Department of Veterans Affairs

Introduction

In 2006, AFGE's 150,000 members who work at the Department of Veterans Affairs (VA) made a great difference in the lives of veterans and VA employees by voicing their concerns to Congress, VA Secretary Nicholson and local managers about critical workplace and veterans' issues. For example, activism by AFGE and AFGE's National VA Council (jointly referred to here as AFGE) at the national and local levels kept hospitals open, stopped contracting out, gave Congress a front line view into the hardships of underfunding, strengthened training for Veterans Benefits Administration (VBA) employees and helped Veterans Health Administration (VHA) medical professionals fight for fair pay.

While their jobs in VBA, VHA and the National Cemetery Administration (NCA) vary widely, our members have many shared concerns. Despite the challenges of working under chronic budget shortfalls and financial uncertainty, AFGE members serve our country's veterans with great compassion and dedication. They face threats to their jobs because of the Administration's unrelenting contracting out agenda. They are left wondering how the recent centralization of VA information technology (IT) will impact their ability to do their jobs. Many VHA employees are facing an additional threat to their workplace rights: Title 38's collective bargaining provision ("7422") is being used to block the rights of physicians, registered nurses (RNs) and many other medical professionals to bargain and grieve over a wide range of issues, for example, number of patients assigned per physician and employment discrimination.

Increased Congressional oversight of VA operations and policies is greatly needed. Congress, labor representatives and the public face many roadblocks to obtaining information about critical VA issues such as funding, staffing, VBA claims processing and nurse professional standards. Recent studies by the Government Accountability Office (GAO) found that the VA uses incorrect assumptions and outdated numbers for its budget forecasting, and lacks the tools to implement cost saving measures or track health care dollars spent on cost comparison studies.

The VA denies many of AFGE's information requests under the Freedom of Information Act (FOIA) and the Federal Service Labor Management Relations Statute without legal basis. In many cases, after agreeing on a new policy developed through labor-management collaboration, management refuses to implement it.

The 110th Congress offers AFGE members a unique opportunity to advocate for new legislation that will strengthen veterans' services and improve the workplace for its dedicated employees, and for increased oversight of VA spending and policies.

Funding

"VA must not be seen simply as another department or agency, coming hat in hand to seek funding."

Chairman Daniel Akaka, Senate Veterans' Affairs Committee, January 9, 2007.

The "hat in hand" method of funding VA is clearly not working. Every year, VA's ability to hire and provide timely services to veterans depends on how well it competes for discretionary funding. Politics may determine how much funding the VA gets but it does not determine how many veterans will age or become injured and need VHA doctors and nurses to treat them and VBA claims adjudicators to process their benefit claims.

Clearly, the current funding process is broken. The VA had a $3 billion shortfall in veterans' health care in fiscal years 2005 and 2006. The waiting list for new veterans' health care appointments doubled in a year. The current backlog of benefit claims is approaching 400,000.

Underfunding and financial uncertainly year after year also waste taxpayer dollars. VA is forced to turn to costly contracting out and fee basis care as short term solutions to hiring freezes, broken equipment and construction delays. Staffing shortages increase errors in claims adjudication and medical care. Patients who wait longer for care get sicker and when they do get treated, it ends up being more costly and extensive.

VA's poor track record for forecasting and requesting needed funds makes it all the more critical for Congress to enact an assured funding formula for VA services, including a health care budget based on actual need and health care costs. In 2005 and 2006, the VA withheld critical information about its VHA budget problems from Congress, leading to a $3 billion shortfall. The Administration promised that FY 2007 would be different. It announced its "historic budget" with great fanfare. However, reading between the lines, what the Administration actually proposed was cost-shifting through increased drug co-pays and new user fees, and a 13% decrease in health care funding over five years. Similarly, the Administration's response to growing backlogs in VBA was a proposed *decrease* in the number of claims adjudicator positions. The proposed funding levels for FY 2007 funding were lower than that recommended by veterans' advocates in their Independent Budget, and endorsed by AFGE.

