we actually did change that.

Ms. BROWNLEY. Well, let's get back to what Ms. Draper said in terms of root causes. Do you think a plan to mitigate challenges with regards to recruiting medical directors, do you think we need to get down total root causes, in order to have a positive, effective plan?

Mr. SHELBY. Yes, ma'am.

Ms. BROWNLEY. And do you think the VA is going to initiate that or, you know, how are we going to get to that place where we can understand what the root causes are?

Mr. SHELBY. Yes, the VA is absolutely doing that, and it is across the board. We found several reasons why it varies why we don't have strong retention in certain positions. Medical center directors, it is the demand and the pay. It is an extremely demanding job. The counterparts in the private sector, in some cases, make four or five times what we are capable of paying in certain markets. And so, you combine that with the workload, it is very difficult to retain them. And then recruiting them, like we alluded to at the beginning, we got Direct-Hire Authority. We moved to use that, and we are capped on salary at \$153,000.

We tried Direct-Hire on two medical centers. We got through the entire process, made the offer, and they rejected the offer just because we could not meet their salary demands.

Ms. BROWNLEY. My time is over. I yield back.

Mr. DUNN. Thank you, Ms. Brownley.

We have been joined by the Chairman of the Full Committee, Dr. Phil Roe. I now yield to you 5 minutes, sir.

Mr. ROE. Thank you, Mr. Chairman and Ranking Member.

Medical staffing is something I know a lot about and spent a career dealing with it. And we have at VA, some incredible challenges going forward, I can tell you that. We had a roundtable in this room a week ago that the AAMC, the American Academy of Medical Colleges said that we would have a forty to a hundred-thousand-dollar doctor shortage by 2030. That is not very far away.

I mean military—folks that have served in the military, like you, Mr. Shelby—and, again, thank you for your service in the Marine Corps—who are just starting; that is going to affect them.

So, I think we do need to have a long-term strategy, but all health care is local, as you all pointed out. I mean, what Mr. Missal said was if you are doing maybe it is mental health in one place, those needs are different in a rural area than they are and the challenges—and you can't do that centrally. I think you have to recruit locally. That is where a lot of your people are from, and it is hard to move and up people into a place.

So, one of the things that we have done in our Committee is we have sent people out to various VA hospitals and—you know, with just one-hours' notice just to sort of see what was going on at that medical center and one of the things that struck me was that one of the material weaknesses I think I found was HR, is recruiting. You have someone who is—has this position as the HR director trying to recruit a professional person and they don't know how to recruit to these people, and it was amazing to me to see the disconnect.

I totally agree with you that, as I help run a hospital, you are no better than the weakest link in that hospital and that may be

the environmental services, food services, staff in the ORs to make sure the instruments are clean; all those are critically important. They are just as important as I was as a physician in the operating room. If they didn't do their job well, I couldn't do my job well.

So, I think you have got a huge challenge ahead of you. And one of the things, Mr. Shelby, you said, was if we are meeting the needs of the veterans, I would disagree with that, because if we were, we wouldn't need the Choice Program or the Mission Act we just passed. So, I think we have huge challenges ahead and I think HR, believe it or not is one of the critical ones. And I don't know how you are going to recruit all of these people.

I know my hospital at home recruits nationwide. We had a huge nursing shortage, so what did they do? They provided scholarships for nursing students, their third and fourth years of school, and for that, when you ended up with no debt when you left, you had a time obligation to serve at that hospital. It is worked incredibly well. They stopped it for a while and learned their lesson. They started over again.

So, if you could bring us ideas like that, we want to help. We want to be—we are not here fussing; we want to be part of the solution in trying to help.

And Ms. Draper, I think you mentioned something that shocked me a little bit, but it was that a third of the medical personnel turned over in what length of time was that or someone said there was that much turnover with the physicians and nurses and so forth or maybe it was—

Mr. STIER. That was in six years, so 2011 to 2017

Mr. ROE. That is amazing.

Mr. STIER. So, it is double the attrition rate for the rest of the Federal government.

Mr. ROE. Yeah, that is—why is that?

Mr. STIER. I think that is a good question that I am not likely to offer you real insight on. I do think that fundamentally it begins with the question that the Chairman asked before: What are the big issues here? It starts at the top and making sure that you have medical center directors in place and that they are going to be there for a long period of time, which requires a different funding model than you have right now.

If you think about it, you offer Direct-Hire, but at a lower pay than what you were able to do before. You are paying the medical center directors less than you are paying the individual physicians in a marketplace in which those folks, as you heard earlier, can make four, five, six times that amount.

You asked for real concrete things Congress can do, like the scholarship issue. Offer market-sensitive pay for medical center directors to those folks. As you say, it is all local; they are going to figure out a lot of the answers that they need to in their own hospital or hospital system.

Mr. ROE. Now, I agree with you. We have a hospital—a private hospital and VA campuses that meet each other, and I can assure you that the hospital director at the private hospital is not compensated the same as the one at the VA is; I agree with that 100 percent.

Any other suggestions that you all have of how we can be of help to you all in making think job easier for you in getting those personnel that you need?

Mr. SHELBY. Yes, sir. I think Max alluded to it; having three pay systems does not give us the agility that we need. And as you saw in the IG report, it is very unique and local and having a market rate-based personnel system will give the agility we need in each market to target the town and compete with the local competition there. And then you have a national strategy for implementing all of your HR strategies, but you have the flexibility at the local level for them to meet the needs there.

Mr. ROE. Just—thank you—just one other comment before I yield back is that in my opinion, all the years I worked in health care, I don't—the personnel, the people who work in the systems are the most important. That is the engine. I don't care if you have got a shiny outside—brand new hospital at Denver, Colorado—if you don't have great people working in it, you will not have a good facility. So, the people are the most important part of a health care system, more so than buildings; they are the engine that drive it. They are the face of it who provide the care.

So, anything that we can do to help you all do your job, we are here to do. I yield back.

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

Now, I yield 5 minutes to Representative Takano from California.

Mr. TAKANO. Thank you, Mr. Chairman.

You know, as Members of this Committee, we can't find solutions to problems until we understand the full scope of the problems that we are facing. We saw over the last few years, the staffing reports mandate under the Choice Act weren't giving us all the details that we needed. I am pleased to see that this latest report by the IG breaks down the staffing shortages into more specific occupations and also includes non-clinical positions.

Of all the employees at our medical centers, all of our employees play a vital in ensuring veterans receive the highest quality of care that they deserve. And I know from visiting Loma Linda in my own—near my own district, one of the challenges they face is hiring custodial staff and I see that reflected in the IG's findings.

I want to get right into my questions. This Committee has long been raising the issue of VA's lack of staffing models. At present, VA only has three staffing models: primary care, mental health, and nursing.

Mr. Shelby, when can we expect to see additional clinical staffing models?

Mr. SHELBY. Sir, I would like to yield that to Jessica, because she's been working on several staffing models.

Mr. TAKANO. Of course, yes.

Ms. BONJORNI. Sure. Thank you, sir.

As Ms. Draper mentioned, I think, and Mr. Missal, we have been working on those staffing models for some time, for some time. We have a specialty care workgroup that is working on developing multiple staffing models for clinical occupations that will be done by the end of this year.

Mr. TAKANO. By the end of this year?

Ms. BONJORNI. Yes.

Mr. TAKANO. By the end of this calendar year?

Ms. BONJOURNI. Yes.

Mr. TAKANO. Okay. Mr. Stier, as I look over the findings from the GAO and IG, both make recommendations for the under secretary of health to improve hiring at the VA; unfortunately, that position is currently vacant, and we still don't have a nominee. There has been uncertainty about who would lead the Department as secretary for nearly two months.

Based on your organization's mission, can you speak to the importance of having stable leadership in key positions and what impact these vacancies may have on the VA's success.

Mr. STIER. So, I think that is a question that you have answered already. Anyone who has been involved in any organization knows that stable leadership is fundamental to the success of that organization. It is one of the unique challenges we have in our own government that you have so many political appointees—4,000 of them. No other democracy has anything else like that. By its very nature, these folks aren't sticking around for a long period of time.

What we are seeing right now at the VA is particularly problematic and it has massive impact. It is very difficult to run an organization when people are in short-term positions. My analogy is the substitute teacher: they may be wonderful educators, but the reality is that they don't get a lot of respect from the people in the classroom or they don't take on the long-term challenges.

So, if we want to see VA succeeding, we need to see long-term, capable, stable leadership.

Mr. TAKANO. So, I am really concerned about our move toward the electronic medical records and our attempt to get them interoperable with the Department of Defense and our non-VA providers. Are you concerned at all that lack—you know, these vacancies are going to set us up for some sort of failure or boondoggle down the road?

Mr. STIER. I think the reality is that these are incredibly challenging issues, whether it is staffing medical professions where there is a shortage, or changing electronic medical systems which are phenomenally complex systems. You want everything aligned right to make it work and right now we don't have that, so for sure, this adds another risk factor.

Mr. TAKANO. As you know, the commission on—you might have—are you familiar with the Commission on Care report? All of you are nodding your head.

Mr. STIER. Yes.

Mr. TAKANO. You know, I recall those hearings very, very vividly about—we had them about accountability and they said you can't have accountability—we know done an accountability bill and we spent a lot of time on that, but I don't believe—I don't think the Commission on Care, the bipartisan co-chairs believe that accountability will be achieved without a robust HR Department which does the hiring, but also the kind of training with progressive discipline that our managers need to implement to be able to really—they said you can't fire your way to excellence and you can't discipline your way to—you need trained personnel.

I understand that through April 2018, VA has hired 4222 human resource specialists. We also know that from work that GAO has

done that attrition rates among HR specialist rose 7.88 percent in 2013 to 12.1 percent in 2015.

How many vacancies are there currently for these positions?

Mr. STIER. That is not a question that I would be able to answer.

Mr. TAKANO. Mr. Shelby?

Ms. BONJORNI. We have—we still have several hundred vacancies for HR specialist, however our turnover rate did go down over the last year, but that was primarily because of the Federal hiring freeze, so they couldn't leave for other agencies.

Mr. TAKANO. Do you collect exit surveys for these positions?

Ms. BONJORNI. I'm sorry?

Mr. TAKANO. Do you collect exit surveys for these positions?

Ms. BONJORNI. Yes, we do.

Mr. TAKANO. And if so, why are the general reasons listed for why they are exiting and what are you doing to address them?

Ms. BONJORNI. For HR specialists our exit-survey data shows that they are leaving for advancement at other organizations or concerns about the volume and nature of the work, due to the complexity of the work.

Mr. TAKANO. Okay. Thank you.

I yield back, Mr. Chairman.

Mr. DUNN. Thank you, Mr. Takano.

And we now recognize Mr. Bilirakis from Florida for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much.

Mr. Shelby, thank you for your service. I have a question for you. The testimony mentions 422 new HR specialists hired into the VA and that is good. While this is—again, it is progress—one of the last year's—one of last year's GAO reports express concerns about the attrition rate amongst the HR staff. I understand 13 and a half percent in fiscal year 2015; significantly higher than the VA employees in general.

What does VA plan on doing to help continue the progress and retain those 422 new specialists that you have hired in 2018?

Mr. SHELBY. Part of what we are doing is developing them. We have re-implemented a development program to make them more effective and efficient at their jobs. The other things are we are way too decentralized, so there is too much demand at local level. We are consolidating into centers of excellence so you have depth at any given organization, and they can shift their resources to the demand signal rather than have a full burden on a single one and you miss capacity where there is capacity. So, we are consolidating those.

And we also have to get operations much more involved in HR. The supervisors and managers have to get involved in talent management. They own their organizations. HR is a consultant to make sure we hire it legally. They are the experts that run their organizations and understand the talent they need, and so they have to be more involved and so we are working towards that model where HR is a consultant and a business partner, and we have operations supporting every effort to find the right talent to bring into those organizations.

Mr. BILIRAKIS. Very good.

Ms. Draper, do you have any suggestions? Does GAO have any suggestions, additional suggestions, recommendations for VA in order to reduce the attrition rate?

Ms. DRAPER. Yeah, in our report that we issued in 2017, we made a number of recommendations and it wasn't just about the hiring. The hiring—the attrition was very high, but it is also about training the HR specialist and making sure that they are adequately trained to do their jobs.

There are other issues that we identified. One was problematic information technology systems that really did not support good practices. So, that was a—so that is another big issue, is our multiple systems that HR has to use.

The other thing is that there is just poor performance management system that really does not provide clear distinctions amongst staff and their abilities and, also, it limits employee accountability.

And I think the other thing we identified is that weak internal control. So, the overall oversight of HR functions was inadequate. So, those were all in that 2017 report.

Mr. BILIRAKIS. Okay. Mr. Shelby, I mean, can you respond to that—

Mr. SHELBY. Yes, sir. We have addressed—

Mr. BILIRAKIS [continued]. —with regard to inadequately training—

Mr. SHELBY. We have implemented training. So, there is no organization or school outside of government that is going to create an HR professional to work in the government and, in particular, in the VA. We are the only education around Title 38, hybrid Title 38. And so we are implementing a robust development program to give those HR professionals that we bring in, the education they need.

Mr. BILIRAKIS. Okay.

Mr. SHELBY. But we absolutely need systems, right. When all the demand is on individuals, rather than systems to support, and self-service of our customers, there is always going to be too much tactical demand in non-HR professionals. We have upgraded our HR SMART system. Are cleaning up data corruption. I inherited a system that they told me was going to cost \$120 million to clean up. We have spent nothing. We have gotten to the 70 percent solution. We are able to give accurate data on vacancies now.

In the next few weeks, I anticipate us cleaning up enough where we can launch individual self-service and manage-self-service. So, as I alluded to, more and more onus upon operations to lead and manage their people where HR can be consultants and we can move them from the tactical day-to-day personnel actions up to the talent-management, recruiting, and getting the people onboard they need to run their organizations.

Mr. BILIRAKIS. Very good. I have a second question, again, for you Mr.—VA is currently expanding residency training and has recently offered scholarships to those currently in school. You say in your testimony that the VA is in the process of completing a review of physician- recruitment strategies. When will the review be complete and what is VA doing for the current employees to ensure retention, such as educational—education reduction programs, which are very important?

Mr. SHELBY. We are using every resource at our disposal to retain those that we have. I personally don't think we tapped into enough. Almost every doctor in America, about 80 percent, come through our systems and we don't—we haven't been proactive enough in recruiting those.

Nurses, same thing—offering scholarships—we have to catch them early. We are exposed to them early in their educational career and we haven't taken advantage of that. I want to start bringing in interns between their sophomore and junior years and vet them then, and then at the end, between their junior and senior year, vet them again and if they are meeting the standards of the VA and if they are somebody we want to bring onboard, I want to start offering tentative job offers, so we get a whole year ahead of them. So, a year before they are graduating, they have a tentative offer from the VA and then using the resources that you have giving us with debt reduction and debt repayment in order to entice them to come.

Mr. BILIRAKIS. Okay. Can we help you with that? Do you need legislation for anything like that?

Mr. SHELBY. Where we run into problems is caps, you know, current caps—

Mr. BILIRAKIS. Yeah.

Mr. SHELBY [continued]. —the recruiting, retention, and relocation bonuses, we have caps. We appreciate the bump in that cap that we just had, but we have the resources there. We have already burned through that bump in the cap. So, we absolutely need to flexibility. It is market-based. Somewhere we are going to have offer more than in other markets and if we have caps on it, we are always going to run into that.

Mr. BILIRAKIS. Thank you very much for bringing that up. I appreciate it. Thank you.

I yield back, Mr. Chairman.

Mr. DUNN. Thank you, Mr. Bilirakis.

Now, recognized for 5 minutes, Mr. O'Rourke from El Paso, Texas.

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

Mr. Stier, I appreciate your points about the need to ensure that we have leadership and we, in El Paso, saw firsthand the consequence of not having that leadership. We were out a medical center director for two years, had a series of interim directors. There was no captain setting the course and holding everybody else accountable and we, at one point, had the worst performance in mental health care wait times in the country; out of 141 measured systems, we ranked 141st.

We—the veterans there, their families understood that care delayed became care denied. It led to really tragic outcomes.

With the director that we now have, permanent director, we now sometimes match and are better than the national wait time average for mental health care. We are better than the national wait time for primary health care. We have consistency in recruitment and retention. So, it really makes a difference.

One of the challenges that you laid out to hiring all of these directors is the pay. And I just heard Mr. Shelby say that he has capped out at 153,000. What does market pay look like?

