J. DAVID COX, R.N. NATIONAL SECRETARY-TREASURER AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

STATEMENT BY

J. DAVID COX, R.N.
NATIONAL SECRETARY-TREASURER

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS,

CONCERNING HEALTH CARE FUNDING FOR THE DEPARTMENT OF VETERANS AFFAIRS

JULY 25, 20075

Dear Chairman and Members of the Committee:

The American Federation of Government Employees, AFL-CIO (AFGE), which represents more than 600,000 federal employees who serve the American people across the nation and around the world, including roughly 150,000 employees in the Department of Veterans Affairs (VA), is honored to testify today regarding the current process for funding veterans' health care and alternative funding approaches.

It is also an honor to participate in this important discussion along with the Partnership for Veterans Health Care Budget Reform (Partnership). AFGE is a long time supporter of the principles endorsed by the veterans' organizations that comprise the Partnership and the Independent Budget, including the need for an assured funding approach that uses a systematic methodology for funding veterans' health care.

The Partnership has presented a very compelling case for assured funding. The nation's largest integrated health care system must receive its funding through a predictable, needs-based funding formula if it is to remain a leader in health care quality and respond to growing demand. Assured funding is the only approach that can utilize a systematic methodology; a systematic discretionary funding methodology is practically an oxymoron.

What I would like to address through my testimony today is the perspective of AFGE nurses, physicians, and other Title 38 professionals who see first hand the harm caused by the discretionary funding process. As a registered nurse at the Salisbury, North Carolina VA Medical Center for almost 25 years and a long time union president and officer of the National VA Council, I have received a great many reports from VHA employees struggling to care for veterans under a constant cloud of continuing resolutions and unpredictable funding.

The wear and tear of a broken funding process on the VA health care system is cumulative, steadily depleting its infrastructure and workforce at a time of burgeoning demand from veterans

of the Global War on Terror and an aging population. Facilities remain in disrepair, hospital beds stay closed, and staffing shortages and workforce morale worsen. The occasional emergency supplemental infusion of cash leads to a rush to spend, without adequately addressing long term needs.

Opponents of assured funding contend that the VA budget will reach unmanageable levels, but they fail to point out that a discretionary funding process results in great misallocation of health care dollars, and threatens the VA's exemplary quality record. Facilities with hiring freezes and noncompetitive physician and nurse pay rates, and delayed purchases of medical equipment must contract with the private sector at much higher costs. Facilities with unstaffed hospital beds and too few specialists spend huge sums of money diverting patients to non-VA hospitals.

The following troubling reports were recently provided by members working in VHA facilities:

- Delays and cutbacks in diagnostic testing: VA pay scales for scarce medical specialists are far below the private sector. Facilities address unfilled positions by turning to high priced fee basis care. Shortages in gastroenterologists are impacting the VA's ability to implement a new policy to offer screening colonoscopies to all veterans age 50 or older, regardless of prior risk factors. Primary care physicians attempting to make colonoscopy referrals according to the new guidelines are being pressured to cut back, and offer stool cards - a far less effective tool for detecting cancer at early stages - instead.
- Reduced access to state-of-the-art treatment: A primary care physician reports that her patients who are in extreme pain are not able to receive the most effective injection-based pain treatment because her facility is unable to hire an anesthesiologist at current VA pay levels and management has capped spending on fee basis care.
- Budget driven equipment purchases: During months of the fiscal year when dollars are short, money needed to update or repair medical equipment is used for payroll. Then, at the end of the fiscal year, the rush to spend and justify next year's budget results in hasty, lower priority purchases such as furniture.
- Inadequate training in specialty care: Nurses working in new spinal cord units were told that there was no money to send them to conferences or other facilities where they could observe best practices. Similarly, ICU nurses were not permitted to attend cardiology training due to a shortage of funds and staff.
- Inadequate time with patients: Many VA providers are working with patient panel sizes (some as high as 1,400 patients or more) that exceed VA's own recommended ceiling. Nurses are discouraged from setting multiple follow up appointments even when the veteran's health problems warrant close monitoring. In addition, facilities set fixed time limits for examining each patient regardless of the individual's needs.

• Psychiatric care: Staffing shortages result in delays in treatment of PTSD and other mental health conditions, and constrain the amount of time staff can spend with each patient or visit veterans in other locations such as homeless shelters. New PTSD and suicide prevention programs have drawn staff away from patients in other mental health units; the positions they vacate are not filled, leaving remaining staff with larger patient loads.

- Safe patient handling. Although VA is a world leader in state-of-the-art patient lifting equipment, sufficient funds to equip all VA hospitals and nursing homes have not been

provided. The costs: more nurse back injuries, lost work time, patient skin tears, and workers compensation claims.

- Nonmedical tasks divert time away from patients: Budget problems have resulted in widespread hiring freezes and lags for support positions, for example, clerks who check in patients, schedule reminders for future appointments and answer phones. Team leaders of new health care initiatives lack staff support for added duties.
- Understating access problems: The current funding process encourages management to hide the true gap between patient need and available resources through patient appointment processes that "shape demand", manipulation of wait list data and empty "ghost beds" that lack staff.

• Discretionary style diversion policies: Patient care is compromised when decisions whether to divert to non-VA facilities are based on budget problems rather than good medicine. When VA beds are unavailable, and dollars are tight, patients who need to be admitted wait in ERs and hallways instead.