Although House and Senate appropriators rejected many of the harmful VHA and VBA budget proposals, politics prevented passage of a final spending bill for the VA before Congress recessed. As a result, in FY 2007, the VA will have to operate on a continuing resolution – the same fate that the VA has met for 12 of the past 13 years. Whether additional funds to operate above FY 2006 levels are available will once again depend on politics instead of need.

The Administration's budget proposal for FY 2008 uses recycled proposals to shift health care costs to veterans through higher drug co-pays and new user fees. As in previous years, proposed increases in staffing are insufficient to address growing waiting lists for health care and backlogs in claims processing. Proposed funding for institutional long term care fails to keep up with the growing need for this level of care by elderly and severely disabled veterans.

Congressional Action Needed:

- Enact assured funding legislation this year.
- Provide supplemental funds in FY 2007 to prevent shortfalls and meet increased demand for VBA and VHA services.
- Increase oversight of activities impacting veterans' access to services, including VBA claims processing backlogs, VHA waiting lists for health care and data on numbers of veterans diverted to non-VA medical facilities.
- Increase oversight of VHA VISN budgets and staffing levels, bonuses for managers and other items not directly related to patient care.

Contracting Out

VHA

Currently, the VA is prohibited from using medical dollars to conduct cost comparison studies under 38 USC 8110(a)(5). Under this spending ban, the VA can only use dollars specifically appropriated for VHA cost comparisons. (Congress has not appropriated specific funds for these studies for many years.) In addition, as will be discussed in the next section, it is also illegal to contract out VHA jobs without competition.

Despite these protections against outsourcing, AFGE members regularly report contracting out activity by their facility directors, one of many ways that the Administration's outsourcing agenda takes its toll on veterans and VA employees, particularly in VHA. In the 109th Congress, AFGE successfully fought back against proposals to repeal the ban on using medical dollars for cost comparison studies. The original bill, S.1182, which was considered by Senate authorizers on the Senate VA Committee, would have completely repealed the spending ban. The full Senate agreed instead to a pilot project that would have allowed $15 million in VHA funds to be used to conduct these studies. When the House and Senate negotiated an omnibus health care bill at the end of the 109th Congress, AFGE succeeded in getting all contracting out authority struck. As a result, the current ban on spending VHA dollars on privatization studies stands.

In 2005, the GAO found that VHA had used substantial time and effort on illegal cost comparison studies. Since VHA had no means of determining the total

amount spent on illegal activities to be repaid, AFGE requested a federal criminal investigation under the Antideficiency Act.

Reports of illegal contracting out in VHA facilities are concentrated in low wage jobs such as laundries, housekeeping, painting and groundskeeping. When facility directors contract out these types of jobs, a lot more is lost than an "FTE." By the VA's own estimates, the vast majority of these employees are veterans, and many of them came to these positions through rehabilitation programs for homelessness, and physical and mental disabilities. Minorities and women also comprise a disproportionate share of the workforce holding low wage VA jobs on the outsourcing "hit list."

VA data provided to Congress indicates little or no savings from laundry outsourcing, and in some cases, dollar losses. Past outsourcing has also led to many complaints of lower quality services by contractors.

Department-Wide

While the VA can conduct privatization studies using VBA, NCA and Departmental funds, two other federal rules require that all public-private competitions conducted by the VA comply with specific rules.

Congress passed competition rules as part of the FY 2006 Transportation-Treasury appropriations law (T&T) that apply to the VA and most federal agencies. This law, which is still in effect, states that no work may be directly converted without first conducting a public-private competition and that the in-house workforce must always be allowed the opportunity to submit its most competitive bids, known as Most Efficient Organization plans. This law applies to all functions involving more than ten employees. Note that even if only ten or fewer employees are actually affected by the contracting out, T&T will apply if the *function* involves other employees and/or supervisors.

Second, the Office of Management and Budget (OMB) A-76 Circular requires a competition prior to outsourcing. Unlike T&T, A-76 applies to any outsourcing regardless of the number of employees performing the function. (The ten employee requirement was dropped from the OMB A-76 Circular in 2003.)

It also appears that the VA has failed to comply with the requirement in 38 USC 8110(c) to provide annual reports to Congress on contracting out activities in VHA, VBA and NCA. The most recent report filed by the VA omitted many instances of contracting out that have been reported by AFGE members.