Mr. STIER. Well, it is going to be dependent on the market, so—
Mr. O'ROURKE. Give me a ballpark. Give me a range.

Mr. STIER [continued]. —I mean, there are—and it depends on the nature of the medical center, but there are medical center directors that are paid in excess of a million dollars.

I don't think you have to do that. One of the incredible advantages VA has is the mission. The mission is powerful, but you can't pay a tenth or, you know, a fifth and then expect that you are either going to be able to recruit people in or retain them. Right now, I think the average is under three years that you have medical center directors in place. It is essential to ensure that VA can offer more flexibility in terms of salary, surely more than you are going to offer just with an individual doctor and making sure that the Direct-Hire Authority you provided doesn't actually require a lower level of pay than the standard SES pay scale. I am confident if you do that, you have great folks at the VA who will use that authority to great impact. That is the point of highest leverage.

The last thing I want to say is I was very impressed the last time I was in here when you described how you personally recruited the medical center director. It matters when you hear from a Member of Congress that they want you, that it is important that they take this job. That kind of engagement is phenomenal.

Mr. O'ROURKE. Let me ask Mr. Shelby, 153,000 is the cap right now. What would the cap need to be for you to have the flexibility necessary to hire the directors that you are missing?

Mr. SHELBY. The cap has to be flexible. It is market-based.

Mr. O'ROURKE. Unlimited?

Mr. SHELBY. No.

Mr. O'ROURKE. To the moon?

Mr. SHELBY. So—

Mr. O'ROURKE. So, what should the cap be?

Mr. SHELBY. So, if you combine our mission—

Mr. O'ROURKE. Okay. I am just looking for a number.

Mr. SHELBY. Six-hundred-thousand dollars.

Mr. O'ROURKE. Okay. How many medical center directors are you missing right now, permanent medical center directors?

Mr. SHELBY. We have 20 vacancies right now. I think we have five impending vacancies. I believe we are recruiting right now for 15.

And what we have changed is we do national recruiting efforts, rather than individual requisitions, so we are being much more proactive in finding those vacancies and putting several of them out at the at the same time every single month. So, we are trying to stay ahead of that turnover.

Mr. O'ROURKE. How many clinical positions are you short?

Mr. SHELBY. I can't tell you specifically how many clinical positions we are short.

Mr. O'ROURKE. Is that to Ms. Draper's point, that the VA doesn't know?

Mr. SHELBY. It is a—

Mr. O'ROURKE. If you don't have an accurate count of the physicians that you have, do you agree with that assessment?

Mr. SHELBY. I agree.

Mr. O'ROURKE. Okay. And is that why you can't answer our question?

Mr. SHELBY. No, I can't specifically answer the question because it is such a large system and it is changing every single day.

Mr. O'ROURKE. It is a pretty important question.

Mr. SHELBY. And if you look on the IG report, on every single day—

Mr. O'ROURKE. Yeah.

Mr. SHELBY [continued]. —it is different and in every single market it is different.

Mr. O'ROURKE. Give me a ballpark. Thirty thousand is the number that I have heard; that is the most recent number that I have heard. I have heard as high as 40,000 from the secretary of the VA. Where—are we in the ballpark, 30,000 clinical?

Mr. SHELBY. Yes. So, a 10 percent rate in 385,000 is 38,000 on any given day.

Mr. O'ROURKE. Okay.

Mr. SHELBY. So, I can give you that. But, specific—maybe I understand—you wanted specific clinical vacancies, and it fluctuates so much—

Mr. O'ROURKE. And do you have a ballpark of how many of those are mental health care positions?

Mr. SHELBY. I know we are very short. So, in mental health, we have targeted that. Our goal is to increase it by 1,000 by the end of the year. We have already increased it, net gain, of over 400, and we are targeting by January of this year, to reach that thousand.

Mr. O'ROURKE. Last question. Mr. Stier was talking about some of the morale challenges within the VA. Talked about double the attrition rate. One of the lowest morale rankings in the Federal government. That doesn't seem to match your description of what is going on in the VA. You offered a far rosier picture.

Is he wrong? Are you right? Do you see what he has seeing? Do you acknowledge the attrition rate and the morale challenge?

Mr. SHELBY. I absolutely acknowledge the attrition rate. It is very difficult in a system where we are competing for limited talent, you have a high demand, and we are working people a lot. So we have to get better at that.

But I can tell you this, I have been out to medical centers. I have been out to benefits offices. I have been out to cemeteries. And the VA workforce is the most amazing, dedicated workforce I have ever seen, and their morale is high. And we have to help them be successful because of us and not in spite of us. We have removed impediments—and a lot of these are hiring impediments—and the market—and our inability to compete in the markets that they work in for the talent we need.

Mr. O'ROURKE. The last thing, and I am going to yield back to the chair, but you say morale is high and I think morale is something that can be measured and maybe imperfectly, and it seems to be measured low. I would love to understand, maybe for the record, maybe for a future conversation, why the discrepancy between what we are measuring and hearing from VA employees and what you are telling Members of the Oversight Committee right now.

Mr. SHELBY. I have our own employee survey out now. It goes to 100 percent of our employees. We expect a 65 percent return rate on that. So, that is nearly 300,000 employees. I will have a clearer picture and I would welcome the opportunity to come back and share that information with you.

Mr. O'ROURKE. Thank you. Appreciate it.

Mr. DUNN. Thank you, Mr. O'Rourke.

And I wouldn't wait to come back. If you would share that report when you get it, I know we would all be interested in it.

I now recognize Captain Clay Higgins from St. Landry's Parish, Louisiana, for 5 minutes.

Mr. HIGGINS. Thank you, Mr. Chairman.

Mr. Shelby, you gave us a number of \$600,000. I think that is probably a good estimation on your part regarding the disparity between the pay for directors of our medical centers and our VISNs, compared to the hundred-and-fifty-three-thousand-dollar cap that you are currently working with. And we can certainly understand the challenge of maintaining those positions and filling those slots and retaining qualified personnel in those positions because of the disparity of pay that is available in the civilian world, but at the same time can you imagine how a regular American veteran, you know, coming from a middle-class family, earning \$34,000 a year would feel when they can't get an postponement for weeks and weeks and weeks at a medical center, knowing that the director is getting paid 600 grand?

As a marine, give me your feelings on that, sir.

Mr. SHELBY. Yes, sir. I am the checking account person you described. I am the eighth of nine kids. Joined the Marines when I was 17. My father was a police officer, retired. And that type of pay is mind-boggling to me. I never anticipated my father would make a hundred thousand dollars so—

Mr. HIGGINS. Exactly. We talk about numbers in this body like it is—like we are operating in a vacuum and in many ways, DC is a vacuum; it is certainly a bubble that is in far too many instances, is disassociated from the reality of American struggle.

So, I would hope—I am very glad that we are focused on directors and filling these positions. Mr. Chairman, Madam Ranking Member, my colleagues have brought up these challenges that we face, and I would hope that we have a spirit of being able to do more with less and tapping into the patriotic service of the Americans and medical professions across the country that have a desire to serve their country.

So, I am going to shift to what you had stated, sir, regarding recruitment out of our universities' medical schools. I am very encouraged by what you stated regarding offering jobs to pending graduates coming out of medical schools. How is that process going? Have you had any success with it? Because I think that is certainly an answer.

For a graduate, a medical school graduate to have a job waiting for them when they graduate is important and the VA has not been participating in recruiting during that internship of their medical training in the past and you are telling us they are now. How is that working? Have you had success? Is anybody in place right now, based upon that level of recruitment?

Mr. SHELBY. They are not. This is a disrupter. This is a complete change in the mindset of how we do government hiring.

Mr. HIGGINS. Congratulations. That is a damn good change and I encourage you to pursue it aggressively.

Is there anything this body can do, that this Committee can do legislatively to help your clear any obstacles to that mission, because I think that is key.

Mr. SHELBY. I think part of it is the caps. We need to be able to offer scholarships and debt reduction and that is going to fluctuate. And so, working with Congress to identify what the demand is going to be on that, but I promise you this, I will do a cost-benefit analysis in losing that talent and not being able to bring them in and how that impacts wait times and our ability to serve veterans.

To me, it is a no-brainer, right; the costs far outweigh not doing it. And I am working closely with OPM. I am hoping to get policies and process in place. You know, we are in the midst of civil-service reform with them, as well. We need them to facilitate the ability to do our job and not be an impediment to that and I am confident that we are going to get to that with working with OPM.

Mr. HIGGINS. And, quickly, with regard to filling the slots to directors' positions, is there a way to incorporate a similar policy of recruiting out of the collegiate level? Do they just not have the life experience?

Mr. SHELBY. We could put them into an intern program, like a management intern program—

Mr. HIGGINS. Yes, sir.

Mr. SHELBY [continued]. —but it is going to take, you know, 10, 12, 15 years in my estimation, to develop to the point where you can run a facility.

Mr. HIGGINS. Understood. Thank you for your candid response, sir, and thank you for your service to our country.

Mr. Chairman, I now yield back.

Mr. DUNN. Thank you, Mr. Higgins.

I now recognize Representative Correa from California for 5 minutes.

Mr. CORREA. Thank you, Mr. Chairman.

First of all, I want to thank the Members on the panel for your good work and, of course, thank our veterans that are here today with us, thank you for your service for our great country.

And I wanted to start out by following up with some of the comments that Mr. Higgins made, which are, you know, our priorities should be—is and should be taking care of veterans in a timely manner, best quality health care. And as I listen to the testimony, not only of you here, but of our Members here of this Committee, I was thinking to myself, what are the impediments that we, as a legislature, legal impediments, regulatory impediments that we putting upon you, because we are, again, addressing a set of issues that have been with us 5, 10 years, maybe longer and we keep doing the same thing over and over again.

I am not pointing the fingers at you. What are we not doing up here to help you do your job? Dr. Roe talked about some of the things that he was doing when he was practicing medicine, scholar-

ships, how do you recruit nurses, how do you recruit folks, do you need more flexibility?

Dr. Roe, my wife is also a doctor and she will come home and tell me we have got a doctor shortage in this area of the organization and they go out and they have to raise salaries to bring in folks.

You talked about decentralization and then you talk about centralization. I don't think that is really the issue. What I am hearing is you don't have the flexibility to respond to the market forces in your area. If it is West LA, I don't care who you are hiring in West LA, you are going pay that person more than you are somebody in the Midwest; that is just the way it is.

And I guess I am asking—and maybe you don't answer it today—but what can we do to give you that flexibility? And it is going to cost more, but maybe we can get innovative and make it less costly by some of the ideas that you are talking about already—some scholarships, some debt forgiveness. There are a lot of patriots that are graduating from medical school, from nursing school that maybe do want to come to the VA to learn things and also to give back.

Can we help them with scholarships with debt forgiveness? Can we legislate a good program to move ahead in this direction, so the VA becomes a place that everybody wants to go to, to learn and to serve America? What can we do to move in that direction?

Again, we keep doing the same thing over and over again expecting different outcomes. And I think we are really tying you up, because, again, you are moving from decentralized to centralized, but I don't think that is the issue. I think the issue is you don't have the ability to move to react to recruit people that you need.

Mr. SHELBY. Exactly, sir. We need the agility in each of our markets to compete with the local market there for talent. And so, I want to build a pipeline of youth—youth nurses, youth doctors. And so, having the flexibility and the funding to have those scholarships and debt-reduction programs to entice them as they are going through school would be huge for us.

Mr. CORREA. Do you need a legislative act by this body to help you go through?

Mr. SHELBY. I would like the opportunity to come back and see what flexibilities we have. I want to explore everything—you have already been generous with and given us—and make sure that we are taking advantage of those and if there are still gaps in that, I would like the opportunity to bring that back.

I think the most glaring is the market pay, as you alluded to. West LA is going to pay much differently than Louisiana. I want the flexibility within that market to compete with the local talent there and I won't have to pay as high. The benefits packages that the Federal Government provides are better than most private-sector benefits packages. That combined with the mission of serving veterans, we can compete, and we won't have to pay as high, but we can't pay as set, 5 percent, 10 percent, 15 percent of what their market value is. We have to be able to compete at that 80 percent level.

Mr. CORREA. You know, I keep hearing about these wonderful, brilliant people graduating from high school, graduating from col-

lege wanting to go to the Peace Corps, wanting to serve somewhere in that world, wanting to give back. I am just trying to figure out, is there a place for them at the VA where they can come and spend a few years moving in another direction and fulfilling their life's dream and help our veterans help our country do some real good work with you.

Mr. SHELBY. Absolutely. You know, I was a chief learning officer for 10 years and I think we need to target them in middle school, right. So, they are getting the grades. They see that they have an opportunity. There are Federal programs that will help them pay for their bachelor's degree, their master's degree, even all the way up to their Ph.D.—

Mr. CORREA. I have got 7 seconds, so my question is, I presume you also have programs that hire our veterans that are coming out of the service to get to the next level of life?

Mr. SHELBY. Absolutely.

Mr. CORREA. Thank you, very much.

To the Chair, I yield.

Mr. DUNN. Thank you, Mr. Correa.

Now recognized for 5 minutes, Representative and Army Major Brian Mast.

Mr. MAST. Thank you, Mr. Dunn.

I want to start with one of the comments my friend, Representative Higgins, made about the ability to do more with less and this is an opinion question for you, Mr. Shelby. It is your opinion that those that are VA directors are willing to take on the job by doing more with less or are we hiring people at a certain pay scale amount that we are bringing in somebody who is unqualified? If they are willing to do more than less, are you saying that there is a fuse on that and at a certain point, they are just saying, we are going to turn this over.

Mr. SHELBY. I have always called it “more with different” rather than “more with less.” You have got to change the way you think about your business model and I think we absolutely bring in people that are capable of that.

What I am doing now is developing them to be able to engage their staffs and their teams. Great ideas come from everywhere and the diversity of thought and thinking of different ways of doing business have to be a team effort. And so, engaging the entire team to figure out how to do things better, faster, cheaper, is the way to go and we can absolutely get there.

Mr. MAST. Thank you. Mr. Missal, I would like to go to some of the questions—it hasn't really been touched yet—but the VA inspector general's fiscal year 2018 report dismiss also talk about staffing shortages, as it related to police officers within the VA. I have gone to the headquarters here in DC, spoke to the focus that run everything as it relates to the VA police force.

The report said in the state of Florida that the State of Florida is 18 officers shy of the number they need; that is 14 in Orlando and 4 in Tampa. I was wondering if you could elaborate a little bit on that. What are the metrics that are used to determine VA police staffing for facilities? Does it go by what the VA medical center director wants? Does it go by what is determined here in Washington? How is that number determined and what level of security

is needed at a facility when we do know in the past, groups like ISIS have called and said, Let's go to a VA medical center, there is a bunch of veterans there, let's go target them. How do you determine that?

Mr. MISSAL. The VA police actually report to the medical center director, so it is up to the medical center director to determine what is an appropriate level of staffing at the police. So, in our staffing report a number of the medical center directors did identify critical shortages with police.

I do also want to note that we are coming out with an audit report in the near term with respect to looking at the whole governance structure of the police force and other issues because we have been concerned about some of the issues related to the police force.

Mr. MAST. Okay. So, if a security need is not reported by a hospital director, then there is an assumption here by DC that there is no security shortfall if it doesn't make it from the security force through the director to DC?

Mr. MISSAL. It was up to the medical center director to determine what they believed were the critical shortages. We didn't verify that or look behind it; we relied on what they told us.

Mr. MAST. Okay. I appreciate your answers on this. I want to continue on this track a little bit. What is the stance, when it comes to the VA, on who should have access to the grounds of a VA hospital? What is the stance of the VA on who should have access to the grounds of a VA hospital?

Mr. MISSAL. In terms of, are we talking about the police or are we talking just in general?

Mr. MAST. Any individual that wants to enter the premises of a VA hospital, what is the stance of who should have access to get on, walk in the doors? Who should be allowed to walk in the doors?

Mr. MISSAL. I don't know if there is a set policy—in a number of the facilities, I think it is up to the director to determine the level of security within a particular facility.

Mr. MAST. And I have to believe that you are right in saying that. In my VA hospital, it feels to me like we have on and off policies of enforcing, okay, we are going to check people's ID at the door and an hour later there is not going to be somebody there to check somebody's ID at the door and then an hour later there is going to be somebody there.

So, it is as though they want to make sure that the right people are entering the VA, but there is not a priority that is necessarily put on. It is not a paid position, I believe. I believe it is volunteers that check these IDs at the door. And that is something that also plays into the security of our veterans on this facility. So, I would appreciate it if you would take a look into that as you are looking at metrics on what is needed for VA facility security. What is the stance of who you believe should have access to the VA medical centers and what are you doing to actually ensure that that is enforced by the VA police force and that might have an impact on the numbers that you determine you need in terms of a VA police force and their presence in each state.

