

THE STATUS OF RECRUITMENT, RETENTION, AND
COMPENSATION OF THE VA HEALTH CARE
WORKFORCE

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
ONE HUNDRED SIXTH CONGRESS
SECOND SESSION

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THE STATUS OF RECRUITMENT, RETENTION, AND COMPENSATION OF THE VA HEALTH CARE WORKFORCE

WEDNESDAY, APRIL 12, 2000

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

The subcommittee met, pursuant to notice, at 10:10 a.m., in room 334, Cannon House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Gutierrez, Doyle, Peterson, Moran, Carson, Chenoweth-Hage, Snyder, Simpson, and Shows.

Ex officio present: Representative Evans.

Also present: Representative Filner.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning. Welcome to the Subcommittee on Health, Committee on Veterans' Affairs. Last week we held a hearing which underscored that more than 25 percent of veterans' medical care budget is spent on operations and maintenance of VA's many buildings, some of which, according to the GAO, are unneeded.

But the largest part of VA's medical budget is spent on VA's clinical workforce. This year, for example, VA expects to spend more than \$11 billion of an approximately \$20 billion budget on employees' salaries.

Needless to say, the issues before us today, while often technical in nature, are hardly insignificant. Within our obligation to veterans who rely on VA for care, we must make certain the VA maintains a competent workforce, and that it has the means to recruit and retain needed caregivers and support staff.

The Veterans Committee has certainly given a vote of confidence to VA's health care workforce in recommending a record medical care funding increase last year, and a more than a billion dollar increase again this year, but we have been asked to enact legislation to address several major pay issues.

This hearing gives us an opportunity to begin to explore those and any other issues relating to VA's personnel needs. I must caution my colleagues that the pay systems now in place are complex. We should also bear in mind that the issues which have been brought to our attention are said to have been created by, or in

some cases overlooked in, prior efforts to remedy particular recruitment and retention difficulties.

We surely want to satisfy ourself that the laws establishing the various employee pay systems are sensible and fair and that we are doing right by those who serve who veterans. At the same time, we surely want to avoid a response to any particular issue that would create new and potentially greater problems down the road.

Both myself and my colleagues approach this hearing, therefore, with an open mind, and with a goal of broadening our understanding. In helping us gain that understanding, I hope our witnesses, and particularly our VA witnesses, will address themselves to the following two general questions.

First, does the Veterans Health Administration have serious recruitment and retention problems at this time? And second, in those cases where nurses, dentists, or others have raised concerns, to what extent has VA exercised in full the authority it has in law to solve these problems?

With that, I welcome all of our witnesses and thank them for being here today. I regret that a mark-up in the Commerce Committee requires I step away for a period. I will, however, review the full hearing record and intend to discuss these issues further with my colleagues.

Before introducing our first panel, I would like to call on my friend, the ranking member, Mr. Evans.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. We are here to address the VA's most important resource, its workforce. I am a proud co-sponsor of H.R. 1216, the Department of Veterans Affairs Nurse Pay Appreciation Act of 1999. I am also an original co-sponsor of Bob Filner's bill, H.R. 2660, as he calls it, put your money where your mouth is, the VA Dentist Equity Act.

Action on both of these bills will give us the tools to create a stable workforce within these professions now and for the future.

I have also been concerned that VA's physicians assistants have no one within the VA's management hierarchy to voice their views and promote their profession. VA should be a large part of our response to providing primary care from new points of access to our veterans.

Chairman Stump and I recently asked Secretary Garthwaite to address the need for a consultant for PA's. I was disappointed with the non-responsive reply we received. I will be happy to include both the letter and the reply we received for our hearing record. I would appreciate it if the VA took this opportunity to re-examine the need for a consultant for PA's, and respond to this need in the near future.

Again, Mr. Chairman, I appreciate you holding this hearing and look forward to the important testimony of our witnesses.

[The prepared statement of Congressman Evans, with attachments, appears on p. 39.]

Mr. STEARNS. Thank you. I thank my colleague. Mr. Shows?

Mr. SHOWS. I have no comment, Mr. Chairman.

Mr. STEARNS. Dr. Snyder? Ms. Carson? Then Mr. Filner, Dr. Filner.

OPENING STATEMENT OF HON. BOB FILNER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. FILNER. Thank you, Mr. Chairman. I want to thank you for the courtesy of sitting on the Health Subcommittee today.

Mr. STEARNS. Absolutely.

Mr. FILNER. I appreciate your interest in this. I think we all know and we are going to hear that a quality workforce depends on good working conditions, good pay, good morale, and we have seen in various instances a turnover which threatens the quality of our health care.

So I hope we pay close attention today. I have a bill, of course, about dentists within the VA and their equity. Mr. Chairman, there was some confusion about whether the American Association of Oral and Maxillofacial Surgeons would testify. I think they have some witnesses, and if there is time, perhaps we may hear a few words from them.

I thank the Chair.

Mr. STEARNS. You're welcome, and thank you for your interest, for being here, and for H.R. 2660, and what you are doing.

We will now have the first panel, if you will be kind enough to come forward—Mr. Kenneth Clark, Chief Network Officer, Department of Veterans Affairs, and he is accompanied Mr. Walter Hall, Assistant General Counsel, VA; Mr. Thomas Hogan, Director of Management Support, VA; and Ms. Mari Horak, Management Support, VA.

I want to thank you folks for being here. I think most members would agree that one of the important aspects of VA health care is ensuring that the employees are adequately compensated, and at the same time, are encouraged so that we retain these individuals.

As any corporation, both private or public, you can have a lot of money, but if you don't have people that are inspired, you don't have a good system, so we look forward to your opening statements.

STATEMENT OF KENNETH J. CLARK, CHIEF NETWORK OFFICER, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WALTER A. HALL, ASSISTANT GENERAL COUNSEL, THOMAS J. HOGAN, DIRECTOR, MANAGEMENT SUPPORT, AND MARI A. HORAK, MANAGEMENT SUPPORT, DEPARTMENT OF VETERANS AFFAIRS

Mr. CLARK. Thank you, Mr. Chairman and members of the subcommittee. I have been asked to appear before the committee to discuss the recruitment, retention, and compensation of health care professionals, and to present the Department's views on H.R. 1216 and 2660.