THE IMPACT OF THE CURRENT FUNDING PROCESS ON STAFFING

VHA's aging workforce should provide a wake up call to management to take succession planning more seriously than it has. Unfortunately, yearly funding fluctuations and shortfalls have undermined succession planning efforts in the past. The average age of VHA employees has risen from 45.4 years to 48.3 years over the past decade, and 44% will be eligible to retire at the end of 2012.

Adequate nurse staffing is a critical component of improved patient outcomes, e.g. decreases in urinary tract infections, pneumonia and shock or cardiac arrest, avoided hospital stays and fewer in-hospital deaths. The impending RN workforce shortage at the VA is startling: almost 22,000 of the RNs caring for our veterans will be eligible to retire by 2010 while 77% of all RN resignations occur within the first five years.

In 1991, in response to a growing nurse shortage, VHA collaborated with a panel of staffing experts to recommend a complete overhaul of VHA's staffing methods. Unfortunately the new methodology was sparsely implemented, due in part to a lack of resources.

In 2002, Congress sought to address the growing nurse staffing crisis by establishing the National Commission on VA Nursing. As a member of that Commission, I participated in extensive discussions about the need for a systematic staffing methodology. Our final recommendations included a call for VHA to "develop, test and adopt nationwide staffing standards that assure adequate nursing resources and support services to achieve excellence inpatient care and desired outcomes." Unfortunately, the Commission's recommendation met the same fate as the previous attempt: a national staffing methodology was never implemented.

Ironically, the one Commission recommendation that was enacted into law - 2001 nurse locality pay legislation - has not achieved its potential due to the reluctance of cash-strapped managers to conduct pay surveys or provide increases commiserate with private sector pay surveys. The significant inequity between locality pay increases for the rank and file and supervisory nursing staff hurts morale and worsens VA's nurse shortage.

The greater problem is that any staffing methodology operating in a system with unpredictable funding is bound to fail. Without a sound funding methodology for the larger health care system, it is our firm belief that VHA will not have the resources to adopt the Commission's important staffing recommendations. In contrast, an assured funding approach would enable the VA to base staffing on all relevant criteria, including patient acuity, the impact of alternative work schedules, the staffing needs generated by new health care directives and the impact of nursing shortages nationwide on nurse pay and other incentives.

The discretionary funding process took its toll again when Congress tried to address the VA nursing shortage through 2004 legislation that increased the availability of RN alternative work schedules and restricted mandatory overtime, in order to become more competitive with private sector nurses. Management operating under hiring freezes and uncertain funding streams continue to require or pressure RNs to work overtime and are reluctant to offer alternative work schedules, further contributing to recruitment and retention problems.

We thank Chairman Akaka for requesting a GAO study of the cost and quality impact of agency nurses in the VA. Facilities continue to over utilize costly agency nurses rather than adopt policies to improve recruitment and retention of staff nurses. Agency nurses are unfamiliar with VA's specialized care, new directives on traumatic brain injury, mental health and hospital infections, and the VA's bar code medication administration system, electronic health records or clinical reminder systems. They lack security clearances to access certain computer files. As a result, they cannot work as independently as staff nurses and must be given more desirable day shifts sought by senior in-house nurses.

Provisions in 2004 legislation that addressed pay for physicians and dentists have met a similar fate. The law established new systems for setting competitive salaries ("market pay") and for performance pay awards. The chaos of the current budget process struck again. Even before the compensation panels to set new market pay rates were in place, management in many locations told physicians not to expect much of any pay increase because of budget problems, and that is just what happened on a widespread basis.

When we asked about the pay surveys that facilities used to set physician market pay, we were told it was too confidential to reveal. What we do know, however, is that the process was anything but systematic. Each facility chose its own pay surveys and had complete discretion to select compensation panel members, the resultant variations in pay decisions were often suspect. More generally, the current process is flawed in that raises for VHA employees are not addressed until after the projected budgets are submitted, leaving the facility director to absorb proposed salary increases.

The impact of a flawed budget process was even more obvious in the implementation of the physician performance pay provisions in the 2004 law. Congress set a yearly award of up to $15,000 or 7.5% of salary to reward quality performance. However, in the first year, the VA revised the national cap downward to $5,000 and local management has continued to play the budget card by setting even lower caps (in many cases, under $1000 or no awards at all). Needless to say, these pay policies have failed to improve the VA's ability to recruit and retain health care professionals or reduce spending on fee basis physicians and other contract care.

In the words of one of our primary care physicians, "physicians would flood the VA" if pay rates

were competitive because they are attracted to this patient population, the computerized medical record, single drug formulary and the ability to provide high quality care without worrying whether the patient will be able to pay his out-of-pocket share of services and medications.

In closing, AFGE has sadly concluded that the VA will not be able to undertake meaningful succession planning, effectively address recruitment and retention problems, or engage in strategic, long range planning for other aspects of health care delivery so long as discretionary funding is creating a constant state of financial uncertainly and the demand for and cost of delivering health care to our veterans is based on a yearly political fight rather than a systematic funding methodology.

CONCLUSION

AFGE greatly appreciates the opportunity to submit our views and recommendations to the Senate Committee on Veterans Affairs. We look forward to working with Chairman Akaka and the Committee on short term and long term solutions to the VA's health care funding problems.