And that, I will yield back any additional time Mr. Dunn. Thank you.

Mr. DUNN. Thank you very much, Representative Mast.

I now recognize for 5 minutes, Representative Anne Kuster from Concord, New Hampshire.

Ms. KUSTER. Thank you very much, Mr. Chairman, and thank you to our panel.

I am going to move quickly because I have a number of issues to cover, but—oh, I was hoping Dr. Roe had—would stay. I agree with his assessment and one of the most effective recruitment measures would be loan forgiveness for the incredible public service of people working within the VA, but I need his help in convincing the speaker not to bring to the floor the Prosper Act because one of the greatest concerns is that bill H.R. 4508 eliminates the Public Service Loan Forgiveness Program; it is completely contrary to the whole purpose of this hearing. And so, I will work with Dr. Roe and my Republican colleagues to make sure that that Prosper Act does not come to the floor.

And, in fact, what I would prefer to do is to increase the incentives for people to join public service at the VA. And to that end, I have sponsored a bill that has been passed in the House, the Grow Our Own Act. This is with regard to medics and other health care professionals coming out of their military service who have the skills to serve the needs of our VA population. It gives them competitive pay and it also—the House version recognizes the skills that they gained in the field during their military service.

I am just wondering if you have considered that for any other types of medical credentials. Ours was focused on physician assistants, but is that something that is under consideration and would you need legislation to do that? And that is for the VA.

Mr. SHELBY. I am going to have Jessica respond to that to see if we need legislation.

Ms. BONJOURNI. Thank you. We would welcome the opportunity to work with you on that. I know that we have been focused quite recently on hiring corpsman and medics to come into our Intermediate Care Technician Program and we are really trying to grow that program because it gets rave reviews from our veterans. They appreciate being seen by those who have also served. So, we would welcome the opportunity to work with you on that.

Ms. KUSTER. Absolutely. And the other issue, I just think it is a waste of people power. They have fantastic skills and they're coming back, and it is making for a very difficult transition when they are told they have to go back to school for two years to get a specific credential. So, we would love to work with you.

I am going to switch gears entirely to a March 2018 Merit Systems Protection Board release report on the incidents of sexual harassment across the Federal government. The VA was the worst offender with 22 percent of the employees reporting sexual harassment. And I just would like everyone on this panel to consider the impact on morale and certainly on retention when 1 in 5 employees in the VA has experienced sexual harassment, it is no wonder that we have very high turnover and we lose valuable and qualified employees and it is no wonder that it would be difficult to recruit and retain qualified employees.

So, one very specific question: With the rate of our human resources officers being so low with the shortage, where are employees expected to go if they have a sexual harassment complaint and

if you could also comment on sexual harassment training and how we are going to lower this abominable rate. I am embarrassed that it is the VA that has the very worst rate across the Federal government. Thank you.

Mr. SHELBY. Yes, thank you for allowing me to respond to that. I took a look at the study. It was done—the data was collected between 2014 and 2016 and they only interviewed 1100 people so, about .003 percent of the VA population—

Ms. KUSTER. That is quite a big sample, 1100 people.

Mr. SHELBY. And since 2016, we have implemented a very robust civility in the workforce program. We have continuous training. We have an office of resolution management with several hundred people—you have a difference between 201s and ORM. They are embedded throughout the organization.

Ms. KUSTER. To you have a statistic on the number of VA employees that have received this sexual harassment training?

Mr. SHELBY. One hundred percent. It is required learning—everybody, including supervisors and managers. We have six and a half hours of training for supervisors and managers and three and a half hours for general employees. Our statistics—in 2017, there were only 17 reports of sexual harassment and only 3 total in 385,000 were validated as a problem—

Ms. KUSTER. Well, sir, I apologize for interrupting—my time is up—I have requested of Chairman Bergman that we have an oversight and investigation Subcommittee hearing on this topic, and we would be very interested in hearing the progress that has been made since that original statistic was gathered.

So, I yield back.

Mr. SHELBY. We look forward to that.

Mr. DUNN. Thank you, Representative Kuster.

If there are no other questions, the panel is now excused. And I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous materials.

Without objection, that is ordered, and the hearing is now adjourned. Thank you very much.

[Whereupon, at 11:23 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Max Stier

Chairman Dunn, Ranking Member Brownley, members of the Subcommittee on Health, thank you for the opportunity to appear before you today to discuss the implementation of the VA Choice and Quality Employment Act of 2017 (P.L. 115–46). I am Max Stier, President and CEO of the Partnership for Public Service. The Partnership is a nonpartisan, nonprofit organization that works to revitalize our federal government by inspiring a new generation of Americans to enter public service and by transforming the way our government works.

The success of the Department of Veterans Affairs depends upon a highly qualified, engaged and accountable workforce operating at full capacity and equipped with the knowledge and resources it needs to achieve its mission. Congress is an essential partner to the department in building and sustaining this workforce, and I commend this committee for its continuing focus on how best to do so, including by holding this hearing and passing laws like the one we are discussing today. The Partnership strongly supports this legislation and believes that, if it can be fully realized, it will reduce critical vacancies in key mission-critical occupations and, more importantly, ensure that veterans receive the care they have earned through their service.

But this law, though helpful, represents just a first step. To the department's credit, it has continued to add employees—its total medical workforce grew by 2.9 percent in 2017.¹ The department has also reduced wait times overall and maintained satisfaction levels equal to or above those of the private sector.² However, over the next decade, our nation will face potential shortages of between 42,600 and 121,300 physicians, and this will be the environment in which VHA must recruit.³ More action needs to be taken to modernize the VA, including smart implementation of the tools provided by the VA Choice and Quality Employment Act, better data about the agency's workforce, talent needs and applicant pools, additional legislation to address fundamental problems with the VHA's complex and burdensome personnel systems, leaders at the VA who are focused on and committed to these issues, and sustained oversight by this committee.

State of VA Choice and Quality Employment Act Implementation

When Congress passed the VA Choice and Quality Employment Act last summer, it provided VA with several new authorities and tools to streamline the hiring of mission-critical talent. These included an expanded direct hire authority, unique promotional tracks for technical experts, better sharing of information regarding applicants for shortage positions, and new training for human resources staff. Collectively, this legislation and the personnel authorities granted by the VA Accountability and Whistleblower Protection Act of 2017 (P.L. 115–41) empower VA to recruit, hire and retain the talent it needs to serve veterans.

Our understanding is that the VHA is working hard to implement the bill and has already made progress on several fronts. The agency is working with the Department of Defense to stand up joint programs that will bring more transitioning service members into the VHA, as directed by Section 207 of the Act. The agency as a whole is continuing efforts begun in the prior administration to improve collaboration and coordination with the DOD. Next, the VHA is beginning to make use

¹“U.S. Office of Personnel Management - Ensuring the Federal Government Has an Effective Civilian Workforce.” FedScope - Diversity Cubes (Enhanced Interface). Accessed June 18, 2018. <https://www.fedscope.opm.gov/employment.asp>.

²Sisk, Richard. “VA Wait Times As Good or Better Than Private Sector: Report.” Military.com. Accessed June 18, 2018. <https://www.military.com/daily-news/2017/09/20/va-wait-times-good-better-private-sector-report.html>.

³“New Research Shows Increasing Physician Shortages in Both Primary and Specialty Care.” AAMCNews. April 11, 2018. Accessed June 18, 2018. <https://news.aamc.org/press-releases/article/workforce-report-shortage-04112018/>.

of the direct hire authority authorized under Section 213.⁴ The Office of Personnel Management has approved a set of fourteen positions, both clinical and non-clinical, which the VA can fill through the use of this authority.⁵ Our understanding is that the VHA has already begun to use the authority to fill vacancies. We also understand that the VHA is looking at how to use the authority granted under Section 206, which speeds the hiring of students and recent graduates, to fill vacancies on the business side of the agency.

For an agency the size of the Veterans Health Administration, any change, however small, will take time to implement. And because the authorities and programs enacted by this legislation did not come with significant new funding, implementation will be slower as a result. In this case, the example of the 2015 Enhanced Physician Recruiting and Onboarding Model (EPROM) is instructive: the VHA issued a set of recommendations to VAMCs designed to improve physician recruitment and speed hiring. However, GAO found that a lack of resourcing and capacity at the facility HR level led many VAMCs to ignore the EPROM or implement it in only a limited fashion, resulting in minimal impact overall.⁶ Turnover among HR specialists in facilities across the VHA system is also contributing to lagging action on various provisions of the legislation. A large number of relatively new HR specialists means more preparation and work required to make sure the agency implements new rules and programs effectively. Long-term under-resourcing of the agency's HR function is acting as a drag on the agency's ability to implement the new law as quickly as the committee and stakeholders might prefer. For example, in 2015 more than 80 percent of VAMCs failed to meet target staffing ratios of one HR specialist to 60 employees and it is our understanding that this remains an issue today.⁷ These challenges underscore the importance of focusing the committee's oversight on how to ensure the VHA can implement the law and seeking additional ways to improve its personnel system.

Enabling More Effective Implementation

More and Better Data

An organization cannot manage what it cannot or does not measure. For the Department of Veterans Affairs and the Veterans Health Administration, a failure to effectively combine and scale strategic priorities with data about the composition and commitment of its workforce hinders effective hiring and talent management. More broadly, a risk-averse culture which resists change makes the task of using data and building a performance culture even more difficult. Research by the Partnership has found that while many agencies have "taken the first step toward creating a performance management culture" by regularly and systematically collecting data, few are processing it in a meaningful way.⁸ John Kamensky of the IBM Center for the Business of Government has similarly noted that agencies have plenty of data but are "information poor."⁹ Like other agencies, the VHA has plenty of data, particularly at the facility level, but fails to make full use of it. The decentralized nature of the organization means data is not aggregated to provide a complete picture of the state of the organization. This lack of data is especially true in the workforce space, where GAO has found that VHA lacks detailed information about the overall composition of its workforce and use of hiring incentives.¹⁰ Better data about the composition of the workforce and more sophisticated dashboards that offer real-time views of the critical information that enables better management decisions would greatly enhance the department's talent management and use of workforce flexibilities such as those authorized by the Act.

An effective hiring process makes use of data both at the front end to determine needs and at the back end to evaluate results, and it also provides a means of hold-

⁴Statement of the Honorable David J. Shulkin, M.D. Secretary of Veterans Affairs for Presentation before the Senate Committee on Veterans Affairs, 10 (January 17, 2018). 115th Congress

⁵United States of America. Department of Veterans Affairs. Office of Inspector General. *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY2018*. Washington, DC, 2018. 2

⁶United States of America. Government Accountability Office. *Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies*. Washington, DC, 2018. 27.

⁷Ibid. 13

⁸Taking Measure: Moving from Process to Practice in Performance Management. Report. Washington, DC: Partnership for Public Service, 2013. 8

⁹Kamensky, John. "Government Is Data Rich, But Information Poor." Editorial. *Government Executive*, June 12, 2018.

¹⁰United States of America. Government Accountability Office. *Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies*. Washington, DC, 2018. 12

ing leaders accountable for the state of talent in the organization. The Act took positive steps towards providing more and better data by requiring GAO to examine the department's succession planning practices, mandating the creation of a comprehensive list of vacant positions across VA, and codifying the department's current exit survey. Moving forward, the Partnership believes the VHA should look at ways to align this workforce data with the organization's strategic and service priorities. Better integrating employee satisfaction and commitment data already available to the agency through the VA All-Employee Survey (AES) and the Federal Employee Viewpoint Survey (FEVS), which the Partnership uses to produce its Best Places to Work in the Federal Government Rankings, will be key to this integration. In looking at ways to fill mission-critical vacancies, the department and this committee should not lose sight of the fact that employee engagement is a necessary ingredient for developing a high-performing workforce and attracting top talent. The committee should also look at ways it can use its oversight to track key metrics of the hiring process and agency outcomes, perhaps on a quarterly basis, to work with the department to adjust in real time.

Better use of all of these types of data will be particularly critical because of the troubling quit rates at VHA. Between 2011 and 2017, employees with less than two years of service quit at a rate of nearly 32 percent.¹¹ This attrition rate is especially problematic because less than one-quarter of VHA employees in clinical roles is under the age of 40.¹² Each of these statistics highlights serious retention issues at the VHA. The department's Office of Inspector General noted in September 2017 that, despite some hiring gains, "the percentage of regrettable losses to total onboard staff in many critical need occupations was high relative to overall increases in onboard staff."¹³ Minimizing regrettable losses and retaining talent will require the department not just to understand the size and composition of its workforce, but combining it with insights pulled from surveys like the AES to design national retention strategies. The next step for VHA will be to create an integrated, comprehensive process for gathering and distributing critical workforce data across VAMCs to encourage learning and best practice sharing in the use of various hiring authorities and flexibilities and to get leaders at the facility level to act on it. To its credit, the VHA Office of Workforce Management and Consulting has begun looking at how it can collect and share data better. I strongly encourage the committee to follow up on this work.

Modernizing the Department's Personnel System

The challenges faced by the Veterans Health Administration in recruiting, hiring and retaining mission-critical talent are by no means unique. Agencies across the federal government struggle to function within a system that is "stuck in the past, serving as a barrier rather than an aid in attracting, hiring and retaining highly skilled and educated employees."¹⁴ Much of the Title 5 civilian personnel system dates back to 1949 and has not been revisited by Congress since 1978. Title 38 was created in 1946 at a time when the state of healthcare was far different than it is today.¹⁵ The accretion of new laws, regulations, and court rulings has also added significant complexity to the process. The VHA faces a particular challenge in that it operates three different personnel systems: Title 5, Title 38 and Title 38 Hybrid, each with unique rules and processes. Organizations from GAO to the VA Office of Inspector General and VHA Commission on Care, created by Congress as part of the Veterans Access, Choice, and Accountability Act of 2014, have cited the challenge presented by the department's multiple personnel systems for recruitment¹⁶

¹¹ "U.S. Office of Personnel Management - Ensuring the Federal Government Has an Effective Civilian Workforce." FedScope - Diversity Cubes (Enhanced Interface). Accessed June 18, 2018. <https://www.fedscope.opm.gov/employment.asp>.

¹² Ibid.

¹³ United States of America. Department of Veterans Affairs. Office of Inspector General. *OIG Determination of VHA Occupational Staffing Shortages FY 2017*. Washington, DC, 2017. I.

¹⁴ *Building the Enterprise: A New Civil Service Framework*. Publication. Washington, DC: Partnership for Public Service, 2014. 7.

¹⁵ United States of America. Merit Systems Protection Board. Office of Policy and Evaluation. *The Title 38 Personnel System in the Department of Veterans Affairs: An Alternative Approach*. Washington, DC, 1991.

¹⁶ United States of America. Government Accountability Office. *Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges*. Washington, DC, 2016.

and¹⁷ retention¹⁸. Fixing the department's broken personnel management will ultimately require significant reform and, ideally, consolidation of the personnel systems under which it operates.

Perhaps the clearest example of the way in which outdated and inflexible personnel systems limit the department's ability to recruit and hire is in the area of classification. A June 2018 report by the VA OIG stated that "many facilities noted that...outdated OPM classifications affected their ability to offer competitive salaries and advance opportunities within the organization" with the result that facilities were "less competitive in attracting new staff and retaining highly skilled staff."¹⁹ The link between classifications and uncompetitive salaries is long-standing and critical. GAO noted in its October 2017 report that one VAMC reported losing its chief of cardiac surgery to a nearby hospital, which increased the individual's salary from \$395,000 to \$700,000.²⁰ The VHA has attempted to tackle some issues piecemeal, by working to consolidate classification procedures at the VISN level for example.²¹ However, this reform is unlikely to address many of these long-standing challenges on its own. Unfortunately for the VA, it is operating in an environment in which it competes not just with the private sector for talent, but with other federal agencies as well. Regrettable losses caused by the resignation of medical professionals is a symptom of the broader problem.