With the committee's permission, I would like to comment briefly on these topics, and then we would be prepared to respond to any questions.

VA's health care providers are its most important resource in delivering high quality, compassionate care to our Nation's veterans. Compensation, employment benefits, and workplace factors affect

our ability to recruit and retain employees, particularly in highly competitive labor markets, and for hard to fill occupations.

Thanks to the efforts of this committee and the Senate Veterans' Affairs Committee, the VA has been able to offer generally competitive pay in most markets. At the present time, health care staffing in the VA health care system is relatively stable, and we are not currently experiencing any widespread or critical staffing shortages for our health care occupations.

However, there are some specific problem areas—individual locations that are experiencing some difficulties for some occupations, and non-VA pay trends for dentists and pharmacists are beginning to create difficulties.

My full statement discusses VA's experience using the nurse locality pay system to ensure that pay raises at VA facilities are sufficient to be competitive with those at local non-VA health care facilities for recruitment and retention of nurses and nurse anesthetists.

Although pay and employment trends do not indicate any significant problem at this point in time, the current locality pay system is not functioning optimally and is the source of continuing concern among VA nurses.

In 1998, the Department hired an outside contractor to conduct a comprehensive review to assess the locality pay system. The results of that study were accepted by the Secretary, and the complete report was forwarded to Congress in November of 1999.

The key conclusion of the contractor and the implementation group was that the current survey process is flawed, and that another methodology is needed to ensure more equitable pay adjustments for nurses.

VA has accomplished or is working on a number of the reports' recommendations that can be acted on without legislative action. H.R. 1216 would address many of the implementation group's recommendations. However, we have a number of concerns about the bill as currently drafted.

My full statement provides VA's analysis and comments on that legislation. Basically the bill could result in the VA becoming a pay leader in some communities, does not allow VA sufficient flexibility to address needs in all areas of the country, and expands the locality pay system to other occupations without sufficient justification.

Mr. Chairman, regarding the recruitment and retention of VA dentists, the turnover rate for dentists has historically paralleled that for other health care occupations, and is now increasing slightly, we believe due to the advancing age of VA dentists who are reaching retirement age in increasing numbers, and to a growing gap in VA dentist pay compared to private sector and other federal programs.

Although VA does not currently have widespread recruitment and retention problems for dentists, there are some areas of the country that that currently exists. Almost 70 percent of VA full-time dentists will be eligible for regular or early retirement in the next 3 years. Therefore, we're concerned that as VA dentists retire, it may be difficult to attract the best qualified dentists to work in the VA, given the gap that exists between VA and non-VA compensation packages.

In addition, the overall projections for future graduation rates for dentists foretell a shortage of dentists in the future.

VA is currently reviewing legislative options that would mitigate these potential problems. Our proposals are currently under review, and we will provide them to you as soon as possible.

My statement presents information regarding our current experience in matching community pay for VA pharmacists. We are carefully monitoring pay trends for pharmacists to ensure that the cap on special pay rates does not become problematic.

Our goal for all health care occupations, is to ensure that VA is able to recruit and retain well-qualified health care professionals to meet our obligations to care for our Nation's veterans.

With these brief opening comments, I will conclude my remarks and would be happy, with my colleagues, to answer whatever questions the subcommittee has.

[The prepared statement of Mr. Clark appears on p. 55.]

Mr. STEARNS. Mr. Clark, in November 1998, Congress directed the VA to provide recommended solutions to the locality pay problem by February 1999. The Secretary provided Congress an incomplete answer in December, so I think all of us were a little disappointed.

Do you have a specific legislative proposal, rather than just commenting on pending bills, do you have a specific legislative proposal to offer, and specific administrative steps that you will take? And if you don't have that now, what additional time or work needs to be done before we can get the definite answer that we expected back in November of 1998 when Congress directed the VA to provide recommended solutions?

Mr. CLARK. I apologize for the length of time that it has taken us to do this. As you mentioned in your opening comments, this whole area of pay is exceedingly complex. We are currently exploring a number of alternative options. We have, or are preparing proposals that, as I mentioned, we are not prepared at this time to present, but that we feel will address the current and future needs of VA to have the flexibility in our pay system to address our recruitment and retention problems.

I'm not able to give you a specific time frame in terms of when we would be able to do that. I believe that that would be in the very near future that we would be proposing legislation, but I'm afraid I'm not able to give you a specific answer to that question at this time.

Mr. STEARNS. So Mr. Clark, just to review—you are not prepared today, after the instruction from Congress in 1998, you don't have a specific legislative proposal within the VA, you don't know when you're going to get it done, and you don't have any specific recommendations. Is that true?

Mr. CLARK. What I would commit to you, sir, is that we will accomplish that in the earliest possible time. We are committed to getting proposals, proposed legislation through the process and to Congress as quickly as possible. We need these flexibilities, and we are motivated to get them as quickly as possible.

Mr. STEARNS. I guess the earliest possible time is pretty vague.

Mr. CLARK. I'm sorry I can't be more specific.

Mr. STEARNS. Maybe let's back off from legislative proposals, back off from administrative specifics; can you give me the framework that you are viewing this in, what are the parameters?

You can see I'm seeking some kind of answer from you on how you are going to even formulate a plan, because at this point, we're talking November is about 5 or 6 months away, and that would be 2 years since we asked you.

Now, in the private sector, they would have this solved by now, and the longer it takes you to even formulate some outline and some milestones, the less confidence I have, and I am sure the members here do, that you are going to come up with specific administrative steps as well as a deadline, as well as a specific legislative proposal.