AFGE continues to monitor and oppose other more indirect attempts at outsourcing VA low wage jobs. Currently, the VHA is moving forward with a management efficiency initiative called Business Process Reengineering (BPR) to study and reorganize laundries and food service. Pilot projects of other

functions will follow. AFGE's concerns about BPR are two-fold: AFGE and front-line employees have been denied a meaningful role in BPR studies; and, consolidations may lead to contracting out of low-wage jobs held largely by veterans, minorities and women at a future date.

The outsourcing of VA medical services, known as "fee basis" care, raises other concerns. Title 38 (38 USC 1703) allows VHA to contract for hospital care and medical services when VA facilities are not geographically accessible or specialty care is not available, and in the case of medical emergencies. AFGE is concerned that this authority is frequently abused to use fee basis care in lieu of building additional facilities, and additional hiring of in-house doctors, nurses and other medical professionals, particularly in rural areas.

VHA's Project HERO raises just these concerns. The stated objective of Project HERO is to improve the quality and cost-effectiveness of contract (fee basis) care already in place. However, the last bid put out to contractors could vastly increase the use of fee basis care. AFGE also questions the use of precious medical dollars on coordination, quality and cost containment functions that VHA already performs very effectively in-house.

Congressional Action Needed:

- Retain the current Title 38 ban on VHA cost comparison studies.
- Congress should not appropriate separate funds for these studies.
- Increase oversight of VA dollars spent on contracting out to address GAO findings.
- Strengthen the reporting requirements in 38 USC 305 to ensure that the VA maintains and reports an accurate inventory of all VA contracting out activities and proposals, with penalties for nondisclosure.
- Conduct oversight of BPR to ensure union and employee involvement and prevent illegal contracting out.

VBA

The demands on the VBA workforce are increasing dramatically. The disability and pension claims workload has increased 57% since 2000 and the number of veterans claiming at least eight disabilities has doubled in five years.

Staffing levels and training have not kept pace with the number or complexity of claims. Large numbers of retirements among older, more experienced claims adjudicators have worsened the current workforce crisis. By VA's own estimates, new Veterans Service Representatives (VSRs) require several years of on-the-job training to become fully competent.

AFGE presented its views on VBA staffing and training at two hearings of the House Veterans Affairs Committee last year. The consistent concern of VSRs

and Rating Specialists (RVSR) is managers' emphasis on production over customer service. Employees in the Public Contact Unit are pressured to limit the length of their conversations with callers. VSRs developing cases face crushing caseloads and unrealistic performance standards. As a result, many managers do not allocate sufficient time for training, for example, they do not rotate new employees through all the different job duties. Employees who are shortchanged on training are less able to assist veterans or pass the skills certification test that leads to promotion. Training for ongoing employees, which enables them to learn about new benefit programs and share lessons learned from challenging cases, is also cut short to "make the numbers". At the same time, there has been little progress in the Office of Personnel Management reclassification process to raise the career ladder of the VSR position.

Congressional Action Needed:

- Provide funding to hire additional VSRs and RSVRs consistent with realistic projections of future demand.
- Increase oversight of VBA training to ensure quality, consistency and completion of all needed training throughout regional offices. A joint VBA-stakeholder team should develop a national training plan**.**
- Ensure that employees have rights to participate in task forces addressing claims processing, training and performance standards.
- Develop a firm succession planning to address case backlogs and retirements of older VBA employees.
- Ensure that current performance standards are realistic, so that VSRs and RVSRs can adequately develop claims and receive needed training.
- Ensure that AFGE has a meaningful role in the implementation of the Skills Certification test.

Bargaining Rights

In 1991, Congress enacted 38 USC 7422 ("7422") to clarify the collective bargaining rights of physicians, RNs, and other medical professionals covered by Section 7421.This provision prohibits bargaining over issues related to pay, direct patient care and clinical competence, and states that only the Under Secretary of Health (USH) can determine what falls within this exclusion.