Operating multiple different systems also hurts the effective functioning and retention of the department's human resources staff. The VHA struggles to hold on to HR talent—the VA OIG's FY2018 determination of staffing shortages report noted that HR has ranked among the top ten shortage occupations since 2011.²² Attrition among HR specialists is a significant challenge as well, as three-quarters of HR assistants who left VHA in 2015 did so in their first two years. Overall attrition rates for the position rose from 7.8 percent in 2013 to 12.1 percent in 2015, where they have roughly held.²³ Unfortunately, there is little reason to think this trend has abated; in recent testimony to this committee on May 22, 2018, VA Inspector General Michael Missal stated that vacancies in mission-critical positions at the Washington, DC VAMC were caused in part by turnover in the facility's HR office.²⁴ There is plenty of evidence to suggest that HR specialists are leaving VHA due to their dissatisfaction with understaffing and complexity of the work.²⁵ The result is administrative delays that further lengthen the time needed to recruit, hire and onboard badly-needed talent.

In the short term, there are several actions the committee might consider to strengthen further the department's ability to fill mission-critical vacancies and improve service to veterans. I describe these actions in greater detail in the recommendations below. The committee should address the technical issue artificially limiting pay for VAMC and VISN directors created by the VA Accountability and Whistleblower Protection Act that serves as a significant disincentive to recruitment and retention of these essential leaders. The Partnership also believes the delegation of authority to assess candidates for senior executive roles without advance OPM permission and to make direct hire determinations at the agency level would

¹⁷ United States of America. Department of Veterans Affairs. Office of Inspector General. OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY2018. Washington, DC, 2018.

¹⁸ United States of America. Veterans Health Administration. Commission on Care. Commission on Care: Final Report. Washington, DC, 2016.

¹⁹ United States of America. Department of Veterans Affairs. Office of Inspector General. OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY2018. Washington, DC, 2018.

²⁰ United States of America. Government Accountability Office. Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies. Washington, DC, 2018. 28

²¹ United States of America. Government Accountability Office. Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges. Washington, DC, 2016.

²² United States of America. Department of Veterans Affairs. Office of Inspector General. OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY2018. Washington, DC, 2018. 6

²³ United States of America. Government Accountability Office. Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges. Washington, DC, 2016. 10

²⁴ Statement of The Honorable Michael J. Missal Inspector General of the Department of Veterans Affairs Before the Committee on Veterans' Affairs U.S. House of Representatives Hearing on "The Curious Case of the VISN Takeover: Assessing VA's Governance Structure", 115th Cong., 13 (2018).

²⁵ United States of America. Government Accountability Office. Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges. Washington, DC, 2016.

be highly beneficial. Finally, using provisions authorized by the VA Choice and Quality Employment Act, we recommend the committee work with the department to build a scorecard or other assessment mechanism that can be used to hold VA leaders accountable for their organization's health, including talent management practices.

Beyond small-bore changes to the department's current personnel operating authorities, however, the Partnership strongly encourages the committee to work with the administration to move towards a unified personnel system for the department that will allow the VHA to fully address its hiring, classification, pay and accountability issues. The system should be the product of strong leadership across the branches, employee buy-in, and investment in agency HR and other implementation functions, and should reflect a commitment to the Merit System Principles that serve as the bedrock of the civil service system. The VHA Commission on Care came to this same conclusion. The panel stated that VHA uses "talent management approach from the last century" and that Congress should "create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector."²⁶ Fortunately, the provisions of the VA Choice and Quality Employment Act offer a blueprint for how other committees might jumpstart the process.²⁷ While the Partnership would prefer that Congress apply this system to all of government, the Veterans Health Administration, with its massive scale, specialized workforce, and complex mission, represents a good place to start.

Promoting Leader Ownership

The next secretary of the Department of Veterans Affairs and his leadership team will have a big job ahead of them and relatively little time to do it. History suggests that the department's political appointees, once confirmed by the Senate, are unlikely to stay in their jobs more than two years. They will be in charge of managing an organization with over 300,000 employees, 145 medical facilities, and 9 million veteran patients.²⁸ The secretary and his team will also be operating in a complex environment in which the White House, Congress, veterans' service organizations, employee groups and the private sector will all be demanding action. The incentives faced by the department's incoming political appointees will be to focus on policy and headlines, rather than the sometimes invisible work of strengthening the VA's management systems and structure. It is this work that has some of the most lasting impacts on improving services for America's veterans, even if the sheer size of the department means that achieving results may take years. In other words, the incoming leaders of the department need to take ownership of the health of the organization they run and leave it in a state that is better than the one it was in when they arrived.

Section 203 of the VA Choice and Quality Employment Act included important language to this effect, specifically requiring that the Secretary and other political appointees of the department have annual performance plans which hold them accountable for talent management, employee engagement and development, and promoting effective performance management practices. This provision provides an excellent opportunity both to the department and to Congress. The Partnership's Best Places to Work in the Federal Government Rankings have consistently found that quality of leadership is a key driver of employee satisfaction, but views of senior leadership in the department do not provide much reason for optimism. In 2017 VA ranked 17th out of 18 agencies in employee satisfaction with the effectiveness of agency leadership, declining slightly from 2016.²⁹ Further, FEVS data showed that fewer than half of VA employees had a high level of respect for senior leaders and just 36.1 percent of employees were satisfied with the policies and practices of these leaders (the number rose slightly to 36.3 percent at the Veterans Health Adminis-

²⁶ United States of America. Veterans Health Administration. Commission on Care. Commission on Care: Final Report. Washington, DC, 2016.

²⁷ Neal, Jeff. "How the VA Choice and Quality Employment Act of 2017 May Drive Civil Service Reform." Editorial. Federal News Radio, August 15, 2017. Accessed June 18, 2018. <https://federalnewsradio.com/commentary/2017/08/how-the-va-choice-and-quality-employment-act-of-2017-may-drive-civil-service-reform/>.

²⁸ Statement of The Honorable Michael J. Missal Inspector General of the Department of Veterans Affairs before the Committee on Veterans' Affairs U.S. House of Representatives Hearing on "The Curious Case of the VISN Takeover: Assessing VA's Governance Structure", 115th Cong., 13 (2018).

²⁹ Partnership for Public Service. "Department of Veterans Affairs." Best Places to Work in the Federal Government. Accessed June 18, 2018. <http://bestplacetoework.org/BPTW/rankings/detail/VA00#tab=category=tbl>.

tration).³⁰ And, as noted above, data on talent management at the department shows similar problems and, while removals have gone up, there are concerns that new accountability procedures are being weaponized to retaliate against rank-and-file employees.³¹

These data reinforce the importance of the role of Congress and this committee in particular. Congress is itself an “owner” of the Department of Veterans Affairs and has an important stake in its success or failure. To its great credit, this committee has recognized its stewardship role and done excellent bipartisan work elevating important issues of talent management and performance. There is more the committee can do to build on its work to date. Asking for more real-time data on vacancies and leadership, utilizing a scorecard to measure and assess the department’s leadership, and encouraging system-wide learning by highlighting best-in-class practices would reinforce important norms around leader ownership. These additional reforms would create the lasting expectation that those appointees who answer the call to serve our nation’s veterans are capable of and accountable for effectively leading the agency. Many of the provisions of the VA Choice and Quality Employment Act, including Section 203, provide the committee with precisely these tools.

As of the date of this hearing, the Department of Veterans Affairs lacks a confirmed secretary, deputy secretary, under secretary for health and assistant secretary for information and technology.³² The effect of these vacancies should not be understated. The Under Secretary for Health leads the largest healthcare system in the U.S., with a budget of \$65 billion, hundreds of thousands of employees, and hundreds of facilities.³³ The Assistant Secretary for Information and Technology oversees a staff of over 8,000 employees and a \$4 billion budget that is comparable in scope to the largest private sector IT operations. Further, the VA Central Office (VACO) has a significant number of acting officials, which further hampers policy and management execution within the department. The changes that this committee and the VA’s many stakeholders want to see, including filling mission-critical vacancies, require permanent leadership. The administration and Senate must, therefore, take swift action to nominate and confirm candidates for these critical positions. I strongly urge the members of this committee to speak up for the need for qualified, confirmed leadership in the agency.

Recommendations

Short-Term

Authorize Market Pay for VAMC and VISN Directors

While medical professionals are the individuals on the front line delivering care, the effective functioning of the VHA enterprise is dependent on experienced and capable VAMC and VISN directors. I commend this committee for authorizing direct hire authority for this cohort, and the department deserves credit for maintaining low vacancy rates among this group. But retention of these leaders remains an issue, and a sure way of improving retention is increasing pay, as the SES pay scale was simply never designed for positions like medical facility directors. Individuals in these positions and other similar highly skilled federal employees—those with a professional degree or doctorate—tend to earn far less than their private sector counterparts. Toward this end, the Partnership recommends enacting market pay for this select group of leaders who are so essential to ensuring quality care for veterans. Additionally, we urge the committee to address limitations on the current direct hire authority for this cohort that prevents the VA from paying even at the top of the SES pay scale, hampering successful recruitment.

Use the performance plan required under Section 203 to hold leaders accountable for successfully managing the organization

As noted above, VA lacks critical data to manage its talent or link personnel and resources to strategic priorities and does little to make political leaders take ownership of the organization’s success or failure. The VA Choice and Quality Employment Act of 2017 provides new performance planning and data collection require-

³⁰ Partnership analysis of the 2017 Federal Employee Viewpoint Survey

³¹ Arnsdorf, Isaac. “Trump’s VA Is Purging Civil Servants.” Politico Magazine, March 12, 2018. <https://www.politico.com/magazine/story/2018/03/12/trump-is-trying-to-fix-the-vabut-its-backfiring-217348>.

³² “Trump Nominations Tracker”. The Washington Post. Accessed June 18, 2018. https://www.washingtonpost.com/graphics/politics/trump-administration-appointee-tracker/database/?utm_term=.af6b57628757.

³³ Ibid.

ments that can provide this accountability and give Congress greater visibility into how the VA's leaders are managing the organization. The Partnership recommends the committee work with the department to conduct regular oversight of the extent to which leaders are truly taking ownership and moving the department in the right direction.

Delegate authority to conduct Qualifications Review Boards to VA

The Partnership has previously stated in testimony to this committee that the VA would benefit from the ability to make final selections for SES positions with appropriate OPM oversight. Today, the VA is still forced to ask applicants for senior executive roles, including VAMC directors, to write lengthy essays explaining their qualifications and then to put those individuals before a Qualifications Review Board (QRB) assembled and led by OPM. The QRB serves as the last step in the SES selection process, extending the hiring process but adding limited value. Today, we reiterate our view that Congress should remove this requirement from VA and increase the department's flexibility to recruit the leadership talent it needs to strengthen the VHA healthcare system. The Senate's Fiscal Year 2019 National Defense Authorization Act proposes granting this authority to the Defense Department.

Delegate direct hire authority from OPM to the department

Direct hire authority is an important tool for filling mission-critical vacancies, as this committee has recognized through recent legislative actions to expand its use across the department. However, the current statute still requires the department to receive approval from OPM before finalizing and utilizing this authority. This step adds months to implementation and creates an extra layer of process and complexity. The Partnership recommends addressing this issue by granting the Secretary of Veterans Affairs the ability to designate positions eligible for direct hire authority, with appropriate OPM oversight on the back end and metrics to ensure that it VA uses it responsibly and fairly.

Develop, collect and report more comprehensive measures of hiring effectiveness

The Partnership has previously advocated for expanded collection and reporting requirements for aggregated applicant and hiring data. Given the ongoing concerns about shortages of workforce data raised by GAO and others, the Partnership believes this recommendation remains relevant. Beyond simply looking at vacancies in specific clinical or non-clinical positions, these data would also examine applicant pools, recruiting efforts and manager satisfaction with candidates. In fact, data on applicant pools such as physician trainees would be especially important given GAO's finding that VHA does not currently track the number of trainees hired following graduation, even though this group represents a valuable recruiting source.³⁴ The Federal Hiring Process Improvement Act of 2010, introduced by former Senators Daniel Akaka and George Voinovich, includes several measures of hiring effectiveness that could be instructive.³⁵ Providing such detailed information would make it easier for the committee to target future reforms to the VHA's talent management process.

Authorize VHA to make conditional offers to employees on the strengths of their qualifications

It is common in the private sector for hospitals and other entities competing for medical talent to make conditional offers, pending the individual's completion of their training or educational program. The federal government, however, tends to bias the hiring process against individuals without significant professional experience, even if they possess the skills to succeed. While VHA can technically make these offers now, GAO has found that many VAMC officials believe otherwise.³⁶ A congressional imprimatur in favor of early offers could give VHA officials more cover to promote contingent offers and increase the amount of younger talent.

Long-Term

³⁴ United States of America. Government Accountability Office. Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies. Washington, DC, 2018.

³⁵ Federal Hiring Process Improvement Act, S. S.736, 111th Cong. (2010).

³⁶ United States of America. Government Accountability Office. Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies. Washington, DC, 2018. 29

Create a unified personnel system for VHA

As discussed above, the unruly tangle of personnel systems is a weight around the neck of the Veterans Health Administration. Classification under these systems forces employees to accept salaries below those of both the private sector and comparable federal positions. The complexity of administering three separate systems drives human resources specialists into other federal agencies. The need to understand the unique rules and processes for each adds unnecessary time to the hiring process. The Partnership believes it is time, and well worth the investment of energy and political capital, to create a unified personnel system for the VHA. While there are legitimate concerns about the further balkanization of the federal civil service system, the uniqueness of the agency's mission and the pressing challenges it faces in recruitment, hiring and retention demand action sooner rather than later.

Reform the classification system

The General Schedule classification system, which determines pay for the vast majority of the federal workforce, is nearly seventy years old and hopelessly out of step with modern compensation practices.³⁷ Many facilities cite uncompetitive salaries stemming from administration of the classification system specifically as a key barrier to effective recruitment and retention.³⁸ Modernizing this system in a way which gives the department flexibility to craft competitive compensation packages will go a long way towards allowing the VHA to bring in the talent it needs and better serve veterans.

Conclusion

Chairman Dunn, Ranking Member Brownley, members of the Subcommittee on Health, thank you for the opportunity to present the Partnership's views on the implementation of the VA Choice and Quality Employment Act of 2017 and the continuing mission-critical hiring challenges of the Veterans Health Administration. I applaud the committee for its ongoing, bipartisan commitment to ensuring America's veterans receive the care they have earned. I look forward to continuing to work with you and the department to help it meet its goals and am happy to answer any questions you may have.

Prepared Statement of Debra A. Draper

Steps Taken to Improve Physician Staffing, Recruitment, and Retention, but Challenges Remain

Chairman Dunn, Ranking Member Brownley, and Members of the Subcommittee:

Thank you for the opportunity to participate in today's hearing on the ability of the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) to recruit and retain high-quality physicians. A strong clinical workforce capable of providing quality and timely care to our nation's veterans is critical to the success of VHA, which operates one of the largest health care systems in the United States, providing care at 1,252 facilities, including 170 VA medical centers (VAMC).¹ As the demand for VHA's services grows—due in part to increasing demand from servicemembers returning from the United States' military operations in Afghanistan and Iraq, and the growing needs of an aging veteran population—attracting, hiring, and retaining top talent is critical to VHA's mission to provide high-quality and timely health care for our nation's veterans.

Physicians—who provide and supervise a broad range of care, including primary and specialty care—serve an integral role in VHA's mission. VHA indicated that physicians occupy a top spot on its annual list of mission-critical occupations, as a result of factors including the time frames needed for VHA's hiring process, a limited supply of candidates, and competition for candidates.² Within the physician cat-

³⁷ Building the Enterprise: A New Civil Service Framework. Publication. Washington, DC: Partnership for Public Service, 2014. 16.

³⁸ United States of America. Department of Veterans Affairs. Office of Inspector General. OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY2018. Washington, DC, 2018. 13.

¹ In addition to the 170 VAMCs, VHA also operates 1,082 outpatient sites of care, such as health care centers and community-based outpatient clinics.

² VHA obtains data from its Veterans Integrated Service Networks and VAMCs on which occupations are the highest priority for recruitment and retention based on known recruitment and retention concerns, among other factors. See U.S. Department of Veterans Affairs, Veterans Health Administration, Mission-Critical Occupation Report (2016).

egory, VHA has also identified the top five physician occupations that are the hardest to recruit and retain. We use the term “mission-critical physician occupations” to refer to the top five physician occupations VHA identified in fiscal year 2016 as most in need of staffing: primary care, mental health, gastroenterology, orthopedic surgery, and emergency medicine. VHA hires more than 2,800 mission-critical physicians annually. Yet, physicians have consistently been identified by VHA as a critical staffing priority due to recruitment and retention concerns.