Mr. CLARK. Perhaps I can comment on one strategy that we are exploring, and I will defer to Ms. Horak to comment on some of the details, but we have been, VHA and the Department Human Resources offices, are working currently with the Bureau of Labor Statistics on some aspects of providing the appropriate database that will help us with our pay systems, and I would ask Ms. Horak to comment.

Mr. STEARNS. Ms. Horak, I would be glad to hear from you.

Ms. HORAK. As Mr. Clark said, we are working with the Bureau of Labor Statistics, and we have been in exploratory conversations with them for over a year. The complexities of data collection and ensuring that we get statistically valid as well as relevant information for our pay-setting purposes for nurses is taking a fair amount of time.

Mr. STEARNS. One of the questions that you know, when you are working for the government, and you want to give pay to people, you have got to be careful that a particular agency doesn't become the pay leader. So the question I have, do you think the VA should be a pay leader in the community, or not? And if not, why not?

Mr. CLARK. I don't believe that we should be a pay leader. I think we need to certainly be competitive with the market. I think we can be, and have shown that we can be competitive without being a pay leader.

I think that the systems that we have in place and the systems that we are proposing allow us to do that. One of the concerns we have about H.R. 1216 is that it has the potential for causing VA to be a pay leader by basically duplicating the cost-of-living adjustments and locality pay adjustment. I think that's one of the concerns that we have with that particular legislation.

Mr. STEARNS. Can you assure us that VA would not be a pay leader today? Because I think the whole surveying process, as you pointed out in your opening statement, is very complex. Are you able to assure us that the VA will not be a pay leader?

Mr. CLARK. Yes. The current system that is in place, the way it is set up and carried out, would preclude VA from being a pay leader. In our deliberations, in our proposals, we would have in place provisions that would preclude us from being a pay leader.

But again, I stress that that what we need to strive for is to be competitive in the area of pay in all localities without being a pay leader, necessarily.

Mr. STEARNS. Let me see if I can pin you down on this, on nurses' pay. What do you see as more important, finding a way to assure that VA nurses get a reasonable pay increase annually, or improving the locality pay survey mechanism?

Mr. CLARK. I don't know that those are mutually exclusive. I'm not resisting being pinned down, Mr. Chairman, but I don't see those as being mutually exclusive. I think one of the problems that we have realized in the current system is the fact that although we have in fact provided pay increases to nurses in most years, this past year, virtually all of our medical centers passed on pay increases, but there is a potential in the system for that not to occur.

I think to achieve some level of parity with general system employees, the general schedule employees, I think there needs to be a provision that would provide annual pay increases for all nursing staff that is in some way reflective of local increase in rates.

Mr. STEARNS. I think my time has expired. I am pleased to turn the questions over to Mr. Gutierrez, the ranking member of the House Subcommittee.

Mr. GUTIERREZ. Mr. Chairman, thank you so much for calling this very timely and important meeting this morning. I would like to apologize to you personally and to the members of the committee for my tardiness this morning, and ask unanimous consent that my opening statement be included in the record.

Mr. STEARNS. By unanimous consent, so ordered.

[The prepared statement of Congressman Gutierrez appears on p. 37.]

Mr. GUTIERREZ. Thank you very much, Mr. Chairman. VA's budget for fiscal year 2001 requests \$63.5 million to support pay raises for nurses. Is that based upon the assumption that nurses would receive the equivalent of a nationwide and locality pay raise requested by GS employees?

Mr. CLARK. Yes, that's correct.

Mr. GUTIERREZ. So you are responding to the GS employees and their request, and that's what you're going to use the money for.

Mr. CLARK. Yes, that's correct.

Mr. GUTIERREZ. Good. Could you explain VA's problems with implementing the market surveys on beginning rates of pay raises for nurses in comparable positions in community hospitals?

Mr. CLARK. Yes. The difficulty historically has been the inability to either obtain any information from community hospitals or obtain information that is reliable, or obtain information that is complete.

As you know, that is a completely voluntary arrangement, and what has happened across the country is as we have tried to get information, data that we can use to transfer to our needs in VA, we really are entirely dependent on what community health care facilities will provide us.

They are often not forthcoming in providing reliable, comprehensive information that we need to determine what the appropriate rate increase would be, and that has been the fundamental problem with the current system.

Mr. GUTIERREZ. The Hay group's report on nurse pay recommended the VA establish boundaries for hospital directors in

making its pay adjustments. Does VA intend to institute this recommendation, and how? To anyone on the panel.

Mr. CLARK. I am told that we did not concur with the recommended restrictions on local directors.

Mr. GUTIERREZ. So in terms of the Hay group's nurse pay recommendations, that is not one that you accepted or you are going to implement?

Mr. CLARK. Yes, that's my understanding.

Mr. GUTIERREZ. Could you tell us what your objection to it was? And what you will do in lieu of that recommendation to ensure that there are some situation where nurses can know what the boundaries are, and so that people can know just geographically what we're talking about?

Mr. CLARK. Having formerly been a medical center director and in that position, I guess my response from personal experience would be that I think the people who are closest to the issues of the impact of pay problems are the ones that need to have the authority, the discretionary authority to act in the best interest of the employees at the local level, and consequently in the best interest of the patients that they are serving.

And so I think it needs to be vested in the local directors, the local responsible individuals. We have encouraged from headquarters each medical center director to very carefully consider the need for pay increases, and to take appropriate steps as necessary.

As I indicated, in almost all instances, that has resulted in pay increases being passed on, but I do feel strongly that that needs to be in the hands of the medical center directors, the local officials.

Mr. GUTIERREZ. I understand, but I think that we will continue to probably have huge problems in that when you leave it at the discretion of the local director, it becomes very subjective, what one local medical director will do vis-a-vis what another will do, what his relationship is with the organized labor staff, and what constraints we, in Congress, in terms of what you at the VA are putting in their budget, and priorities within that budget, and discretions that they have.

Unless we have an objective standard, something that everyone uses, I think you are going to continue to get unfairness, and what you're going to get is people more likely than not not give pay increases—that is, refrain from giving pay increases—than to give them.

