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**Testimony of Irma Westmoreland, RN
On Behalf of National Nurses United
Before the
House Committee on Veterans Affairs
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**Hearing on “Building a Better VA: Addressing Healthcare Workforce Recruitment
and Retention Challenges”**

Thank you, Chairman Takano, Ranking Member Bost, and members of the committee for giving me the opportunity to submit testimony for this hearing.

My name is Irma Westmoreland. I am a registered nurse at the Charlie Norwood VA Medical Center in Augusta, Georgia. I am also Vice President of National Nurses United (NNU), the largest union and professional association of registered nurses (RNs) in the United States.

We represent more than 175,000 nurses across the country, including more than 12,000 nurses at 23 VA hospitals. I serve as the Veterans Affairs Chair of NNU. Over the past two years, our nurses, many of whom are veterans themselves, have been on the frontlines of the coronavirus response at the hospital bedside. To be clear, my testimony today is on behalf of NNU and in no way on behalf of the Veterans Administration management.

As in the private sector, Veterans Health Administration (VHA) nurses and their patients are facing a crisis of unsafe staffing that has resulted in nurses fleeing the unbearable working conditions in acute-care hospitals. Many nurses in the VA are pursuing nursing work in other settings, leaving the profession for other types of work, or retiring. The VA chooses to invest in updated dashboards and electronic systems such as HR Smart at the expense of investing in proven solutions – mandatory, minimum staffing ratios to improve patient care, health and safety protections, more flexible schedules, competitive pay and benefits, and the right to collectively bargain over all issues.

This testimony will demonstrate how every barrier to nurse recruitment and retention could be improved if clinical professionals in the VA had the right to bargain collectively. Without the ability to have a full voice on the job, VA nurses consistently face working conditions that harm both nurses and patients, ranging from unsafe staffing levels encouraged by prolonged hiring processes to pay discrepancies between nurses doing the same job. Nurses are the heart and soul of any hospital, and there is no substitute for the care and attention that nurses provide to their patients. As workers on the frontlines of patient care, nurses must have the ability to advocate for their patients and ultimately improve the quality and standard of care provided by the VA as well as the recruitment and retention of their peers.

To improve both the quality of care as well as the recruitment and retention of nurses at the VA, Congress must expeditiously provide full collective bargaining rights to Title 38 employees by passing the VA Employee Fairness Act, a bill sponsored by Chairman Takano that would repeal Section 7422 of Title

38 of the U.S. Code, thereby granting full collective bargaining rights to registered nurses and other clinicians in the VA. Additionally, Congress must adopt the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act (sponsored by Congresswoman Jan Schakowsky and Senator Sherrod Brown) that would establish mandatory, minimum, nurse-to-patient ratios in hospitals across the country, including those in the VHA, allowing nurses to care for their patients safely. Both these pieces of legislation are a crucial part of ensuring that our VA hospitals are staffed to levels that provide the highest quality care for our nation’s veterans and the best possible working conditions for nurses.

Collective Bargaining Rights: The Impact of Section 7422 on Recruitment and Retention

In the experience of bedside nurses, the challenges with recruitment and retention at the VHA begin with the statutory restriction of nurses to bargain collectively over the issues we face every day at the hospital bedside. Registered nurses and select other clinical professionals working in the VA do not currently have the same collective bargaining rights of other VA workers, or of clinicians in other agencies, including the Department of Defense, or in the private sector.

Added in 1991 to Title 38 of the U.S. Code, Section 7422 allows only certain VA professionals to bargain collectively on all issues — giving them the ability to negotiate, file grievances, and arbitrate disputes over working conditions. The statute contains broad restrictions on the rights of RNs to negotiate with management over matters concerning professional conduct or competence (including direct patient care and clinical competence), peer review, and compensation. Because Section 7422 prevents VA nurses from having a voice on the job on such crucial issues, qualified nurses have an incentive to leave the VHA and work at private sector unionized hospitals that pay better and where their union can bargain improved patient care protections.

Patient advocacy often requires speaking up to management about issues in the hospital that affect patient care. Part of why Section 7422 has been so damaging to the VA nurse workforce is because management has used the statute as an excuse to refuse to engage with nurses on issues that affect us and the patients we care for. Without full collective-bargaining rights, management can leave VA nurses without resolutions to disputes over workplace issues that endanger patient safety, such as unsafe staffing, insufficient supplies, or assignment of a nurse to a unit without adequate training.