Over the past two decades, we and others have expressed concerns about VHA’s ability to ensure that it has the appropriate clinical workforce to meet the current and future needs of veterans.³ A 2015 independent assessment found that if VHA does not increase its total number of clinical employees, including physicians, it will be difficult for it to meet the projected demand for services.⁴ Further, in July 2016, we found that the number of physicians who leave VHA had steadily increased from fiscal years 2011 through 2015. During this time, physicians were among the 10 occupations with the highest rates of attrition each year.⁵ The attrition was primarily due to voluntary resignations and retirements.

My statement today is based on our October 2017 report examining VHA physician staffing, recruitment, and retention strategies.⁶ In particular, my statement focuses on (1) VHA information on how many mission-critical physicians provided care at VAMCs; (2) VHA guidance for determining its physician staffing needs; and (3) the strategies VHA used to support the recruitment and retention of physicians at VAMCs, and the extent to which it has evaluated these strategies to determine their effectiveness. As part of that work, we made several recommendations for VHA to improve staffing, recruitment, and retention strategies for physicians.

To do the work for our October 2017 report, we reviewed key documents and interviewed knowledgeable officials from VHA in headquarters offices, as well as in six VAMCs across the country. More detailed information on the objectives, scope, and methodology for our 2017 report can be found in that report. For this statement, we obtained information from VHA officials in June 2018 about any steps they have taken to implement our 2017 recommendations.

This statement is based on work conducted 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 audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The attrition among VHA physicians has been of particular concern given that the Health Resources and Services Administration (HRSA) anticipates that by 2025 the national demand for physician services will exceed supply. HRSA’s Office of Rural Health Policy reported, in 2017, that physician shortages were exacerbated in rural areas, where communities struggle to attract and keep well-trained providers.⁷ This difficulty has posed a particular challenge for VHA, as approximately one in four VAMCs is located in a rural area.

Most physicians providing care at VAMCs are employed by VHA. VHA also supplements the capacity of its employed physician staff by acquiring additional physician services through fee-basis arrangements or contracts. Under fee-basis arrangements, providers are paid a pre-agreed-upon amount for each service provided. Under contracts, physician services may be obtained on a short-term basis; for ex-

³We and the VA Office of the Inspector General have issued at least 16 reports between 1981 and 2017 that raised a variety of concerns about VHA’s workforce. Recent GAO reports include, 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); Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges, GAO 17 30 (Washington, D.C.: Dec. 23, 2016); and 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).

⁴See RAND Corporation, Assessment B (Health Care Capabilities), (Santa Monica, Calif. Sept. 1, 2015).

⁵See GAO 16 666R.

⁶See GAO 18 124.

⁷Department of Health and Human Services, Health Resources and Services Administration, Designated Health Professional Shortage Areas Statistic, HRSA Data Warehouse, accessed May 31, 2017.

ample, through sole-source contracts with academic affiliates.⁸ VAMCs may also use physicians who volunteer their time, who are referred to as work-without-compensation providers.

In addition to VHA-employed, contract, and fee-basis physicians, VAMCs often supplement their capacity by using physician trainees, who include medical residents and advanced fellows.⁹ In 2016, 135 of the 170 VAMCs had active physician training programs. According to VHA officials, there were 43,768 medical residents who trained at a VAMC in 2016. VHA has been expanding its physician training program, as directed by the Veterans Access, Choice, and Accountability Act of 2014, as amended.¹⁰ In 2017, VHA added 175 physician trainee positions across VAMCs nationwide, including 3 VAMCs that did not have physician trainees prior to this expansion. VHA's objective is to add 953 additional physician trainee positions to its VAMCs by 2025 in order to improve access and hire additional physicians. Further, VHA officials told us they want to continue to add new positions that would eventually allow all VAMCs access to physician trainees.

VHA Lacked Information on the Total Number of Mission-Critical Physicians Who Provided Care at VAMCs and Does Not Plan to Collect this Information

In our October 2017 report, we found that VHA's data on physicians who provided care at VAMCs were incomplete. Specifically, we found that VHA had data on the number of mission-critical physicians it employed (more than 11,000) and who provided services on a fee-basis (about 2,800), but lacked data on the number of contract physicians and physician trainees. As a result, VHA did not have data on the extent to which VAMCs used these arrangements and thus, underestimated its physician use overall. Therefore, VHA was unable to ensure that its workforce planning processes sufficiently addressed any gaps in staffing.

All six VAMCs included in our review used at least one type of arrangement other than employment for physicians, and five of the six used contract physicians or physician trainees. (See fig. 1.) On average, contract and fee-basis physicians made up 5 to 40 percent of the physicians in a given mission-critical physician occupation at each VAMC in our review.¹¹ For example, officials from a large, highly complex VAMC told us that, in March 2017, they augmented the 86 employed primary care physicians with eight contract and three fee-basis physicians, which represented about 16 percent of their primary care physician workforce.¹² Further, this VAMC also had about 64 primary care physician trainees providing certain medical services under the supervision of a senior physician.

⁸The term academic affiliate describes any of the following three entities in a partnership with a VAMC: (1) a university medical school, (2) a university hospital, or (3) a university affiliated physician practice group. If VA requires health care resources—such as physician services, medical equipment usage, or clinical space—and intends to acquire these resources from its affiliate due to its connection with a residency program, VA can enter into a non-competitive contract with that affiliate. See 38 U.S.C. § 8153(a)(3)(A). These sole source contracts are available only to VAMCs and their affiliates, and allow a VAMC to obtain physician services directly from the affiliate without competition if those services are necessary to support learning opportunities for physicians during their residency training in VAMCs. See Department of Veterans Affairs, Health Care Resources Contracting-Buying, Title 38 U.S.C. 8153, VA Directive 1663 (Aug. 10, 2006).

⁹A medical resident or fellow is a physician who practices medicine under the direct or indirect supervision of an attending physician. Successful completion of a residency program is a requirement to obtaining an unrestricted license to practice medicine. Advanced fellows are individuals who have completed all desired residency training (including fellowships) and have stayed in VHA for additional training.

¹⁰Pub. L. No. 113–146, § 301(b)(2), 128 Stat. 1754, 1785 (2014), as amended by Pub. L. No. 114–315, § 617(a), 113 Stat. 1536, 1577 (2016) (codified at 38 U.S.C. § 7302 note).

¹¹Officials from one of the six VAMCs we reviewed told us that they used both contract and fee-basis physicians, but they were not able to determine if these physicians worked in mission-critical physician occupations. Also, because physicians who are compensated on a fee-basis do not have an assigned full-time equivalent (FTE), we were unable to calculate the percentage of FTEs that contract and fee-basis physicians contribute to a VAMC. VAMC officials told us that, in order to ensure a physician is on-call 24 hours a day, 7 days a week, they may have a number of physicians on contract that only provide a limited amount of care.

¹²The contract and fee-basis physicians constituted approximately 6 percent of the VAMC's primary care FTE positions, which is lower because contract primary care physicians were often used on a part-time basis. Officials from this VAMC told us that employed primary care physicians filled 85 FTE positions, while contract physicians filled 3, and fee-basis physicians filled about 1 FTE.

Figure 1: VAMCs' Use of Contract Physicians, Fee-Basis Physicians, and Physician Trainees for Mission-Critical Physician Occupations at the Six VAMCs Reviewed for Our October 2017 Report

Facility	Contract physicians	Fee-basis physicians	Physician trainees
A			
B			
C			
D			
E			
F			

Facility used arrangement
 Facility did not use arrangement

Source: GAO analysis of Department of Veterans Affairs Medical Centers' (VAMC) data. | GAO-18-623T

During the course of our work for the October 2017 report, VHA officials told us that its personnel databases were designed to manage VHA's payroll systems, but that these databases did not contain information on contract physicians or physician trainees. VHA officials told us they were working to include information on physician trainees in a new human resources (HR) database—HR Smart—which at the time of our review, was scheduled to be implemented in 2017. However, these officials were not aware of plans to add information to the database on contract physicians. Instead, VAMC leaders used locally devised methods to identify and track contract physicians, fee-basis physicians, and physician trainees. For example, one VAMC in our October 2017 review used a locally maintained spreadsheet to track its physicians under arrangements other than employment, while another VAMC asked department leaders to identify how many of these provided care within their respective departments. At each of the six VAMCs in our review, we found that department leaders were generally knowledgeable about the total number of physicians that provided care within the departments they managed. However, this locally maintained information was not readily accessible by VHA officials.

To address the limitations in VHA's data, we recommended in our October 2017 report that VHA develop and implement a process to accurately count all physicians providing care at each of its VAMCs, including physicians not employed by VHA. VHA did not concur with this recommendation, stating that it uses other tools for workforce planning. However, a VHA official acknowledged that data sources used for workforce planning may not include all types of contract physicians or work-without-compensation physicians.

As we discussed in our prior report, implementing such a systematic process would eliminate the need for individual VAMCs to use their own mechanisms, such as a locally developed and maintained spreadsheet to track its physician workforce, as was done by one VAMC in our prior review. Further, local mechanisms may not be readily accessible to VHA officials engaged in workforce planning, resulting in incomplete information for decision-making purposes.

Since our report, VHA officials told us that they have completed implementation of HR Smart, which provides the capability to track every position with a unique position number, and each employee's full employment history. However, VHA officials told us they do not plan to enhance the capability of HR Smart to track contractors.

We continue to believe that having a systematic and consistent process to account for all physicians who provide care across VAMCs, including physicians not employed by VHA, would help address concerns that VHA is unable to identify all physicians providing care at its VAMCs.

VHA Has Begun to Develop Guidance for Determining Its Staffing Needs for All Physicians

In our October 2017 report, we found that VHA gave responsibility for determining staffing needs to its VAMCs and provided its facilities with guidance, through policies and directives, on how to determine the number of physicians and support staff needed for some physician occupations. Specifically, VHA provided this guidance for primary care, mental health, and emergency medicine, but lacked sufficient guidance for its medical and surgical specialties, including occupations such as gastroenterology and orthopedic surgery. For these occupations, VHA provided guidance on the minimum number of physicians, but did not provide information on how to determine appropriate staffing levels for physicians or support staff based on the need for care.

Specifically, the VHA guidance available at the time set a minimum requirement that VAMCs of a certain complexity level have at least one gastroenterologist and one orthopedic surgeon that is available within 15 minutes by phone or 60 minutes in person 24 hours a day, 7 days a week.¹³ VHA guidance did not include information on how to use data, such as workload data, to manage the demand for care or help inform staffing levels for these physician occupations beyond this minimum requirement. Officials from four of the six VAMCs we reviewed for our October 2017 report told us that because they lacked (1) guidance on how to determine the number of physicians and support staff needed, and (2) data on how their staffing levels compared with those of similar VAMCs, they were sometimes unsure whether their staffing levels were adequate.

In our October 2017 report, we discussed that VHA had previously established, in 2016, a specialty physician staffing workgroup that examined the relationships between staffing levels, provider workload and productivity, veterans' access, and cost across VAMCs for its medical and surgical specialties, including gastroenterology and orthopedic surgery. This group's work culminated in a January 2017 report that found VHA was unable to assess and report on the staffing at each VAMC, as required by the Veterans Access, Choice, and Accountability Act of 2014, because a staffing model for specialty care had not been established and applied across VAMCs. This report made a number of recommendations, including that VHA provide guidance to its VAMCs on what level of staffing is appropriate for its mission-critical physician occupations. However, as we noted in our October 2017 report, VHA leadership had not yet taken steps to develop such staffing guidance. We reported that, according to a VHA official, other priorities were taking precedence and continued work in this area had not yet been approved by VHA leadership. Although VHA officials agreed that further steps should be taken, they did not indicate when these would occur. In our report, we concluded that until VHA issues guidance on staffing levels for certain physician occupations that provide specialty care to veterans, there would continue to be ambiguity for VAMCs on how to determine appropriate staffing levels.

To address this, we recommended that VHA develop and issue guidance to VAMCs on determining appropriate staffing levels for all mission-critical physician occupations. VHA concurred with our recommendation and reported it would evaluate and develop staffing guidance for its medical and surgical specialties.

Since our report, VHA officials told us that on November 27, 2017, the Executive-in-Charge for VHA signed the specialty care workgroup charter. The primary goal of the workgroup is to develop a specialty care staffing model that will include staffing information for all specialty care. VHA anticipates completing its work and issuing staffing guidance by December 2018.

VHA Used Multiple Strategies for Physician Recruitment and Retention, but Has Not Comprehensively Evaluated Them to Assess Effectiveness

In our October 2017 report, we found that VHA used various strategies to recruit and retain its physician workforce, including providing assistance recruiting for mission-critical physician occupations through the National Recruitment Program; policies and guidance; financial incentives to enhance hiring and retention offers; and a national physician training program. (See table 1.)

¹³VHA categorizes VAMCs according to complexity level, which is determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions, and administrative complexity. There are three complexity levels with level 1 representing the most complex facilities and level 3 the least complex. Level 1 is further subdivided into categories 1a, 1b, and 1c. Therefore, VAMCs that are categorized as level 1a would offer the most advanced and complex medical treatment within VHA's medical care system.

Table 1: VHA Physician Recruitment and Retention Strategies

Providing assistance recruiting for mission-critical physician occupations	VHA operates the National Recruitment Program that provides direct physician recruitment services to Veterans Affairs medical centers (VAMC) for hard-to-recruit positions, including physicians. This program, which had 19 physician recruiters as of May 2017, according to officials, represents VHA at medical conferences, screens resumes, and develops marketing materials, among other things, to identify and refer physician candidates to VAMCs..
Policies and guidance	VHA administers the policies and guidance developed by VA that provide the basic framework for hiring, paying, promoting, and retaining physicians. Using in-person and webcast sessions, VHA also provides basic and advanced training to VHA staff on personnel policies..
Financial incentives	VHA provides financial incentives to strengthen efforts to recruit and retain physicians and help to narrow the differences between VHA salary offers and those of private sector employers. VAMCs adjust market pay, one component of physician compensation, to reflect a physician's training, experience, and prevailing pay levels in the local medical community. Additionally, VHA may offer other types of financial incentives such as the Education Debt Reduction Program, which reimburses qualifying education loan debt for employees, including physicians, in hard-to-recruit positions..
Physician training program	VHA's physician training program provides VAMC officials with the ability to regularly interact with trainees and identify top-performing physicians who would be a "good fit" for permanent employment. According to officials, access to this pool of potential hires serves as an important recruitment resource..

Source: Veterans Health Administration (VHA) / GAO 18 623T

In our October 2017 report, we found that VHA faced challenges using its strategies for recruiting and retaining physicians. For example, according to VHA officials, budget shortfalls in the Education Debt Reduction Program—which reimburses qualifying education loan debt for employees, including physicians, in hard-to-recruit positions—reduced VAMCs' ability to offer this recruitment incentive to physician candidates. In addition, the relatively small number of physician recruiters in VHA's National Recruitment Program—19 recruiters for the 170 VAMCs at the time of our report—limited their ability to understand the particular nuances of some markets, particularly in rural areas.

Further, despite VHA's large and expanding graduate medical training program, VAMCs experienced difficulties hiring physicians who received training through its residency and fellowship programs. VHA did not track the number of physician trainees who were hired following graduation, but officials told us that the number was small in comparison to the almost 44,000 physician trainees educated at VAMCs each year.

We found that VAMCs faced challenges hiring physician trainees, in part, because VHA did not share information on graduating physician trainees for recruitment purposes with VAMCs across the system. VHA officials told us that recruitment efforts could be improved by developing and maintaining a database of physician trainees, but said that VHA had no such database. According to VHA officials, information sharing could help both VAMCs in geographically remote locations that do not have a residency program and help identify trainees who want to work at VHA after graduating, but who received no offers from the VAMC they trained at due to the lack of vacancies in their specialty.

We also reported in October 2017 that VHA did not have complete information on whether its recruitment and retention strategies were meeting its needs. VHA had gathered feedback on barriers VAMCs face when offering financial incentives to physician candidates through its Education Debt Reduction Program and created a workgroup to look at its overall use of physician retention strategies, although it had not completed a comprehensive review of its recruitment and retention strategies to identify any areas for improvement. As a result, VHA did not have complete information on the underlying causes of the difficulties VAMCs faced or whether its recruitment and retention strategies met its objective of having a robust physician workforce to meet the health care needs of veterans.

To address these issues, we recommended that VHA (1) establish a system-wide method to share information about physician trainees to help fill vacancies across VAMCs, and (2) conduct a comprehensive, system-wide evaluation of its physician

recruitment and retention efforts, and establish an ongoing monitoring program. VHA concurred with our recommendations, and reported it planned to enhance its personnel database, HR Smart, to include physician trainees. Additionally, VHA said it planned to complete a comprehensive, system-wide evaluation of the physician recruitment and retention strategies.