That has been, at least historically, the norm. So that's why I think we need to give all workers, all the men and women that serve in the VA, a sense of here are some parameters, we know what they are, we know what the rules are, we're happy with those rules, and we are all going to get treated the same, versus one medical director doing one thing—if I'm the medical director, given my past history, I will tell you I will probably give them all the raise, and they will all be thrilled with me. I'm not quite sure that all the medical directors would treat them all the same. It sounds a little self-serving, but that's probably what I would do.

But that's my background. That's why I will never be a medical director, because I would probably be on the other side organizing, but I'm quite serious, though, I think we need objective standards. Otherwise you are—I mean, I can see employees being frustrated,

angry, discontent, productivity and other problems that arise, because in any situation where there is unfairness, or people perceive unfairness because of subjectivity, we are leaving it up to individuals versus allowing an objective standard across the Nation.

So you know, I would suggest that you strongly look at having standards across this Nation so that every doctor, every nurse, every technician, every x-ray, every person that works in the laboratory, every janitor, everybody who works, wherever it is they work, knows what their pay is going to be, and how it is they come about getting that pay and that compensation.

Thank you very much for coming this morning.

Mrs. CHENOWETH-HAGE (presiding). I thank the gentleman, and I'm going to recognize Mr. Simpson for questions.

Mr. SIMPSON. Thank you, Madam Chairman. You mentioned in your testimony that although the VA does not currently have widespread recruitment and retention problems for dentists, that the potential exists because 70 percent of the VA full-time dentists will be eligible for retirement within the next 3 years.

And yet as I look at the statistics, there are 200 fewer dentists employed by the VA now than there was in 1990, is that true?

Mr. CLARK. Yes, I believe that figure is correct.

Mr. SIMPSON. In spite of the fact that we suggest that there is no a problem, the statistics that I have indicate that 40 percent, only 40 percent of the VA patients who are eligible for dental care are actually getting dental care, and in fact, we have 200 fewer dentists. Why is that?

Mr. CLARK. I am not so sure that that is not less a problem of recruitment and retention, frankly, and more a result of historical budget problems. I think as positions that become open, not just positions of dentists but a variety of positions, medical centers striving to live within their budget limits have chosen not to fill positions and to focus resources on mandatory workload.

I think that's probably what has happened in that aspect of our service delivery, and I think that is what has resulted, at least in part, in the reduction in dentists on the rolls.

We recognize that we are staring in the face a potential problem of a tremendous number of dentists who would potentially be eligible for normal retirement or early retirement in the next several years. We believe that we need more flexibility in our pay for dentists in order to avert a problem that is not far down the road from us.

But up to this point in time, we have not been able to record a tremendous problem with recruitment or retention with dentists.

Mr. SIMPSON. I also have information that in many places, the current waiting list for dental visits, for the first time dental visit, is up to 2 years. Is that true?

Mr. CLARK. I wouldn't subscribe to the two year figure. I know, and certainly will acknowledge, we have long waiting times in many of our dental clinics, and that is increasing. I will similarly acknowledge that that is not a problem that is unique to dentistry. We have experienced some waiting time problems across the board, and in fact, in some ways, one of the cornerstones of our 2001 budget request was improving service and access, and we have a number of initiatives to try to improve that.

So I think the waiting times are in part a problem as a result of the reduction in the total number of dentists. I think part of the problem is increase in patient demand and simply the way that we deliver those services. We are taking some steps to try and improve that.

Mr. SIMPSON. What exactly are we doing—you mentioned increased flexibility in the pay for dentists, that you were going to recommend increased flexibility in the pay—what are you doing to implement that?

Mr. CLARK. Well, we haven't implemented anything just yet. What we are doing, again, is considering legislation, a legislative proposal that would expand some of the discretion in certain components of the dentists' pay, particularly with regard to the full-time component and responsibility pay. We think that that would respond in a positive way to our need to have more flexibility in what we can offer dentists for pay that, again, in turn would respond to our anticipated recruitment and retention problem.

Mr. SIMPSON. When can we expect to see something on that?

Mr. CLARK. I apologize that I can't give you a specific time period. I'm told that we are working on that, and we anticipate having something soon. We are motivated to get that out as quickly as possible, but I'm afraid I can't give you a specific answer.

Mr. SIMPSON. Let me suggest to you that you work real hard on it, because if 70 percent of the dentists in the VA system are going to retire within the next 3 years, or eligible for retirement within the next 3 years, we're going to have serious problems in trying to recruit dentists, even though you suggest that we might not have that problem now.

Over the next 2 years, it is going to become a real problem, especially when the rate of dental school graduates is decreasing, and the environment in the private sector is so much more advantageous for those people to enter into the private sector.

If we are going to compete for those qualified dentists to enter the VA and take care of our veterans, we had better get on the stick now instead of waiting 1 or 2 years down the road.

Mr. CLARK. We agree with your assessment, and for those very reasons, we are motivated to deal with this issue as quickly as possible.

Mr. SIMPSON. Thank you.

Mrs. CHENOWETH-HAGE. Thank you, Mr. Simpson. And the Chair now recognizes Dr. Snyder for questions.

Mr. SNYDER. Thank you, Madam Chairman. Mr. Clark, you in your testimony talked about you recognized there were areas in the country that had local shortages. I guess I need you to define for me what you mean by a local shortage. If you have a workload that requires 500 dentists, but you have only through your VA budget got slots for 200 dentists, that would not be a shortage, I would assume by your definition.

Mr. CLARK. Yes. What I was referring to, there are isolated parts of the country where there are now difficulties in finding dentists, finding people in a variety of health occupations, but that varies from place to place throughout the country.

Mr. SNYDER. I want to get—going back to Mr. Simpson's comments, though, I mean, I am hearing the same information he is,

that we have got a national problem with regard to waiting lines for dental services, and that the waits are longer than for other-- for a lot of the other medical services offered at the VA. But you don't define that as a shortage.