The negative impact of Section 7422 has been especially damaging during the Covid-19 pandemic; the restrictions of VA nurses from bargaining collectively over all issues has contributed to unsafe working conditions, including suboptimal personal protective equipment (PPE), unsafe staffing levels, and a lack of accessible testing. Unionized nurses with full collective bargaining rights in the private sector have been able to win increased Covid protections including life-saving PPE, more testing, and improved communication regarding Covid protocols through collective bargaining. These protections help keep nurses, their patients, and our communities safe.

In the VA, nurses were able to win Covid protections with direct action. Through leafleting, protests, and local and national advocacy work, VA nurses at facilities across the country fought for – and won – the protections they needed. For example, in New York, nurses at the Brooklyn VA began the pandemic wearing trash bags to protect themselves, and through collective action were able to win high-quality

N100 respirators for every healthcare worker in their facility. These wins, while substantial, only happened after a concerted effort from VA nurses to engage in direct action.

The inability of nurses to bargain collectively over the issues that impede recruitment and retention – such as the protracted hiring process, pay discrepancies, lack of safe staffing, manageable panel sizes for nurse practitioners, and the inability to contact HR and hear back from them in a timely fashion -- stymies our efforts to provide quality care to veterans and reinforces the feeling by many VA nurses that VA management disrespects them, causing some to leave employment at the VA.

One clear example comes from the Edward Hines Jr. VA Hospital in Hines, Illinois, where last year NNU filed a grievance over hiring discrimination and violations of the seniority rights of internal job bidders. The Hines administration refuses to address these problems because of Section 7422.

Like many VA hospitals, the Hines VA was looking to hire in both the Emergency Department and Post Anesthesia Care Unit (PACU). In the Emergency Department there were seven open positions, and nine qualified, internal applicants applied. Six of the seven positions were instead awarded to less qualified, external candidates. All but one of the selected candidates were white, as opposed to the eight out of nine internal candidates who are people of color. When the union filed a grievance, management responded that they did not need to address the issue, citing Section 7422. Discriminatory practices such as these contribute to nurses feeling devalued and often cause them to leave the bedside, directly impacting patient care and contributing to the nurse staffing crisis.

H.R. 1948, the VA Employee Fairness Act introduced by Chairman Takano, would provide the same bargaining rights to health care professionals as other federal employees, giving RNs in VA hospitals the tools to speak up for patient safety and care. This bill will reduce turnover, increase staff levels, and improve the care that veterans receive by repealing the provisions from Section 7422 that limit collective bargaining rights for VA nurses. VA nurses want what is best for veterans. Providing nurses and other clinicians with full collective bargaining rights is the best way to ensure that problems in our VA hospitals are addressed and that our nation’s heroes receive the highest standards of care.

President Biden’s Executive Order 14003 states, “It is the policy of the United States to protect, empower, and rebuild the career Federal workforce. It is also the policy of the United States to encourage union organizing and collective bargaining. The Federal Government should serve as a model employer.” The VA needs to fully comply with that executive order by respecting the rights of its registered nurse workforce, and Congress needs to codify this by passing the VA Employee Fairness Act.

For registered nurses, union advocacy and representation allow us to focus on what we do best: caring for our patients. Without full collective bargaining rights, nurses’ ability to speak out on behalf of patients is reduced and threatened, and we are constrained from advocating for the highest quality of safe patient care that our veterans deserve.

The Staffing Crisis in the VHA

Nurses at the VA suffer from the same lack of safe staffing that nurses in non-VA facilities across the country also face. There are no federal mandates regulating the number of patients a registered nurse

can care for at one time in U.S. hospitals, including those in the VA. The VA deliberately refuses to staff their hospitals with enough nurses to care for patients safely and optimally, harming both nurses and patients in the process, and contributing to a culture that continues to devalue the work and autonomy of bedside nurses.

Staffing ratios lower the patient assignment load for nurses so that they have the time, energy, and capacity to actively provide the care that patients require. Multiple academic studies have shown that hospitals in California, the only state in the country with mandated nurse-to-patient ratios, have seen steeper declines in mortality and improvements in other indicators than hospitals in other states. Ratios are the single most effective nursing reform to protect patients and keep experienced RNs at the bedside.^{1 2} If the VA truly believes veterans deserve the highest quality and standard of care, then it would implement safe staffing ratios as soon as possible.