Since our report, VHA reported taking some steps to address these recommendations. Specifically, officials told us they are working to include information in the newly implemented HR Smart database on work-without-compensation employees, such as physician trainees, and anticipate conducting pilot projects at various sites before fully implementing this capability by September 30, 2019. Additionally, officials said that they are in the process of completing a review of physician recruitment and retention incentives. Furthermore, according to VHA officials, beginning in October 2017, VHA's Office of Workforce Management and Consulting partnered with the Partnered Evidence-based Policy Resource Center—an internal VHA resource center—to evaluate and recommend a systematic approach for allocating workforce management resources, such as the Education Debt Reduction Program. VHA expects to complete its efforts by September 2018.

Chairman Dunn, Ranking Member Brownley, and Members of the Subcommittee, this concludes my statement. I would be pleased to respond to any questions you may have.

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Key contributors to this statement were Janina Austin (Assistant Director), Sarah Harvey (Analyst-in-Charge), Jennie Apter, Frederick Caison, Alexander Cattran, and Krister Friday.

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Prepared Statement of Michael J. Missal

Mr. Chairman, Ranking Member Brownley, and members of the Subcommittee, thank you for the opportunity to discuss my office's recent report, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages for Fiscal Year 2018*.¹ Although this is the fifth Office of Inspector General (OIG) report on staffing shortages within VA's healthcare system, it is the first report that includes facility-specific data reported by leaders at 140 VA medical centers.

Previous OIG reports examined Veterans Health Administration (VHA) national staffing shortages for clinical staff only. The report released last week, in contrast, allows users to examine the particular self-reported needs of an individual facility as opposed to only national data. In keeping with statutory changes, this report also includes nonclinical occupations (such as human resources and custodial personnel) that ultimately affect the ability of VHA facilities to provide quality and timely patient care in a safe environment. This shift to facility-specific data reveals the staffing gaps in both clinical and nonclinical occupations identified by each VA medical center, which have not been apparent in previous reports containing only aggregate data. The results underscore how variable the needs are from one medical facility to another.

BACKGROUND

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

Our past reports have described the following aspects of staffing:

- Mission critical occupations - Medical officer, nurse, psychologist, and physician assistant were occupations consistently included in our top five determinations of occupational staffing shortages. Physical therapist was initially in the top five, but was replaced by medical technologist in our 2017 report.
- Gains and losses - We reported that overall hiring at VHA is increasing. Our analysis of staffing gains and losses shows that for mission critical occupations, a significant percentage of total gains were offset by losses. We made recommendations regarding reducing the number of regrettable losses and voluntary departures.³
- Staffing models - The OIG has recommended that VHA develop and implement staffing models for critical occupations. We recognize that VHA has implemented staffing models in specific areas such as primary care and inpatient nursing. VHA has also expanded the occupations covered by such models. However, operational staffing models that comprehensively cover critical occupations are still needed. The OIG 2017 report states that, "In the absence of facility-

¹ The report was published on June 14, 2018.

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 Regrettable losses are defined as those individuals who resign from VA or who transfer to other government agencies. Regrettable losses are staff who potentially could have continued employment in VA and represent an opportunity for VA to retain staff.

specific staffing targets or an operational staffing model, determining whether facilities are making meaningful progress in filling critical staffing shortages is challenging.”

The 2017 report also notes that despite having staffing models for some occupations, many medical centers reported relying on additional data when evaluating their staffing needs. An overwhelming majority specified they continued to use a locally developed process as opposed to a formal staffing model. Even when they have a methodology, additional data is desired and greater refinement is needed.

VHA'S OCCUPATIONAL STAFFING SHORTAGES FOR FISCAL YEAR 2018

The VA Choice and Quality Employment Act of 2017 (PL 115–46) expanded the reporting requirement to include both clinical and nonclinical positions as well as requiring information for each VA medical center. Consequently, the OIG conducted a facility-specific survey to determine current local staffing levels and identify shortages. The OIG requested that VA medical center directors designate and rank each occupation for which there is a shortage at their facility. This shortage information should spur discussions about how best to meet facility-specific needs.

As in previous years, the OIG analyzed staffing data using the Office of Personnel Management's (OPM) occupational series. We augmented our analysis this year by including VHA assignment codes to provide additional detail about the shortages in the medical officer and nurse occupational series. For example, these codes help distinguish a psychiatrist from a neurosurgeon—two physicians that would fall under the umbrella OPM occupation series of “medical officer” but provide significantly different types of care.

Recent OIG reports have demonstrated the importance of including nonclinical positions in reports of staffing shortages. For example in our March 2018 report, *Critical Deficiencies at the Washington DC VA Medical Center*, we detail how excessive vacancies in key departments can affect patient care. 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. Without properly cleaned instruments, clinical areas, and storage rooms, the risk of infection increases to patients. Failing to have enough staff to order prosthetics and supplies, and track them, also can impact patient care.

Clinical and Nonclinical Results

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. Our analysis 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. Included in Appendix A is a table with the frequency of facility-designated occupational shortages.

The results demonstrate that although there are clusters of commonality, there is also wide variability in occupational shortages reported by individual medical centers. This is critically important to recognize because facilities have distinct staffing needs that must be considered. For example, a rural facility that specializes in the treatment of mental health will need to be staffed differently than an urban facility in downtown Manhattan that provides a broad array of services.

Reasons for Shortages

The report also identified challenges to meeting staffing goals. Because VHA utilizes OPM's criteria for supporting evidence that must be submitted to claim a “severe shortage of candidates” in generating its Mission Critical Occupation Report, we applied the same criteria. We provided the directors being surveyed with information from Title 5 of the Code of Federal Regulations regarding OPM's Direct Hire Authority Severe Shortage of Candidates. The directors were able to use free text for providing information on the reasons for shortages, and the reasons varied significantly. OIG staff's thematic analysis of the responses resulted in three frequently

cited categories: (1) lack of qualified applicants, (2) non-competitive salaries, and (3) high staff turnover.⁴

OPM Direct Hire Authority Severe Shortage of Candidates
(b)... An agency when requesting direct-hire authority under this section, or OPM when deciding independently, must identify the position or positions that are difficult to fill and must provide supporting evidence that demonstrates the existence of a severe shortage of candidates with respect to the position(s). The evidence should include, as applicable, information about
(1) The results of workforce planning and analysis;
(2) Employment trends including the local or national labor market;
(3) The existence of nationwide or geographic skills shortages;
(4) Agency efforts, including recruitment initiatives, use of other appointing authorities (e.g., schedule A, schedule B) and flexibilities, training and development programs tailored to the position(s), and an explanation of why these recruitment and training efforts have not been sufficient;
(5) The availability and quality of candidates;
(6) The desirability of the geographic location of the position(s);
(7) The desirability of the duties and/or work environment associated with the position(s); and
(8) Other pertinent information such as selective placement factors or other special requirements of the position, as well as agency use of hiring flexibilities such as recruitment or retention allowances or special salary rates.

Figure 1. Provisions of 5 CFR 337.204

Recommendations

Our 2018 report repeats the OIG’s previous calls for VHA to develop a new staffing model that identifies and prioritizes staffing needs at the national level while supporting flexibility at the facility level to ensure taxpayer dollars are invested in delivering the highest quality of care to veterans. Without the ability to analyze accurate data, VHA risks spending significant dollars without any measurable improvement in the quality of health care. VA’s focus on developing a comprehensive staffing model will lead to more efficient hiring practices and result in fewer recruitment challenges and an increased capacity to serve veterans’ needs.

CONCLUSION

The OIG’s 2018 survey provides facility specific data on staffing shortages reported by the leaders of the 140 VA medical centers and highlights the need for a model that identifies and prioritizes staffing needs allowing flexibility at the facility level. This report should prompt meaningful discussions at both the local and national levels about how to implement, support, and oversee staffing in VA medical centers that will result in the best possible care for veterans.

Mr. Chairman, this concludes my statement, and I would be pleased to answer any questions you or other members of the Subcommittee have.

Table 1. Frequency of Facility-Designated Occupational Shortages

	Occupational Series or Assignment Code	Occupation	Number of Facilities Marked the Occupation as a Shortage
1	31	Psychiatry	98
2	0201	Human Resources Management	92
3	P1	Primary Care	66
4	0180	Psychology	58
5	0644	Medical Technologist	56
6	0801	General Engineering	55

⁴The thematic analysis categories were developed after reading all the responses. Responses that fell outside of the developed categories were classified as “other.”

Table 1. Frequency of Facility-Designated Occupational Shortages—Continued

	Occupational Series or Assignment Code	Occupation	Number of Facilities Marked the Occupation as a Shortage
7	0083	Police	52
8	K6	Hospitalist	49
9	16	Emergency Medicine	48
10	0620	Practical Nurse	46
11	3566	Custodial Worker	46
12	25	Gastroenterology	45
13	88	Staff Nurse	44
14	12	Urology	42
15	7	Orthopedic Surgery	42
16	0603	Physician's Assistant	39
17	0622	Medical Supply Aide and Technician	39
18	0647	Diagnostic Radiologic Technologist	39
19	75	Nurse Practitioner	39
20	0633	Physical Therapist	37
21	0649	Medical Instrument Technician	37
22	20	Dermatology	36
23	30	Neurology	35
24	38	Radiology-Diagnostic	33
25	0631	Occupational Therapist	31
26	1	Anesthesiology	31
27	7408	Food Service Worker	31
28	0858	Biomedical Engineering	30
29	21	General Internal Medicine	30
30	26	Pulmonary Diseases	29
31	40	Geriatrics	29

OIG Determinations of Veterans Health Administration's Occupational Staffing Shortages, June 14, 2018, page 11

Prepared Statement of Peter J. Shelby

Good morning, Mr. Chairman, Ranking Member Brownley, and Members of the Committee. Thank you for the opportunity to discuss staffing for the Department of Veterans Affairs (VA). I am accompanied today by Ms. Jessica Bonjorni, Veterans Health Administration (VHA) Acting Assistant Deputy Under Secretary for Health for Workforce Services.

We are excited to report to you the progress VA has made in the last year to support recruitment and retention for the professionals who provide healthcare, benefits assistance, and memorial services to our Veterans.

Leadership Training Plan

VA is partnering with numerous private-sector organizations to strengthen the leadership and technical skills of VA executives, while at the same time leveraging the relationships to identify innovative strategies, best practices and technologies to drive transformational changes in VA healthcare management and delivery systems. The Executive Management Fellowship (EMF) program allows for reciprocal assignments of private-sector executives in VA facilities and VA executives in private sector healthcare organizations. VA is currently finalizing the hosting agreements and identifying the VA participants in this program, with the initial cohort to be selected by mid-July 2018. Once the fellowship agreements are in place, VA will extend reciprocal Fellowship opportunities to employees in the partner private-sector organizations. We anticipate having up to 20 EMFs in the year-long program in private-sector healthcare organizations across the country beginning this October, with private-sector EMFs being hosted in VA facilities shortly thereafter.

Military Transition

VA has developed a three-pronged approach to encouraging transitioning Servicemembers to consider employment at the Veterans Health Administration. VA has partnered with Department of Defense (DoD) military installations in the National Capital Region on an initiative called Military Transition and Training Advancement Course (MTTAC). MTTAC is an entry-level training program for Servicemembers currently enrolled in the transition process, who anticipate being released from active duty within 90 to 120 days. This training program is modeled after VA's very successful Warrior Training Advancement program, which trains transitioning Servicemembers to serve as benefits claims examiners. VA's MTTAC program is currently set up to train Servicemembers to become medical support assistants, with the goal of hiring them into VA immediately upon separation from the military. As part of the course, Servicemembers are also provided with general Federal employment tips, including how to write a Federal resume and how to apply for Federal jobs. The first course was in May 2018, and the next class is scheduled for July 16–27, 2018 at Walter Reed National Military Medical Center. This course is expected to be offered at Fort Belvoir and Aberdeen Proving Ground in August 2018.

VA is also using a direct marketing campaign to attract military medical professionals currently enrolled in the transition process. VA uses the VA–DoD Identity Repository data to identify Servicemembers, time of discharge, and military occupational specialty. The first campaign will launch on June 30, 2018.

In addition, the Intermediate Care Technician (ICT) Program is an established VA program to recruit former military medics and corpsmen into positions in VA Medical Center (VAMC) emergency departments and other specialty areas. ICTs are aligned organizationally under licensed independent practitioners in the clinical setting to maximize their utility and value to Veteran care. This program has been piloted in VA and was deployed to 23 VA VAMCs at the start of fiscal year (FY) 2018. VA intends to expand this program to all 171 VAMCs.

System-wide Method to Share Information about Physician Trainees

In close partnership with the Office of Personnel Management, VA has evaluated new requirements necessary to track physician trainees in HR–Smart and is developing requirements for VA's interface with the USA Staffing information system. The current USA Staffing interface design does not currently include “without compensation” employees. A 90-day pilot is currently underway to test the technical solution being proposed to track physician trainees to assess employment and retention of trainees. Afterward, additional pilot projects at various sites will be performed, including full application of the trainee onboarding initiative. The anticipated completion date for these pilot projects is the fourth quarter of FY 2019.

Physician Recruitment & Retention Strategies

VA has taken steps to complete a comprehensive, system-wide evaluation of the physician recruitment and retention strategies. VA's Office of Workforce Management and Consulting (WMC) is in the process of completing a review of physician recruitment, relocation, and retention incentives by specialty as well as a comparison of salary data for local markets.

VA's WMC is working with VA's Partnered Evidence-based Policy Resource Center to evaluate the impact of market trends and recruitment and retention incentives to target resources effectively. To date, analysis is conducted at the VAMC level. Targets for FY 2018, Q3 are focusing on analysis at the individual employee level to provide a richer variation and more statistical power to measure the impact

of Federal-private wage differential, impact of incentives such as the Education Debt Reduction Program, recruitment, retention and relocation incentives on employees receiving such benefits and other variables of interest.

WMC is also actively collaborating with Quality Enhancement Research Initiative partners to evaluate and refine strategic allocation of workforce resources for critical staffing needs within the top clinical staffing shortage occupations (physicians, registered nurses, physician assistants and psychologists). Ongoing activities include evaluation and development of existing recruitment and retention incentives, loan repayment and scholarship programs. Components of the recruitment and retention evaluation specific tasks include not only evaluating the effectiveness of these recruitment and retention programs, but also exploration of predictive turnover, retention profiling, and a pilot design for a strategic approach of workforce resources. The study is expected to conclude by the end of FY 2018.

Staffing Models for Critical Need Occupations

The VA Specialty Care Staffing Working Group continues its efforts. The team is building and establishing an integrated set of costing, forecasting and productivity tools based upon the latest 2016 and 2017 information. Previous work by the team established a data baseline, demonstrating the relationship between Veteran demand for Specialty Care services with corresponding cost, complexity and productivity factors. The team is now evaluating the results and developing staffing models and decision matrices for medical facilities to use when setting Specialty Care staffing requirements. The anticipated completion date for initial delivery is September 2018.

Meanwhile, VA continues to evolve its clinical staff modeling and workforce planning for other practice areas. VA is leveraging long-standing staffing models for primary care, mental health, and nursing; and is developing, evaluating, and refining additional staffing models for other functional areas. VA provided technical support to the Office of the Inspector General (OIG) for an OIG independent assessment of field occupational staffing priorities in February 2018. VA OIG released their report to VA, the results will be incorporated into the next round of clinical staffing planning assessments. The anticipated completion date is September 2018. The Medical Center results will be published in the Federal Register by September 2018.

VA is establishing a manpower capacity for the entire Department, with the creation of a permanent manpower office in the Office of Management, and is leveraging HR Smart as a technical solution-enabling position management. VHA is closely integrated with the Department's efforts and is committed to deploying a position management solution for both clinical and non-clinical requirements.

An updated, efficiently aligned position categorization structure will enable VA facilities to more precisely define their clinical and non-clinical staffing requirements. Such a structure will also enable staffing predictive power on the part of VAMCs and Veterans Integrated Service Networks, and will simultaneously enable the flow of staffing requirements to the enterprise level, facilitating national recruitment efforts and budget formulation.

Predicting Staffing Changes

The VA Enrollee Health Care Projection Model (EHCPM), developed in 1998, is a sophisticated healthcare demand projection model and uses actuarial methods and approaches to project Veteran demand for VA healthcare. These approaches are consistent with the actuarial methods employed by the Nation's insurers and public providers, such as Medicare and Medicaid. The EHCPM projects enrollment, utilization, and expenditures for the enrolled Veteran population for more than 90 categories of healthcare services 20 years into the future.