Mr. CLARK. I am just defining, again, shortage in terms of recruitment and retention. That most likely, there seems to be an insufficient number of dentists to meet our current workload needs. There is some indication that that is starting to reverse itself, and that we are starting to respond to that, but yes, let me be clear that yes, it would seem as if, given the increase in waiting times, given the downturn in treatment numbers, and the associated reduction in the numbers of dentists, that it would seem at this point in time the number of dentists that we have across the country may not be adequate to meet our current anticipated demand.

Mr. SNYDER. But that is more than just a local shortage.

Mr. CLARK. Yes. I mean, it varies from place to place, but I think when you step back and look at it from a national perspective, yes, I would agree with the conclusion that you are reaching, and as I pointed out, there is—I think at least in part, that has been driven by budgetary issues.

I think given the improved budget picture in 2000 and hopefully in 2001, that is starting to turn around, those numbers are starting to turn around, and we need to monitor those very carefully.

Mr. SNYDER. I think a little of the frustration you are hearing today is most of us have fairly small legislative staffs, and even our committee staff on both sides is fairly small, and we have a lot of issues to face, and at some point we all come to conclusions about these bills.

You have all the resources in the world. This is your shop, and somehow you all haven't come to any conclusions about the answer to this problem. I think that is frustrating for the chairman who would like, I think, to perhaps solve this problem this year.

Would you articulate, you or your panel here, with the rest of my time, the specific problems with Mr. Filner's bill? Sections? Language? This is a hearing on that bill today. What are the specific problems in language with Mr. Filner's bill?

Mr. CLARK. Sir, I'm afraid the response I'm going to have to give you is probably inadequate, and that we are not yet able to take an official position with regard to that piece of legislation.

Mr. SNYDER. I agree with your comment. (Laughter.)

Mr. FILNER. I would like to make a parliamentary inquiry, if I may.

Mrs. CHENOWETH-HAGE. Yes.

Mr. FILNER. Can you give me the definition of contempt of a congressional committee? Or counsel may do that. I find this testimony incredible. It was a noticed hearing. The bills were given. Mr. Simpson is a dentist. He didn't say that, but he has knowledge of this, and the frustration in all of us is just incredible. The Chairman spoke of it in his first comments, and I find this incredible.

I have my own 5 minutes but, if you are not in legal contempt of this committee, you certainly don't show a very high respect for the committee, and I think that is troubling us all.

Mrs. CHENOWETH-HAGE. Dr. Snyder.

Mr. SNYDER. I guess in closing I will just say, Mr. Clark, we are not asking for things written in gospel here. We don't expect you to be Moses coming down from Sinai, but I don't think it's unreasonable, even though you all may have not reached some conclusions in your own house about where are the sections, where are the problems in language with Mr. Filner's bill.

I've got to go to an 11 o'clock Armed Services meeting, and I don't know anything more about Mr. Filner's bill now than when the hearing started, and I don't think I'm going to get any more information, and that's a disappointment since we have allotted a lot of time, and the committee filing this bill has.

Where are the problems in Mr. Filner's bill? You have obviously taken a position why you don't support it. Please, we are not asking for the solution if you don't have it yet. I mean, I would like to have that, where are the problems in Mr. Filner's bill? Specifically I'm not hearing it.

Mr. HALL. I think the problem that we have with the bill basically is that we haven't determined that all the elements of the bill are necessary. As Mr. Clark suggested, we are trying to identify where our problems lie.

We are recognizing that we are facing the possibility of shortages in the future with regard to dentists, and we are trying to identify within house where, what recourse we have that would best meet those impending needs, and we haven't yet come to the conclusion that all the elements of Mr. Filner's bill are necessary.

Mr. CLARK. If I may, too, part of the concern we have is the potential costs of full implementation of that legislation, which we have estimated to be 8 to \$18 million annually.

As Mr. Hall indicated, I think what we are trying to evaluate is to what extent do those full range of changes need to occur in order to respond to our anticipated recruitment and retention difficulties.

So we are trying to balance what's needed to respond to the problem that we see in front of us, and what would the cost, added cost of doing business be to responding to that problem, and so I think our concern is does the bill go too far, and consequently would it cost too much and go beyond what's necessary to respond to the recruitment and retention problem that we anticipate.

Mrs. CHENOWETH-HAGE. Thank you, Mr. Clark. The Chair recognizes Mr. Shows.

Mr. SHOWS. Thank you, Ms. Chairman. The associate degree nursing program, I understand that that's an entry level position now. I understand the VA wants the B.A. degree to be the level of education preparation for the VHA professional workforce.

This seems to me to kind of add to the shortage of nurses. How many people want to go through an associate degree nursing program only to remain at an entry level position? These individuals deserve job security and advancement if they are qualified to do the work.

Can you tell me why you did that?

Mr. CLARK. I think the reason behind it, is simply that we believe that as a health care provider, we ought to be providing health care of a quality that is second to none, and one of the ways that we do that is by hiring individuals who are health care providers who are as well-qualified as any in the field.

The purposes behind the nurse qualifications standard policy was simply to elevate the level of certification of nurses that are in VA medical centers across the country.

We recognize the difficulty that might pose by converting to that standard too quickly, and so we have phased that in over a period of time and have provided educational incentives to assist individuals to become educated and certified.

But, again, the intent was to elevate the level of quality of our workforce.

Mr. SHOWS. And so you are providing financial assistance to nurses to further their education if they want to go beyond that?

Mr. CLARK. Yes, we have a variety of programs, and we did invest over that period of time to provide opportunities for people to move to that higher level of education and qualification.

Mr. SHOWS. Will there be exceptions to the rule for those nurses who already have an associate degree currently in the system?

Mr. CLARK. There is a provision in our policy for a waiver under certain circumstances, of a professional standards board making a recommendation to the local facility director to institute a waiver.

We also are grandfathering in employees, so we feel we responded to the existing workforce.

Mr. SHOWS. Thank you, Madam Chairman. Thank you.