While the media continues to echo cries of a “nursing shortage,” data from a 2017 U.S. Department of Health and Human Services (HHS) report shows that – save for a handful of states -- there is not a shortage of actively-licensed RNs in the United States.³ In fact, there are more than 1.2 million actively licensed registered nurses who are currently not working as bedside nurses.⁴ If the VA were required to invest in its long-term nursing staff through meeting minimum staffing ratios, thereby improving patient care and protecting nurse health and safety, registered nurses who have left the bedside would seek to work at the VHA.

Safe staffing is not only essential to providing the quality of care that patients need, it is also critical to increasing nurse retention. Chronic understaffing can cause a decline in patient care which in turn can lead to moral injury for nurses, causing them to leave the bedside when they feel they cannot provide the level of care they were trained to give. The failure by the VA to staff appropriately and provide the resources needed to provide safe, therapeutic patient care has caused nurses to experience severe moral distress and injury (often incorrectly labeled “burnout”); mental health issues such as stress, anxiety, depression, and post-traumatic stress disorder; and physical exhaustion. If VA hospitals protected nurses with safe working conditions and safe staffing rather than pushing nurses to do more with less, we could keep more nurses at the bedside in the VHA system.

Staffing challenges at VA hospitals existed well before the global pandemic, but Covid-19 has certainly shined a light on the myriad ways that the VHA fails to get nurses to the bedside where they are most needed. The staffing methodology that the VHA uses prevents patients from receiving the highest-

¹ Anders, R. L. (2021, October). Patient safety time for federally mandated registered nurse to patient ratios. In *Nursing Forum* (Vol. 56, No. 4, pp. 1038-1043).

² Carthon, M. B., Brom, H., McHugh, M., Sloane, D. M., Berg, R., Merchant, R., ... & Aiken, L. H. (2021). Better nurse staffing is associated with survival for Black patients and diminishes racial disparities in survival after in-hospital cardiac arrests. *Medical care*, 59(2), 169.

³ Health Resources and Services Administration. 2017. “National and Regional Supply and Demand Projections of the Nursing Workforce: 2014-2030.” U.S. Department of Health and Human Services. <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nchwa-hrsa-nursing-report.pdf>.

⁴ NNU calculation based on data from National Council of State Boards of Nursing. Mar 2, 2022. “Active RN Licenses, A Profile of Nursing Licensure in the U.S.” National Council of State Boards of Nursing. <https://www.ncsbn.org/6161.htm> and the U.S. Bureau of Labor Statistics. 2021. “May 2020 Occupational Employment and Wages.” U.S. Department of Labor. <https://www.bls.gov/oes/home.htm>.

quality patient care by creating unnecessary barriers to safe levels of staffing. At least once a year, the VHA maintains that they hold a panel of experts at the local unit level to determine staffing levels for each unit, but the reality is that this process is controlled entirely by management. While the union cannot formally participate in this process, we usually recommend participants who often get rejected. For example, recently at the Augusta VA we recommended 20 nurses for the panels and just two were selected by management. Using a formula, that panel decides how many nurses it will take to staff that unit. Led by the manager, the panel puts a report together that goes to the nursing leadership group.

Should the nursing leadership group agree to the staffing level, the report goes to a facility-based council where the union has one seat. There, executive-level panel participants look at the report and, should they agree with the proposed staffing levels, the director has the final authority to accept or reject the new levels. At my hospital, the patient ratio in the Med-Surg unit can be as high as one nurse for seven patients, when the scientifically accepted safe staffing level for Med-Surg units is one nurse to four patients.

This entire process of determining staffing levels is predicated on the assumption that the additional staffing positions can even be filled, but vacant positions at the VHA cannot be filled until the previous person has left the role completely and the budget board has approved the request. Once the budget board (consisting of the director’s office and executive staff) has approved the request, it must receive the director’s signature and then it can go to HR. Nowhere in the VA hiring timeline is that time counted as part of the hiring process, except by the nurses on the ground who are working short-staffed.

Of course, staffing issues at the VA are also related to the statutory restrictions of nurses from collective bargaining. Section 7422 provides the VA with an incredibly broad scope to reject all discussions about issues that affect nurses and patients. Last year at the VA Eastern Colorado Healthcare System in Aurora, Colorado, for example, management changed the nursing schedules for every inpatient nurse and used Section 7422 as the reason why it would not discuss the change at the bargaining table with nurses. Part of this change involved aligning all inpatient units to the same start times, creating a gap in time when all RNs are making their rounds and unable to provide patient care, often for periods in excess of one hour.