Over the past few years, many facility level managers have used a broad definition of 7422 to refuse to bargain over workplace disputes that are only indirectly related to patient care, for example, scheduling and promotion processes. Also problematic is that these managers should not be making 7422 decisions on their own. The statute clearly states that only the USH can decide whether 7422 prohibits bargaining. Managers' broad interpretation of the statute conflicts with a stricter interpretation of 7422 reached through a 1996 labor-management partnership agreement that clarified that only matters indirectly affecting patient care should be subject to bargaining. In addition, this

agreement encouraged informal resolution of these disputes and confirmed that only the USH can decide what is covered by 7422. Recent court decisions have adopted the VA's management's broad interpretation of 7422.

Congressional Action Needed:

- Conduct oversight of management decisions to invoke 7422.
- Enact legislation to narrow the scope of 38 USC 7422 to provide a clear definition of direct patient care consistent with 1996 partnership agreement.
- Strengthen the requirement that only the USH can make a 7422 determination.
- Enact additional legislation to ensure the right to bargain in areas such as patient-staff ratios.

Nurse Issues

Staffing: VHA is the largest employer of registered nurses (RNs) in the U.S. Underfunding and staffing shortages in the VA take a very heavy toll on working conditions of front-line nurses. A growing body of medical research indicates that staffing shortages impact the quality of patient care and patient outcomes. Understaffing also increases the incidence of back problems among RNs and other on-the-job injuries. In addition, poor working conditions lead to stress and low morale, which in turn increases turnover and worsens the recruitment and retention (R&R) problem. Rather than address these R&R problems, management is quick to turn to contract nurses, a costly practice that also impacts the quality and safety of patient care.

Pay: The current process for setting nurse pay is not adequately addressing growing R&R problems. VA legislation passed in 2000 was only partially effective in this regard. The Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419) provided nurses with the same minimal annual increase in the GS scale as other federal employees. However, provisions addressing the process for setting locality pay left too much discretion to facility directors. AFGE has received numerous reports of front-line nurses working in locations with significant R&R problems still receiving little or no locality pay after surveys were conducted. At the same time, many management nurses received significant increases based on locality pay surveys. The 7422 problem already discussed prevents front-line nurses from challenging these unfair locality pay awards.

Scheduling: In 2004, Congress passed alternative work schedule (AWS) provisions for RNs as part of the Department of Veterans Affairs Health Care Personnel Enhancement Act of 2004 (P.L. 108-445) (often referred to as the "physicians pay bill"). It authorized the Secretary to offer "3-12s" (40 hours of pay for three 12 hour days) and 9 month schedules, and prohibit mandatory shifts of more than 12 hours except in emergencies. After great delay in issuing the

directives to implement these changes, the VA is refusing to implement the directives on the basis of a national, firm definition of emergency. By leaving it up to each facility to define emergency and thus, to require mandatory overtime, the VA is putting its nurses and patients at risk. This conflicts with the Secretary's public declaration that he wants to limit mandatory overtime by VA nurses. AFGE is currently in negotiations with management over the appropriate definition of emergency.

Promotions: AFGE nurses have growing concerns about the current process for promotions. Many report that their nurse executives are refusing to implement the promotion and pay recommendations of their local nurse professional standard boards (NPSB). At the same time, managers are not informing nurses of their right to appeal to local boards or VA central office. Labor representatives are deprived of the knowledge they need to represent and educate employees who are being excluded from training on national performance standards.

Safe Patient Handling: Both nurses and patients face significant risk of injury from manual patient lifting, transferring and repositioning. Many VA facilities still lack new assistive equipment technology that can prevent nurse back injuries, patient skin tears and other problems.

- **Part-Time Nurses:** Due to a long-standing inequity in the law, part-time VA nurses can never convert from probationary to permanent status. Many of these probationary nurses are long term VA employees who were once permanent employees with outstanding performance. It is illogical and counterproductive in the face of a nurse shortage to deprive these employees of permanent status simply because they changed from full-time to part-time schedules.

Congressional Action Needed:

- Conduct oversight of the VA nurse locality pay process, including strong enforcement of current reporting requirements.
- Ensure that the VA utilizes a workable and well-defined national standard of emergency to require mandatory overtime.
- Enact a nationally uniform standard for safe patient handling and provide funding to ensure that all VA facilities have upgraded equipment.
- Allow labor and management to negotiate safe staffing levels.
- Allow part-time nurses to acquire permanent status.
- Conduct oversight of the VA's growing use of contract nurses, and its impact on cost and quality of care.