A key component in of the EHCPM is "reliance." A unique aspect of the enrolled Veteran population is that enrollees have many options for healthcare coverage in addition to VA: Medicare, Medicaid, TRICARE, and private insurance. Approximately 80 percent of enrollees have some type of public or private healthcare coverage in addition to VA. As a result, enrollees rely on VA for approximately one-third of their healthcare needs. Changes in enrollee reliance occur as a result of many factors, such as enrollee movement into service-connected priorities, changing economic conditions, VA's efforts to provide Veterans access to the services they need, VA's efforts to enhance its practice of healthcare, the opening of new or expanded facilities, and the availability of services and/or the cost sharing associated with services in the private sector.

The VHA Office of Enrollment and Forecasting and the Specialty Care Delivery Network Model Work Group Co-Chairs (WMC and National Surgery Office) are incorporating EHCPM data into its staffing model development, including the Specialty Care Delivery Network Model. VA will continue to expand its capability to

predict Veteran demand for care and to further enhance the ability of its staffing models to leverage demand prediction.

This remains a critical activity, and as noted above is being conducted as a subset of the Specialty Care Services Staffing workgroup. The team is currently analyzing enrollee demand for all healthcare within a healthcare market (whether received in a public or private setting), not just within a framework of demand in the context of VA facilities. The anticipated completion date is the end of 2018.

Training Human Resource Specialists

Through April 2018, there have been 422 new General Schedule (GS) 201 Human Resources (HR) specialists hired into VA. At the start of FY 2018, VA launched a course called 201 Jumpstart. This self-paced virtual course helps orient HR professionals to VA, and includes training on how to best recruit and retain employees. Following the completion of this course, new HR Specialists enroll in the New Talent Development Program (NTDP) which is a face-to-face training that provides comprehensive HR training on two tracks: (1) Staffing/Classification and (2) Employee Relations/Labor Relations/Performance Management. After piloting NTDP in the first two quarters of FY 2018, the program is now expanding to enroll all newly hired HR Specialists, with annual throughput capacity of 900 employees. To date, 120 HR Specialists have completed the NTDP, with an additional 34 currently enrolled.

Mental Health Hiring

VA has committed to achieving a net gain of 1,000 Mental Health (MH) Providers by the end of this calendar year. As of June 8, 2018, VA has achieved a net gain of 424 new MH clinicians. As part of this MH hiring initiative, VA used a new workforce planning approach that has proven to be a successful proof of concept for early VA manpower capabilities, including analysis of workforce and mitigation of regrettable losses. In addition, VA launched the first VA MH Trainee and Early Career Connection and Recruitment event, to help potential candidates connect, match, and interview with local VAMCs that are hiring. Approximately 2,000 matches have been made between participants and 75 VAMCs. The VA MH Trainee and Early Career Connection and Recruitment event will run through late July 2018.

Conclusion

VA appreciates Congress's support, which allows us to train future healthcare professionals to care for Veterans and the Nation as a whole. Mr. Chairman, this concludes my testimony. My colleague and I are prepared to answer any questions you, Ranking Member Walz, or other members of the Committee may have.

Statements For The Record

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO (AFGE)

Chairman Dunn, Ranking Member Brownley, and Members of the Subcommittee:

The American Federation of Government Employees, AFL-CIO (AFGE) and its National VA Council (NVAC) appreciate the opportunity to submit a statement for the record for the June 21, 2018 hearing titled, "More Than Just Filling Vacancies: A Closer Look at VA Hiring Authorities, Recruiting and Retention." AFGE and NVAC represent more than 700,000 employees in the federal and D.C. government, including 250,000 front line employees at the Department of Veterans Affairs (VA) providing comprehensive benefits, health care, and other critical services for veterans.

As numerous studies, reports, and anecdotal evidence have shown, veterans receive the best care for their conditions in a system that is specifically designed for the treatment of veterans, the VA. In turn, it is not surprising that the preferred "CHOICE" of veterans regarding where to receive care is also the VA. Because of these preferences, and the nation's commitment to those and the families of those who have served, Congress must do all in its power to staff the VA to a point where capacity meets the VA's exceptional demand, and where veterans receive the VA care they have earned. If proper staffing is not accomplished and positions are not filled, the VA will continue down the path of privatization, and veterans will instead have a "CHOICE" made for them by being sent to non-VA care.

AFGE and NVAC welcomes the opportunity to comment on several components that have an impact on the future of VA staffing, including:

Office of Inspector General Report on Staffing

For years AFGE and NVAC have urged Congress to take a real look at hiring at the VA. With over 33,000 unfilled positions currently on the books at the VA, this hearing is timely. It is impossible for us to keep the promise made to our veterans without adequately funding and staffing the VA. The VA provides world-class, comprehensive, veteran-centric care and services that simply are unavailable elsewhere and that is a system which must be preserved. We hope that the end result of the hearing today is with an even greater interest in staffing and a desire to fill all 33,000 vacant VA positions.

Additional data on nonclinical staffing needs: Last week the VA Office of Inspector General (OIG) released its annual report on staffing at the VA. Unlike past years, Congress directed the OIG to now include the top five clinical and non-clinical occupations which are the most short staffed. To comply, the OIG released data from 140 VA facilities nationwide and rank ordered the data based on how frequently the facilities cited an occupation as short staffed.

AFGE and NVAC were pleased to see the OIG provide a more thorough and complete review of facility staffing deficiencies including additional data on nonclinical staffing needs. This information will be useful to all stakeholders as we attempt to identify how to best staff the VA and fill these vacancies with fulltime federal employees who will make a career out of serving our veterans.

AFGE and NVAC are pleased to see an increased spotlight on the need for adequate staffing of nonclinical positions. Staffing levels for VA police ensure the safety of patients and employees, and staffing the VA with an appropriate number of custodial workers reduces the risk of hospital-acquired infections. These are life and death issues.

Given the enormous burden that Choice and other non-VA private care programs have placed on VA's own support staff who are handling consults, medical records and requests for assistance from patients trying to navigate the private care maze, AFGE and NVAC strongly recommend that additional staffing data be collected to reflect staffing needs for these support positions as the Mission Act is rolled out.

Mental health staffing needs: Sadly, once again mental health topped the list of difficult to fill positions in the OIG report. Of the 140 facilities surveyed, 98 facilities listed psychiatrist as the position which is most difficult to fill. This made mental health the top category of those reported in the surveys. At a time when private sector entities are hoping to carve out mental health care as a primary avenue for privatization, this finding is particularly disturbing. The VA does veteran-centric mental health care better than any comparable entity in the private sector, and those professionals work every day to make sure our veterans get the help that they need.

AFGE and NVAC urge Congress to work to increase internal capacity within the VA's mental health practices instead of supplementing this care with the private sector. AFGE and NVAC are very troubled by field reports from our locals who have observed that there appears to be widespread noncompliance with VA's own mental health staffing ratios. Chronic short staffing of clinicians providing mental health treatment to our wounded warriors will directly undermine VA's continued ability to provide the exemplary specialty mental health care and Primary Care Mental Health Integration that are a national model.

Direct Hire Authority

The VA has long called for, and the Congress has consistently provided, direct hiring authority to bypass the regular civil service process and fill positions within the VA. Less than a year ago, in August of 2017, the "VA Choice and Quality Employment Act of 2017" was enacted into law. This law goes beyond traditional direct hiring authority, and exclusively grants the VA additional direct authority when "there exists a severe shortage of highly qualified candidates" (Sec. 213). Furthermore, just as recently as last month, the VA MISSION ACT was signed into law, making two distinct references to how the VA should use direct hiring authority. Specifically, it says it should be used as a part of the remediation of closed medical service lines (Sec. 109), as well as for addressing the problems facing underserved facilities (Sec. 401).

Currently, tens of thousands of vacancies exist throughout the VA, and short staffing requires some veterans to receive non-VA care despite their preference to be treated within the VA. While the aforementioned laws address VA's direct hire authority, we must ask how the VA is using these hiring tools to address staffing challenges.

Accountability Act

Since the day of its introduction, AFGE and NVAC have vociferously opposed the “Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017.” AFGE opposed this law with the belief that it would lead to a purge of front-line employees at the VA, including many veterans continuing their service to the nation within the VA, while failing to address managers who have failed in their ability to lead staff and serve the mission of the VA. While the VA has made collection of data related to terminations under the powers granted by the Accountability Act difficult to say the least, AFGE and NVAC have worked to compile and analyze data from these terminations. Through February 2018, 1646 individuals were removed under the Accountability Act, including 44 physicians, 100 Registered Nurses, 51 Licensed Practical Nurses, 40 Nurses, and eight Physicians Assistants, while only 18 Supervisors were terminated. With so many veterans requiring care, it is counterproductive to arbitrarily terminate medical personnel in short supply, while simultaneously failing to hold supervisors accountable. AFGE and NVAC are very pleased that a bipartisan bill, the VA Personnel Equity Act of 2018 (HR 6101) has just been introduced to restore critical workplace rights that the 2017 law severely weakened or eliminated. Regarding staffing, passage of this legislation will enable the VA to restore a more just and fair workplace that will enable it to be on a more level playing field in competing with other health care employers,

Transparency

AFGE and NVAC have urged Congress to seriously address VA staffing in a way that is transparent to patients, workers, and job seekers. We were pleased to see Congress include new transparency language in the VA MISSION Act, which is now law. Specifically, Sec. 505 of the new law requires the VA to submit a report to Congress outlining how many unfilled positions exist by occupation and by facility. This information will be posted on a publicly available website so that all interested parties will have access to the information. This section of the new law is an important step forward in staffing transparency at the Department. For entirely too long we have allowed the public to only see one side of the VA story: wait times. Now the public will be able to see how many unfilled positions exist at these facilities and ask questions about why those positions are going unfilled. We were also pleased to see Sec. 505 include a reporting requirement so that the Department will have to face Congress and explain what steps it is taking to fully staff every VA facility across the country. This new transparency requirement is important, and we ask that Congress make certain that the VA complies with this section of the new law.

Other comments: Physician Assistant Pay

As the OIG noted in its June 14, 2018 report, VHA has consistently faced a shortage of physician assistants (PA) in its workforce. Section 212 of the VA Choice and Quality Employment Act of 2017 (VCQEA) added the requirement that physician assistants employed by VHA receive competitive pay through the same locality pay setting process already in place for registered nurses.

AFGE and NVAC have monitored the implementation of this new PA pay requirement. Our locals in multiple locations report problems with the types of surveys used. Management at some facilities are using 2016 contract wage surveys and they appear unwilling to consider any other options. Given that the Medical Center Director has total discretion over the salary levels when converting to the new salary schedule and is only required to notify the Secretary of his decision, this leaves little recourse for the PAs adversely affected by the choice of survey, or their employee representatives to challenge unfair salary schedules.

As a result, despite these new provisions in the law, PAs working for the VA are paid significantly less than other PAs in the same local market; some report a \$20,000 pay gap. PAs with longstanding tenure with the VA are facing some of the worst pay gaps due to the VA’s current pay ceilings for PAs.

PAs also report that their years of experience are undervalued relative to VA advanced practice registered nurses (APRNs). For APRNs working at the VA, nursing years of experience are counted as years of experience towards their APRN salary determination. This practice results in APRNs receiving higher salaries than PAs with the same or less APRN experience.

AFGE and NVAC appreciate the opportunity to comment on these important staffing issues.

WHISTLEBLOWERS OF AMERICA

Mr. Chairman and Ranking Member:

Whistleblowers of America (WoA) was established as a nonprofit in 2017 to provide peer support and advocacy to whistleblowers suffering the ill-effects of retaliation. Although it receives contacts from various sectors and communities, whistleblowers from the Department of Veterans Affairs (VA) is the clear majority. When similar concerns were raised by VA employees about their retention, reprisal, demotion, termination, and constructive dismissal WoA wanted to learn more, so we asked for feedback. We were hearing multiple concerns from employees (and veterans) about the new Office of Accountability and Whistleblower Protection (OAWP), WoA wanted to develop a more comprehensive understanding of interactions people were having with the OAWP. WoA has included the Findings section upfront and actual comments for VA whistleblowers in Background.

In previous testimony to this Committee, WoA has cited its concerns for high turnover rates and vacant positions in the neighborhood of 40,000. WoA believes some of this turnover and difficulty to fill position is due to the retaliation, discrimination, harassment, and hostile work environment that VA employees find themselves subject to. This reputation does not make VA an organization of choice. The Federal Employees Viewpoints Survey (FEVS) of all government employees shows VA to be amongst the less favorable places to work. If we want to hire qualified, competent providers, we must give them a positive work environment.

Summary of Findings:

Although whistleblowers are bringing forward a variety of different issues related to disclosing wrongdoing, the retaliation occurs along similar lines. Whistleblowers report to WoA that they experience further reprisal in the form of harassment/violence, gaslighting, mobbing, ostracizing, marginalizing and devaluing, double-binding, blackballing and counter accusing.¹ They describe these conditions as evidence of retaliation in hopes that OAWP will be able to protect and assist them quickly. However, that is often not the case. The OAWP is plagued with deficiencies related to timeliness, process and staffing further effecting outcomes.

Timeliness - The OAWP, which employees perceive as having been created to help them, has caused most of them more harm as evident by some of the comments. Across the board, OAWP does not provide timely responses. When a whistleblower contacts the OAWP, they are assigned a case manager who asks them to fill out the VA Form 10177. Whistleblowers wait several months and are then given “boilerplate” answers. They are told that they will hear back, but then they never do.

Process - Another consistent issue with OAWP is that it appears limited in its protocol for engagement. Because of the language in the VA Form 10177, attorneys have advised clients not to sign it because it creates some conflicts of interest and may be interpreted to waiving certain rights. However, once signed and a case manager assigned, the process entails a report to the OAWP Director, but then the information goes back to the VISN or RO Director, the hospital director and then to the supervisor, who is usually the person reported in the first place. Retaliation increases.

This process seems to also involve hospital chiefs of staff sending letters of investigation to license boards and professional association that have career ending implications. Doctors are reported to the National Practitioner Data Bank (NPDB) even when no charges have been substantiated but once identified to the NPDB a medical career is virtually over. Living under this threat is causing some practitioners to leave the VA out of fear. A Readjustment Counseling Services conference in June 2018 reportedly ended with Vet Center employees being reminded that Trump has curtailed your due process rights and that they can be fired at any time.

OAWP engagement seems limited to “trafficking” the paperwork and monitoring the whistleblowers, but not a lot of advocacy or assistance. They do not appear to have the capability to investigate, mediate, or arbitrate an outcome. They should also be required to provide case management updates and disclose an outcome. Although privacy of all parties must be respected, the whistleblower should at least be able to receive notice on the section(s) of law reviewed and how it was applied.

Staffing - The one whistleblower who identified the job series issue appears to have hit a key element that is challenging engagement effectiveness. Since the OAWP was created by overtaking the former OAR - an HR function, the staff tends

¹ Garrick Inventory: Whistleblower Retaliation Checklist. I developed this checklist with indicators to help assess whistleblower retaliation.

to have that background. Therefore, there is a shortage of the right staffing mix of HR specialists, investigators, mediators/arbitrators and decision makers. The office would benefit from being authorized to engage independent consultants to conduct these investigations and issue reports. This would increase transparency, accountability and confidence in the system.

When employees leave the VA (regardless if they are terminated, resign or retire), they should be required to participate in an exit interview process that captures information related to their employment experience and reasons for leaving. This information should be reported to Congress annually.

Performance - The OAWP is reporting accountability and disclosures on their website.² The accountability report (adverse actions) details demotions, suspensions and terminations while the disclosure report identifies the types of whistleblower reports made. However, almost half of those contacting the office were not found to be whistleblowers. This data point is concerning because it either means that employees are not being educated in accordance with the NO FEAR Act or whistleblowers are being unjustly denied. There is also a lack of data on how they are being assisted as described by the WoA respondents. The OAWP needs to open the aperture on how it is defining its whistleblower terms and capturing retaliation (in its many forms) and be able to account for the assistance provided. It should denote how many of the adverse actions they took involved any whistleblowers and who were veterans.