In a survey conducted by NNU about the issue on April 2, 2021, one Aurora VA nurse provided a compelling example of how these schedule changes have affected patients, writing, “Early and frequent patient ambulation is critical to positive outcomes for post-op patients. Morning ambulation has nearly ceased since the shift change. It has become problematic to fit the morning ambulation in without forcing a patient awake during early morning hours. It is then delayed by shift change, interdisciplinary rounds, breakfast, and other morning obligations.” Clearly, patients are not receiving the highest standard of care if these schedule changes have caused nurses to be unable to help patients with a critical part of their recovery. Another nurse wrote simply, “I think patient safety stands at the front of this issue.”

The inpatient units affected by these schedule changes have since lost over a dozen experienced RNs and are having a difficult time replacing them. One of the nurses above wrote in her survey that she knows of “at least seven RNs that are currently looking for other jobs.” Being understaffed has led to severe nurse-to-patient ratio problems at the Aurora VA, causing dangerous and unsafe situations for

veterans. Due to short staffing in units like the Intensive Care Unit (ICU), one of the most severely impacted by this schedule change, RNs from other units are being floated to units (such as the ICU) where they have not been properly trained, creating the potential for harm to both the veteran and the RN. This is happening in VA hospitals across the country.

Changing nurse schedules creates instability and confusion for nurses and their patients, and the Aurora VA is just one example of how VA management uses Section 7422 in ways that harm nurses and patients at the VA. Understaffing is a problem across the entire VA system; as of the last quarter of FY 2021, the VHA had 8,577 nurse vacancies.

The VA also continues to balance the budget on the backs of the nurses – due to the fiscal year calendar it is nearly impossible to get a new hire after July 1. In FY 2021, the Augusta VA lost 59 nurses and hired 72. However, from October 1 to December 31 (the first quarter of FY 2022) we have lost 49 nurses and have brought in fewer than 20. Only a third of those nurses went to the hospital direct bedside, as the remaining two-thirds were slated into expanded roles.

To support safe staffing at our hospitals, Congress must pass H.R. 3165, the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act, that would establish minimum, numerical RN-to-patient ratios in hospitals across the country, including those in the VA. Studies have shown that minimum RN-to-patient staffing ratios mean better patient outcomes, safer and healthier nurses, lower rates of moral distress (also called burnout), and higher nurse job satisfaction.⁵

Registered nurses in the VA are consistently required to care for more patients than is safe, which compromises patient care and negatively impacts patient outcomes. A Journal of the American Medical Association (JAMA) study found that the likelihood of death increases by seven percent for each additional patient in a nurse’s workload above the baseline nurse-to-patient ratio prescribed by HR 3165.⁶

The bill requires hospitals to annually develop safe staffing plans that meet the bill’s mandated minimum RN staffing ratios and provide for additional staffing based on individual patient care needs. It also requires hospitals to post notices on minimum ratios and maintain records on RN and other staffing, and provides whistleblower protections, including administrative complaint process and cause of action, for nurses who speak out against assignments that are unsafe for the patient or nurse.

Finally, the bill authorizes the Secretary of the Department of Health and Human Services to enforce the minimum RN staffing ratios through administrative complaints and civil penalties. This bill, alongside full collective bargaining rights for VA nurses, would significantly improve VA’s efforts at both recruitment and retention.

Hiring, Compensation, and HR Processes in the VA

⁵ Aiken L et al. 2010. “Implications of the California Nurse Staffing Mandate for Other States.” Health Services Research. 45(4):204- 21. <https://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2010.01114.x>.

⁶ Aiken, L. H.; Clarke, S. P.; Sloane, D. M.; Sochalski, J.; & Silber, J. H. (2002) Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. JAMA, 288(16), (1987-1993)

The inability for unionized VA nurses to bargain over the hiring process has led to an absurdly long hiring period for VA nurses. According to VA Data released on January 20, 2022, the average length of hiring for a nurse in the VA today is 100 days, but many nurses I have spoken to report a 9-18 month long hiring process.⁷ In the current hiring market, that same applicant could go to another hospital in that same community and start a job within two weeks. These delays in hiring dramatically reduce the number of nurses willing and able to work at the VA, which means we lose out on qualified applicants ready to leave their current position in the private sector. While the VA has attempted to address this issue using direct-hire authority, it is not currently being utilized effectively as hiring times are still significantly longer than those in the private sector.