Mrs. CHENOWETH-HAGE. I thank the gentleman. I have some questions. Mr. Clark, is there a risk that legislation to address nurses' complaints with the locality pay system, do you feel that that would create inequities, or what seems to be the problem?

Mr. CLARK. Our concern is not with a system that would provide an annual increase in salary. I think what we want to do, and caution Congress to do, is to make sure that the language in the legislation doesn't create a situation where the VA would, in fact, be a pay leader, basically compounding locality pay increase on top of another locality pay increase.

There are potentials in the law where we see that that might occur, and we want to make sure that it doesn't put us in a position to actually move VA nurse pay beyond what the pay rate is in the community, and we feel that there is the potential in the legislation for that to occur, given the current language.

Mrs. CHENOWETH-HAGE. How do you guard against that?

Ms. HORAK. Certainly one way that one could guard against becoming a community pay leader would be by obtaining accurate survey information, and to that end, the Department is pursuing with the Bureau of Labor Statistics the potential for obtaining statistically valid salary information on nurses from them.

Mrs. CHENOWETH-HAGE. Well, it is my understanding that the VA conducted a survey on nurses' pay in 1998 in which 33 of the 58 facilities surveyed reported complaints from nurses about the locality pay system. Do we have a situation here in which nurses in some locations are generally satisfied with the locality pay, while others are really disturbed and deeply dissatisfied? And if this is the case, how do you account for that?

Mr. CLARK. Well, I think there probably is some regional variation, but I would have to say that there has been widespread dissatisfaction with the current system. I think it, to some extent, did what it was originally designed to do, but we have grown to realize

that there are shortcomings in the locality pay system, particularly, as I mentioned earlier, with regard to the reliability of data.

So not only has there been dissatisfaction in the ranks of the nursing profession about it, we, too, have recognized its shortcomings. I made earlier reference to a task force over the last couple of years that worked within VA to work with a contractor to study the system, and that was their conclusion, too, that the current system is not optimal, and in large measure because of the flawed database that we have to work on to set locality pay. We recognize that one of the principal things that we need to do is to find a better database of actual rate changes and a range of those changes in the community in order to base our decisions on pay changes.

And the current system just doesn't do that, in large part because it is entirely voluntary and we don't have good reliable data to base those decisions on.

Mrs. CHENOWETH-HAGE. Mr. Clark, there is something I would like for you to explain for the record. I was struck by the fact that during your tenure as director of the West Los Angeles Medical Center, nurses in Grades 1 through 3 apparently received no pay increase in either January 1996 or January 1997. For the record, could you explain those circumstances for us?

Mr. CLARK. It seems like several lifetimes ago, but I will go back and do that to the extent that I can recall it. Over the last several years, there have been locations around the country, certainly Southern California being one of them, where there has been dramatic downsizing in the health care inpatient infrastructure.

That probably has been more pronounced in California and particularly in Southern California than anywhere else in the country. The number of beds that are being operated in community facilities as well as VA facilities, had changed dramatically.

Over that period of time, many nurses that were engaged in support of the inpatient activities, frankly, lost their jobs through downsizing in the community. That had an impact on pay. I can't remember the precise facts back to that date, but I would speculate that if that decision was made, it was probably reflective of a downturn regionally in nurse pay rates, for those reasons that I just mentioned.

Mrs. CHENOWETH-HAGE. So it was the issue of supply and demand affecting that period.

Mr. CLARK. Purely, and that affects recruitment and retention of all health care professionals.

Mrs. CHENOWETH-HAGE. You know, Mr. Clark, it seems that we do have a dilemma. Your best answer to getting reliable data is the Bureau of Labor Statistics, but the Bureau of Labor Statistics data are years away from really giving us the answers that we need in reliable data, aren't they? Why are we relying on them when we need the answers now?

Mr. CLARK. I will, again, defer to Ms. Horak, who works with that more closely, but your assertion is correct. We know that it will take a considerable period, a long period of time and would be expensive to use BLS data, but let me ask Ms. Horak to comment on that.

Ms. HORAK. Thank you. It is true that we would not obtain, if we were to enter into an arrangement with BLS right away, a complete set of survey information until 2003, but they would start providing some salary information to us beginning in 2002, and in the meantime, or in addition to, or in lieu of the Bureau of Labor Statistics information, we can explore, and we are looking at the availability of contract information from third party private sector providers.

Mrs. CHENOWETH-HAGE. I see. Well, I will have some follow-up questions to that, but I see my time is up, and so the Chair recognizes Mr. Filner, or Mr. Doyle.

Mr. Filner, the chair is anxious to hear from you, I just made a mistake. (Laughter.)

Mrs. CHENOWETH-HAGE. Mr. Doyle.

Mr. DOYLE. We are going to save the best for last, Madam Chairman. I would like to ask unanimous consent that my opening statement be made part of the record.

[The prepared statement of Congressman Doyle appears on p. 37.]

Mrs. CHENOWETH-HAGE. Without objection, so ordered.

Mr. DOYLE. Thank you very much. Mr. Clark, it seems like, you know, before we can begin to visualize solutions to the problems, we have to acknowledge that one exists, and it seems that what I'm hearing somewhat is at the DVA you are just not quite there yet.

When you listen to Mr. Simpson's remarks and recognize that we have had an almost 11 percent decrease in dentists in the last 5 years, we have lost 7 percent of our workforce in nurses in the last 5 years, the increased waiting lines, nurses in Pittsburgh got no raise in 1996, no raise in 1997, a 2.3 percent raise in 1998, and in the next 5 years, you're going to require a bachelor's degree for your nurses—only 42 percent of the nurses have such a degree, and enrollment in nursing schools is declining, not increasing—I think it's the consensus of most of us here on the panel that there is a problem, and we need to start looking at possible solutions, and you know, perhaps the bills that we're looking at today, Mr. LaTourette's and Mr. Filner's bill, aren't perfect, but they are beginnings of recognizing that we need to start addressing these problems and looking for solutions.