There is also very limited accountability for when the OIG makes recommendations related to disclosures. Those should be better tracked and reported. There are no mandates to implement an OIG recommendation. Those can literally, "sit on the shelf." Only the OSC can mandate any corrective action and rarely do they because they do not have the resources to take cases to that level of litigation and the MSPB has not had a full panel of judges to hear cases in years. According to OSC, about 40% of its cases are VA, so an improved internal VA process could alleviate this burden and increase effectiveness for all federal employees. Respondents demonstrate their reliance on OIG and OSC investigations to support them. Furthermore, managers who were guilty of the wrongdoing or the retaliation are not held accountable - rarely are they even identified by the OIG. Most of the time, the OIG recommendation is for "further training." There should be serious penalties for retaliation (fines, demotions, loss of retired pay, etc) to discourage the tactics related to it. Congress could create a fund that requires those identified as engaging in retaliation to contribute fines. Whistleblowers who must defend themselves against retaliation are out-of-pocket - sometimes upward of \$100,000 while the wrongdoer is defended by the government, which wastes taxpayer money for veterans. This is antithetical to common sense, so this fund could be used to offset those costs by being used to retain private sector attorneys chosen by the whistleblower (similar to a risk pool created for insurance coverage) and reduce the burden on the taxpayer when damages are awarded. Plus, the lack of serious accountability furthers a corporate culture that allows retaliation to fester.

Suggested Next Steps:

1. Host a roundtable with whistleblowers to hear firsthand about retaliation at VA and the career impacts it has had.
2. Conduct a hearing on Whistleblower Retaliation and the effectiveness of the OAWP
3. Draft legislative requirements for staffing (government and independent) and performance measures (to include timeliness and process outcomes) as described above

Background:

WoA contacted 22 current and former VA employees for their feedback and insights into retaliation at the VA and the effectiveness of OAWP. Responses came from 13 current and former staff (some who are also veterans) at VA Central Office, the VA Medical Centers and the VA Regional Offices from around the country. They are medical doctors and other clinical providers, claims representatives, lawyers, law enforcement officers, contracting experts and senior officials. We are particularly concerned about disabled veterans who are hired and then terminated during their probationary period, especially after asking for reasonable accommodations.

The following questions were sent out and their answers are imbedded below:

What did you ask OAWP to do on your behalf?

² <https://www.va.gov/accountability/>

- My case was presented to OAWP for review because I was being retaliated against for disclosing fraud, waste, abuse and substandard care. My law firm on my behalf, requested OAWP to assist with getting the VA to immediately cease and desist reprisal against me. After my case was presented to OAWP, the retaliation intensified and became more frequent.
- I was removed in 2014. I think (co-worker³) had me talk to Brandon (OAWP staff)⁴ for some whistleblower Dept in VA that was new and supposedly for whistleblowers. I called him. Spoke more than once. He had me submit a form⁵ and then some. I tried to follow up a couple of times. I never heard back from him.
- They conducted a full board investigation of me in June 2017 due to an anonymous complaint sent to OIG in 2015. Why it was sat on for 2 years is a mystery to all. Board ruled the complaint was not substantiated. However, they never closed the case with OIG though so I'm still under law enforcement review until they close it. We have members of Congress trying to help. OIG says 10N still has the same open complaint, but they haven't heard from them. I requested documents from OAWP to which the guy called me to complain and amend. I did. No response. FOIA appeal. No response. Requested new FOIA based on additional info. They haven't read it. Will file another FOIA appeal.
- I specifically asked the OAWP to investigate my loss of employment and to review my evidence the VA OIG refused to investigate on failed temperature monitoring systems at the Denver VA facility. I was the Manager since June 28, 2012. The only contact I ever received was from Mr. Brandon Coleman. Mr. Coleman informed me that Mr. Peter O'Rourke had received all of my information and that they (OAWP) would soon be contacting me. OAWP never requested any of my evidence. I even CC'd Dr. Shulkin, OIG Director Mr. Michael Missal, (private consultant) and sent letters of concern to the White House. Never once have I ever received a response. I even attempted to report the "Double Billing of Windows Operating Systems" VA purchases from Dell corporation. Nothing was done nor was I ever contacted. I can prove this is taking place in less than 10 minutes. This is literally hundreds of millions of dollars of waste taking place each and every year. These includes fabrications that VA Leadership provided to the OIG to cover up the abandonment of the VA Research facility that resulted in the dismantlement of my Management Position and our local research activities to the Academic Affiliate (3 HVAC hearing have been held on this topic). Evidence that supports a much greater level of corruption that the Denver VA has successfully been allowed to subvert and cover up. The reason I lost my job.
- Investigate the issue I reported of management cancelling Veteran orders for radiologic exams, fix the problem and protect me from reprisal.
- 1. Give me unredacted audits (disclosures) of everyone who has accessed &/or queried my C-file, 2. make veterans a watchdog over the C-file by releasing unredacted audits whenever requested and immediately when requested, 3. make reporting privacy violations easy and efficient, 4. make those accountable for violating existing laws
- The Salt Lake City Fiduciary regarding elder abuse, I informed them that the SLC fiduciary hub was not helping (a veteran) who is being financially abused, and that VA officials gave the abuser permission to sell his home against his wishes. They said there was nothing that they could do except send a message to have SLC look into it.
- Investigate misconduct and intervene in retaliation. I filed two separate complaints in August 2017, and again in April 2018.
- Investigate misuse of funds by RO senior officials.
- I reached out to three arms of that office. HR and Brandon Coleman. He was useless. I am so dissatisfied and disappointed.
- On August 30, 2017; I submitted per their request an email with my recommendations to improve OAWP. This email was addressed to the vaaccountabilityteam@va.gov. Please be advised that at the time this email distribution was sent to everyone associated with the OAWP, which included every

³Parenthesis and italics denotes a person was named that is not a known VA senior official, so their identities are protected.

⁴Brandon Coleman was the addiction counselor at the VAMC in Phoenix who made headlines with his whistleblower retaliation case and was subsequently awarded a high-level position at VACO with the OAWP. Because of his notoriety, many VA whistleblowers reach out to him looking for help.

⁵VA Form 10177

one of the former employees of OAR⁶. After waiting for Brendan Coleman to get settled in to his new position at OAWP, I submitted my Disclosure to him in his formal capacity as a OAWP employee. In summary, I asked them to look into the retaliation against me, allow me to be detailed to another facility, request that OIG or OAWP look into the perjurious statements & manufactured documents made against me in order to obstruct any legitimate investigation, request that any denial of my request that justification be provided by Medical Center Director or higher, And since I had been detailed with nothing to do for 6 months pending the outcome of Northern Indiana's fact finding investigation, that OIG or OAWP conduct an investigation into criminal misconduct by management officials for wasting VA resources & taxpayer's monies based on allegations that they couldn't even prove.

- I didn't go to OAWP. I went to EEO and MSPB. I was retaliated against and terminated by the VA in May '15 for reporting medication mishandling, sterile protocol breaches in surgery (surgeon operating while bleeding), failure to chart medications in the patient EMR, failure to encrypt sensitive patient data for 5 months, gender harassment & discrimination, and a hostile workplace (to name a few) all by the same physician/surgeon, which escalated into a smear campaign to retaliate against me by administrators. I was stalked and devastated financially. My family has been pushed to the brink. I am unemployed currently and just certified to work in the field of addiction medicine and aspire to help mitigate the opioid crisis. Still paying the price for speaking up.
- I have had no relief of whistle blower retaliation. I asked for them to hold those accountable. They assigned an inhouse investigator to gather some of my documents. I was not allowed to give him all the documents proving whistleblower retaliation due to being arrested⁷. I've been barred from the Cincinnati VAMC and several surrounding VA medical center's. I'm unable to get medical care due to the whistleblower retaliation. My only concern is that I have an 11-month-old child and one on the way.
- I asked for assistance from the retaliation to stop and help to reassign for an investigation.

Did they help you?

- NO!
- The results of all my work with them was nothing. No one got back to me. No one.
- No Response
- I had a private conversation with Peter (O'Rourke) when he first arrived. Offered help with PR and strategic positioning to help develop the office further. Offered to assist on detail. Never heard back. We had a joint call with several WBs and Peter. He said they'd follow up. Never heard back.
- I have contacted the OAWP on repeated occasions since August 4, 2017. Never, not once have I received any correspondence. These including overlapping Whistleblower evidence that the VA OIG has since substantiated to be true. Substantiated evidence that I have further attempted to report to the OAWP.
- Not one bit. They have done nothing whatsoever.
- NO
- Never heard back on the privacy issue requests
- They said they could not in fiduciary cases, even when there is suspected foul play of government officials at the hub.
- No, they have taken no perceivable action.
- No, closed my case with no finding when I gave them ample evidence to have a huge finding related to \$1.5 million in payoffs even though we already had a member of the region counsel confirm our allegations. It's a fake office and then they leaked my name to Diana Rubens who then sent harassing emails. You go to them in confidence and they send what you reported to the person you reported.
- There is zero support or outreach to whistleblowers. If you go to them then you are targeted and attacked. I feel the office is not about accountability but firing/targeting the dissidents/whistleblowers. Taxpayers are funding "monster-like" tactics with that office.

⁶Office of Accountability Review

⁷I have contacted DepSec Tom Bowman about this case and Brendan Coleman. VA has charged him with "harassment and menacing behavior" after he filed EEOC complaint. He is an OIF disabled Marine Veteran. I contacted the Veterans Treatment Court, who are supporting him. VA continues to work on a reassignment for him while still holding charges against him. I've met with Rep. Brad Wenstrup staff on this case.

- On September 4, 2017; I was contacted by Brendan Coleman asking me to participate in a OAWP listening session conference call on September 13, 2017. The purpose was twofold, first for Mr. Peter O'Rourke to hear from me, along with others, what was going on in our individual retaliation cases. This call also included (Several Others). The second, was to give my chain of command notice that I had the interest of the OAWP and provide me a breather from the retaliation. On December 11, 2017; the Northern Indiana VA issued me a proposed removal along with over 1,500 pages of documents that were never seen before & I was given seven days to respond. My attorneys weren't provided copies of this voluminous 'justification' until almost a week later. I was advised on or about December 14, 2017 by Brendan Coleman that the OAWP was going to put a 'delay' on any action against me. The purpose of calling it a 'delay' rather than a hold, is because of legal ramifications & to avoid publicity. Which honestly didn't make any sense. On January 22, 2018; I was offered a 120-day detail to the Puget Sound VA Health Care System to be the Chief of Facilities Management. I contacted the OAWP after the management at Northern Indiana VA refused to release me for the detail. I was contacted by Brendan Coleman and Peter O'Rourke to provide information regarding the detail. In summary, in the most general sense "yes" they did help me.
- I did receive an email from the OAWP. However, (Consultant) advised me not to respond and forewarned me that they are an unethical entity. Since I trust his legal advisement, I did not respond. I did not reach out to them first, so I do not know how they got information on my case nor do I know the status on their end.
- They said they called my HR and told them to reassign me. (That did not happen.)

How did they help you?

- Not applicable.
- They did not. They have done nothing.
- They have not.
- N/A
- In September 2017, they tried to put my chain of command on notice that OAWP was watching. I'm sure it had the effect we hoped. In December 2017, they did 'delay' any adverse personnel actions against me. And in January 2018, I believe Peter O'Rourke tried to get the Northern Indiana VA to release me to go on the detail to Puget Sound.
- The retaliation never stopped and only continued to get worse and my case worker from OAWP said she was a HR employee being assigned to help with case part time. How can the HR's properly help when they are the ones helping to retaliate?

How long did it take for them to respond to you? (If at all)

- Months
- They have not, ever responded.
- I was contacted after my initial disclosure, after supplying the OAWP with over 1600 pages of documentation of both canceled orders and retaliation paperwork. I NEVER heard from them again.
- I received an email after contacting them several times that was cryptic. I contacted Brandon Coleman who emailed me a form that was supposed to have been given to me several months prior. No response after I submitted the whistleblower form.
- I received only initial acknowledgements that they received the information.
- Because I had a relationship with Brendan Coleman before he started at the OAWP, they were responsive in pumping the breaks on the proposed termination that took Northern Indiana almost a year of me doing nothing before handing me a giant box of manufactured nonsense.
- They never called me, and when I contact them, they just said 45 more days...and then I resigned for constructive discharge and I was assigned new case manager, but they didn't inform me, and the new CM said she couldn't find any data I sent in.

Did they close your case without sharing information with you?

- Yes. I routinely contacted OAWP one time per month for an update. It required a lot of time and effort to get them to respond. And even after they did respond, OAWP refused to tell me what, if anything, they had done for me. Since my employment was eventually terminated, obviously, OAWP did not help me at all.

- I never heard from any individual at the OAWP regarding any aspect of my reporting to the OAWP (let alone opening a case). I have copies of every correspondence with OAWP. No reply, no response.
- Yes, I have made several attempts to gather more information, but was told due to privacy issues they are unable to give me any information.
- I have no idea what they did.
- Unknown, although their template email response indicates they will not share information.
- They did close my case without informing me. I have no I idea what the OAWP is doing. The only information that I received that the VA was still investigating my claims was while listening to the NPR story about me on April 27, 2018.
- I have no idea what they have or have not done, they don't let me know and Brandon Coleman stopped answering me.

What would you suggest be done to improve the OAWP?

- Immediately close the office. Please note, I did not make that comment to try and be funny. Whistleblowers are under the impression that by contacting OAWP will help stop the retaliation. I'm unsure if there is one whistleblower who has submitted a claim to that office who has actually had the reprisal stopped. In fact, the contrary. It appears as if VA prefers whistleblowers to report to OAWP as opposed to OSC. Furthermore, the VA is utilizing the office to collect information about whistleblowers, so the agency can use the shared information against the whistleblower. Whistleblowers would be better off if OAWP did not exist because it gives whistleblowers a false sense of security where none exists. And obviously, it wastes taxpayers' money because OAWP is ineffective.
- Feedback is...needs major work.
- Waste of resources in my opinion and likely more of the David Shulkin show. He did nothing except create shiny new things to brag about to the media.
- Respond to the Whistleblowers. Not "Stone walling" as VA does best.
- As far as I'm concerned, the OAWP is yet another "Whitewash machine" that the VA has successfully constructed as a "False Accounting" system the does not exist. I hope to talk Congressman Jeff Miller soon as he may become our new VA Secretary. He will get the OAWP working as intended.
- My view of the process and the concept does of course come with an understanding that they are a startup organization that may be struggling to find identity. They cannot organizationally depend on the Office of General Counsel (OGC) for legal. OGC is tasked with protecting the agency and defending it in litigation, therefore it is a conflict. They cannot be transparent with that relationship. I have looked at job postings for OAWP. They hire for job series 0201, Human Resource Specialist. That job series shouldn't be the occupational series for the Investigators in OAWP. Any qualified candidates under the 0201 series will qualify based on HR experience, not necessarily investigative technique skills.
- Find a different group to manage them. An HONEST group.
- Improve communication and actually do something.
- The office needs to purge the corrupt investigators that came from the OAR. I am one of numerous VA employees that have gotten copies of their reports only after the court forced the issue and found that the OAWP had intentionally ignored exculpatory evidence to provide findings that were favorable to the VA as cover in case news reporters started asking questions.
- Don't use VA employees for case workers and just shut down the VA all together. Give Whistle Blowers other Federal Jobs to be able to have our retirement. I'm a 10 year AF veteran and lost my 20 year retirement by 5 years. No one will hire me in social work or any other field.

Did another entity act when the OAWP did not?

- OSC completed one investigation and ruled in my favor.
- OIG has been trying to help. And has responded timely to FOIA. GAP is reviewing my case for my defense.
- OSC is still investigating this issue.
- In all fairness, no one has helped me. VA OIG did not return communication and OSC wants me to develop my case, so we meet a threshold for them to ask for an investigation.
- VA OIG said they cannot help in fiduciary cases and referred me to OSC. I am acting as a family member to a veteran in this instance not as an employee.

The Justice Department refers people to VA OIG on elder abuse fiduciary cases, but VA OIG refers to OSC or back to the hub.

- I am engaged with OSC for the issues I want to see corrected that affect care.
- I honestly believe that OIG Special Agent did try to help me. Unfortunately, because of how the rules are, only OSC can help me. After intense lobby by Tom Devine at GAP, the OSC reopened the investigation into my case. However, the Northern Indiana VA and the OGC Midwest Region keep delaying providing supporting documentation in order to move the investigation along. I do want to say that the OGC is as corrupt as the rest of the VA. The misconduct and obstruction by VA attorneys is criminal.
- I went all the way up the chain and OIG report, and not one agency or person was able to help at all. Not even EEO at the VISN level and higher. I continue to be retaliated against.

Thank you for considering this information.