The nurse hiring process begins with submitting a resume to USA Jobs and applying for an open position. The VHA has a number of continuous open job announcements in addition to specific positions at various facilities. The system then checks the nurse applicant’s minimum qualifications and every two weeks HR sends the names of qualified applicants along to the manager of the open position. That manager can decide to hire from those applications or through an interview process, and will then send those applicant names along to their managers, then to the chief nurse, and finally back to HR where they start the next phase of the hiring process. At no point in time during this process is the nurse told she has been hired yet.

In the next phase, HR does a check of the applicant’s nursing license and criminal background before sending the applicant’s name to a pay panel that will set her salary. That may take up to a month, as every facility has its own locality rate and at some facilities pay panels meet as infrequently as just once a week. These panels create large discrepancies in the salaries of different nurses based on the way a nurse may have organized her resume and add unnecessary delays to the hiring process. Nurse applicants are not told to include examples of evidence-based practice on their resume, for example, but leaving such information out may result in being placed in a lower pay band. After the panel has met and determined the salary for the nurse applicant in question, HR can officially offer the nurse the job.

The centralization of HR Services at the VISN level has led to some success in cutting down the length of time it takes to hire new nurses. For example, a clinical contact center in VISN 8 recently advertised for 139 nurses and received over 400 applicants. The center’s existing small HR office was not able to process that level of applications, but through the centralization of services at the VISN level, 80 nurses were hired and are due to start in the next two pay periods. While 80 nurses hired is far short of the 139 necessary to maintain an appropriate level of patient care at that center, the utilization of the HR services at the VISN level led to nurses being hired more quickly than in the past. The same process could be implemented for the pay panels mentioned above – consolidating the Nurse Professional Standards Boards at the VISN level and mandating a daily meeting would significantly increase the speed at which new hires could begin work.

Ultimately, each nurse vacancy strains the system of care at the VA and adversely affects patients. Both nurse recruitment and retention could be improved if nurses had full collective bargaining rights, and if the hiring process, timeline, and pay scale were clearly detailed in a bargaining agreement visible to all

⁷ Veterans Health Administration, Office of Nursing Services presentation to the National Partnerships Council on January 26, 2022. Slide 5, “Number of VHA Nurses in Pipeline.”

nurses. Expanding collective bargaining rights for nurses is one way to accelerate the hiring process at the VA.

The discrepancies in nurse pay continue to make recruitment and retention difficult at the VHA, another problem that could be solved by collective bargaining. Each facility in the VHA has their own locality rate based on geographic location, and nurse pay varies within the hospital depending on unit, years of experience, and education. Because nurses are not allowed to bargain over the pay that they receive, this process varies significantly from facility to facility, and the lack of procedural transparency has opened the process to manipulation and abuse by management, who refuses to pay nurses what they are worth. Because the union cannot be involved in this process, there is no recourse for a nurse whose job gets matched at an incorrect level, or for locality pay data that hasn't been updated since before the pandemic.

Additionally, while the consolidation of HR services at the VISN level has created some benefits for the hiring process, it has also created some tangible disadvantages for nurses working at the VHA. For example, if a nurse wanted to utilize the FMLA benefits provided to her through her job, she would have to get in touch with personnel at the VISN level, instead of with someone at her facility. Those staff do not have email addresses that are listed on any website, and experience has shown that it is often difficult to reach them or have them return your call in a timely manner. There are proficiency evaluations from 2020 that still have not been entered in the HR Smart system by staff, which means those nurses are not yet eligible to receive the raises or performance bonuses they deserve. The elimination of HR staff due to the VISN-level consolidation has made it significantly harder for VA employees like nurses to access the benefits afforded to them as part of their work, and these difficulties and complications lead to frustration and higher rates of attrition.

Conclusion

In conclusion, the staffing crisis, specific VA-level policies related to hiring and compensation, and the inability of VA nurses to collectively bargain has created a VHA workforce that is understaffed, over-extended, and unable to advocate for the changes they know need to be made to deliver the highest quality care to our nation's Veterans. Improving recruitment and retention at the VA does not require consultants or extensive dashboards of electronic data, it requires listening to and supporting the working nurses who deliver the most important service the VA offers – care for our nation's heroes.