Physicians and Dentists

In January 2006, new pay and leave rules for physicians and dentists took effect. (The leave rule also covers podiatrists, chiropractors and optometrists.) The implementation of both rules has been plagued by lack of collaboration with AFGE and front-line providers, delays and confusion.

Pay Bill: AFGE was a key participant in negotiations that led to passage of the physicians pay bill (P.L. 108-445, previously mentioned in connection with nurse alternative work schedules.) AFGE successfully fought for annual pay raises, bi-annual step increases, public disclosure of pay ranges and a right to provide input into regulations implementing the new law.

The pay bill was intended to address recruitment and retention problems by establishing new market pay and performance pay systems for physicians and dentists ("provider"). The law required the input of unions and front-line providers. Unfortunately, management began excluding labor's perspective even before the January 2006 effective date. First, the VA denied AFGE's request to be included in steering committees selecting pay surveys and setting national pay ranges. Then, the compensation panels at the facility level that set market pay largely excluded practicing physicians and dentists and disregarded AFGE locals' recommendations for panel members. There was also great variation among facilities as to which survey data was used to set individual provider pay, and troubling reports that different surveys were used to provide larger pay increases to management. The VA denied AFGE's repeated requests for local survey data, asserting, among other reasons, the 7422 ban on bargaining previously discussed. AFGE has filed a national grievance requesting new compensation panels and readjustment of market pay.

The performance pay phase of the pay bill has also been plagued with problems. The statute requires that the Secretary prescribe specific performance objectives and pay yearly awards of up to the lesser of $15,000 or 7.5% of pay. Unfortunately, providers ended up with something very different. At the national level, VA delayed in issuing performance standards and then decided that the dollar cap would be lowered to $5,000 for 2006. In addition, the Secretary left it up to each facility to develop its own standards, with no requirement for labor-management collaboration. The result was low or no awards and great inconsistency in the standards that were applied around the country. At most facilities, employees had no input into the standard-setting process. The standards themselves were often too vague to comply with or involved improper criteria, for example, patient outcomes beyond the control of the individual provider or working after hours without compensation. This year, reports of facilities setting lower dollar caps prior to evaluating individual performance are already emerging.

Leave: In 2004, AFGE successfully negotiated with the VA for changes to the administrative rules that required providers to take annual leave for weekends and other non-duty days. The new rule reduced the annual leave by four days and ended the practice of charging for non-duty days. Another provision that took AFGE and providers by complete surprise "froze" leave above an 86 day cap, making it available for cash out only at retirement or separation from service. Providers were not given any advance opportunity to use this leave prior to the effective date of the new rule. As a result of further pressure by AFGE, the leave rule was revised, giving providers the right to request the use of frozen leave and forfeited leave. Unfortunately, since then, AFGE members in many VISNS are still being charged leave for non-duty days and are finding errors in their leave records.

Other workplace issues are also adding to the R&R problem for physicians and dentists, including caseload ("panel size"), uncompensated overtime in non-emergency situations and management's failure to comply with Title 38 requirements to reimburse providers for continuing medical education (CME) expenses.

Congressional Action Needed:

- Conduct oversight of implementation problems with new pay and leave rules. Require new market pay decisions based on a fair process, and accurate computation of leave under new rules.
- Ensure more transparency in the processes for setting market pay and performance pay in future years.
- Conduct oversight of other workplace issues including panel size, scheduling and educational reimbursement, and the status of physician and dentist succession planning.

Conclusion

Congressional oversight and increased labor-management collaboration on VBA and VHA workplace issues will ensure that policies affecting pay, leave, scheduling, training and performance are implemented fairly, consistently and in the best interests of veterans. Congress should investigate possible pay and staffing problems in other VA positions such as pharmacists. Meaningful Title 38 bargaining rights will provide further checks and balance against unfair management actions. Assured funding of veterans' health care is long overdue. Laws prohibiting contracting out and requiring fair public-private competitions must be enforced, and scarce VA medical dollars should not be appropriated for privatization studies. All cost comparisons conducted should include consideration of the benefits of bringing contractor work back in-house.