I think until we agree that there is a problem, we're going to—these hearings won't be as productive as they can be, so let me ask you a couple of questions. Does the Department provide any type of guidance to the directors in determining whether or not they should be increasing pay to prevent nursing shortages?

Mr. CLARK. Yes. Information is provided, and in fact, when the local medical centers go through the process of surveying locally, that information is all analyzed at the local level, so yes, medical center directors across the country do have a range of statistics and data.

Again, it may not be the most reliable set of data, but they have the information that is available to them at the time, and in fact, since you mentioned it, yes, guidance as well. As I indicated, we have previously sent out information to medical center directors, guidance encouraging them to very carefully look at the locality

pay needs in their area, and where it is indicated, to pass on that grade increase to nurses.

And again, in the most recent year, it would appear that virtually all of our medical center directors heeded that advice, and in fact, did pass on those rate increases.

Mr. DOYLE. How do you think the current operating procedures in this regard impact the number of instances in which medical directors have refused to extend raises that were warranted and validated by the survey process?

Mr. CLARK. I don't have the information that you have, but the information that is available to me indicates that in the past when decisions were made to not pass on those rate increases, it was because the local survey data indicated that to do so would make VA a pay leader, and in fact, the increase at that point in time would not be warranted, given the data.

But again, the most recent information I have is that medical center directors have, in fact, acknowledged the need to pass on those rate increases, and have done so.

Mr. DOYLE. Do you think the VA being a pay leader is a bad thing?

Mr. HALL. It is statutorily prohibited as part of the pay statute. It says that we will not be a pay leader.

Mr. DOYLE. Mr. Clark, you are aware, I know, that the VA is required by law to maintain the capacity of its specialized services, but it seems the VA appears to be having some trouble in maintaining beds and staffing in the VA spinal cord injury centers and other programs for veterans who have spinal cord dysfunction.

Part of the problem as we understand it has also been the difficulty that VA has had in recruiting and retaining staff, particularly nurses and therapists. Would the VA consider extending its existing authority to implement specialty pay and education incentives to enhance its ability to recruit and retain nurses and therapists in the field of spinal cord dysfunction medicine?

Mr. CLARK. I would certainly acknowledge that we have had difficulty in maintaining our capacity in those areas, for a variety of reasons. That is a highly specialized area, and one where we do, in fact, have recruitment difficulties in certain medical centers in certain parts of the country, and so yes, I would certainly agree that we would want to have the flexibility, discretionary authority to respond to that specialized need in our recruitment system.

Mr. DOYLE. I see my time is just about up. Thank you, Mr. Chairman.

Mr. SIMPSON (presiding). Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman, and thank you for your earlier questions, which I'll refer to, also. I appreciate your expertise in this.

When Chairman Stearns started off the hearing, he asked some questions which revealed, I think, a real lack of responsiveness from the VA on these issues. He pointed to a 1998 directive apparently asking for a report on this area which has not been delivered.

The bill I introduced was close to a year ago, and you haven't figured out what you like or dislike about it. You were given some warning I suspect about this hearing, and yet you come with very little to say to us.

Mr. Chairman, I was not facetious about contempt of Congress, by the way, and I intend to look into how we pursue a lack of responsiveness, because this is one of the worst cases I have personally been a part of in a long time.

These are real issues. Mr. Simpson pointed out, and you affirmed the data as far as I could tell, although I am not sure of what the circular reasoning that you use is saying, but you apparently confirmed Mr. Simpson's data about the close to 200 less dentists, for example, over the last 5 years, turnover rates 11 percent, waiting times of up to 2 years. He didn't go into the time it took for vacancies to be filled. I'll just use the dentists because it's my bill here, but other Congresspeople have asked other questions, and you keep saying it's not a problem.

In fact, you ought to look at your quotes by Mr. Simpson or someone earlier when they asked about this data—you were too polite, Dr. Simpson, but you said no, it's not an issue of recruitment and retention, it's an issue of historical budget problems.

Now, I don't know what the difference is, frankly. You've got problems and you are not acknowledging the severity of them, certainly not in public, here, which means that as Mr. Doyle says, we are less likely to find solutions. The frustration that I feel in not only not getting the responses to substantive questions, in refusal to even take positions on issues that have been around for a while, is that I could imagine the frustration that our veterans must feel in trying to deal with their questions when the very top of the VA structure talks in circles and doesn't give any answers.

I am going to enter your testimony, Mr. Clark, in a contest I have about how to say the least in the most words. You just go around in circles; that average veteran, I'm not sure how they ever confront these issues.

You can't give us any time as to when you are going to answer these questions. We have a surplus of immense proportions right now. Now is the time, it seems, to deal with some of these issues.

You are supposed to be an advocate, and I have said this to other panels, the VA is supposed to be an advocate for our veterans. You should tell us what we need to do. You should be wringing our necks saying, here's what we need. The waiting time of the dental clinic is 2 years. I want that down to a couple of weeks. I want no positions vacant in our office. I want us to keep the highest quality dentists or nurses or whomever we are talking about.

I want you to demand that we help you, but you sit here and give us non-responsive answers. I'm sure you want to do a good job, and I'm sure this hearing situation puts you in a certain bind, but I will tell you that anybody listening to what you said today, or anybody reading your testimony—I hope you do, because you will be amazed at how circular your reasoning is—will see no advocacy. We see no emotion. We see no sense that there is a problem here. You show no willingness to solve it.

What are we supposed to do with your testimony? I have given up trying to ask you questions because I heard eight other people ask questions, and I didn't hear any answers. I heard one yes in your whole testimony, by the way, when Mr. Doyle asked you something. There is not any responsiveness. You talk to each other with the microphones closed, how are we going to deal with this?

We just asked the question when are we going to get an answer, and you couldn't even tell us 2 weeks, 2 years.

I guess you think that, with new elections, hopefully we are not here and you are going to go through the same thing with a new group of people. I find it extremely frustrating. I intend to pursue somehow an oversight situation when we don't get any answers to questions that elected representatives of the people ask.

You are not prepared for this hearing, and I find that an insult. You can respond any way you want. I don't intend to ask you a question, because I haven't heard any answers today, and I'm sorry to treat professional people in this way, but it was an insult, Mr. Clark.

Mr. CLARK. Mr. Filner, I certainly didn't in any way mean to insult the committee or you. I also didn't mean or appear to be unresponsive.

Let me try to provide you a direct response to the questions that you raised about dental pay. I'm not suggesting that there is not a problem with recruitment in some parts of the country with regard to dentists. There clearly is, and I didn't mean to indicate otherwise.

The data that we have indicates that there are parts of the country—there are medical centers that do, in fact, have difficulty recruiting dentists and are realizing a turnover in dentists. That is not uniform or consistent across the country, and that's why if it appeared as if I was waffling in my response, it's only because it has to do with the particular locality.

But there is a concern that we share with you about recruitment and retention of dentists and a variety of health care professionals, and I don't mean to indicate otherwise.

The concern with the bill principally rests with whether it goes too far, whether the added cost to the VA's budget would be such that we would have difficulty bearing that burden if these increases went across the board. We are looking at a more scaled-back version, if you will, that would allow us latitude to increase costs in certain discrete parts of dentists' pay that we think would respond to the recruitment and retention problem.

But again, let me state again I do not suggest that there isn't a recruitment/retention problem in the VA system for dentists.

Mr. FILNER. Mr. Chairman, I know I am at my time, but you used some data. You suggested that there was almost a 200 position decrease. You confirmed that at some point.

Mr. CLARK. That lines up with—

Mr. FILNER. So tell me where in the country those 200 vacancies are, where these specific problems are. Is San Diego missing 200 dentists? Is that where the problem is?

Mr. CLARK. No, it's—

Mr. FILNER. That's a decrease of 25 percent, right? So you have only 677 full-time dentists in the system, as my data shows. I think Mr. Simpson used that data. Where are the 200 missing from? One place? Two places?

Mr. CLARK. No.

Mr. FILNER. You said some sections of the country. Where?

Mr. CLARK. I can't tell you now specifically.

Mr. FILNER. Why? Why can't you tell me now?

Mr. CLARK. I haven't committed that to memory. I would be happy to provide that for the record. We do have that information. We have it broken down.

Mr. FILNER. So tell me, by the way, what is a specific locality? How do you define that?

Mr. CLARK. A major metropolitan area, like let's say, Los Angeles or Southern—

Mr. FILNER. How many major metropolitan areas are there?

Mr. CLARK. Probably eight to ten across the country.

Mr. FILNER. And you're saying, some localities have a shortage. How many of those eight to ten have shortages?

Mr. CLARK. That may not be only major metropolitan areas. Many of our problems with recruiting and retaining dentists are—

Mr. FILNER. You're defining it, not me. I'm just asking you what you said, that's all.

Mr. CLARK. Are in—

Mr. FILNER. You said in certain places. What is a certain place? How do you define that certain place?

Mr. CLARK. It might vary—

Mr. FILNER. Is it a metropolitan area? Is it a network area? Is it a state? Tell me how many states have shortages? How many centers?

Mr. CLARK. I would be happy to provide that for the record. I don't have that immediately—

Mr. FILNER. I will bet you it is more than a few. I will bet you it is more than a few. You can't have a 25 percent reduction in your full-time force and tell me that it is only a problem in one or two places. It just doesn't make any sense. That's what I mean by insulting us. I mean, it doesn't make any sense unless San Diego is 200 short and they were the only place that was short. It's impossible.

I am not the expert. You are the professional expert. I just see the data and hear your answers; they don't make any sense to me whatsoever.

Mr. SIMPSON. I have a question that I am going to ask on behalf of Congressman Smith. In 1990, the provisions of the bill that Congressman Smith authored, the Veterans' Health Professionals Education Amendment, H.R. 3199, became law. This established a program whereby in return for monthly tuition assistance toward the completion of a health degree involving direct patient care, members of the select reserve eligible for Montgomery G.I. bill assistance would agree to work as full-time health care professionals for the Department of Veterans Affairs.

Ten years later what I would like to ask is what has been the impact of the Health Professionals Education Assistance program on the recruitment of nurses, dentists, and other health care professionals within the VA? How many people have taken advantage of that program in each year of its existence, and what has been the retention rate of these critical health care professionals in the VA after the required time of service has expired?

Mr. CLARK. The specific questions that you ask, we would be happy to provide for the record. We do have that information. I can say generally that that has been a very, very positive addition to

the VA. Many people have taken advantage of that, and it has been useful in recruitment and retention, so I can respond in a very positive way to the impact that that's had on VA and its workforce.

The specific questions at the end of that question we can provide you certainly for the record, and we have that available.

Mr. SIMPSON. We would appreciate that. I would like to ask a couple of other questions if I could. It seems like we are very good at studying problems, and not very good at solving problems. One of the answers that you have suggested dealing with the shortage of nurses and so forth, and the ability to pay them a higher salary, is that we haven't got the Bureau of Labor Statistics and the difficulty and complexities of determining what the exact salaries are and the appropriate pay level. Is that accurate?

Ms. HORAK. I'm sorry, could you repeat the question, please?

Mr. SIMPSON. You seem to indicate that one of the difficulties you have is the complexities of determining what the appropriate pay levels and so forth is, and the surveys that are done by the Bureau of Labor Statistics that you depend on, and take, I think I heard you say it would take until 2003 to complete?

Ms. HORAK. Yes, we do not currently use BLS survey data. Right now all of our nurse pay schedules are based on surveys conducted by VA nurses and management employees, and there is difficulty in obtaining accurate information, as Mr. Clark had said, because many facilities, private sector facilities, are reluctant to participate.

Mr. SIMPSON. I find that incredible that it would be that difficult to obtain accurate information, and it would take 2 years for the Bureau of Labor Statistics to come up with that information. I mean, have we gone out and asked people?

Ms. HORAK. Asked BLS?

Mr. SIMPSON. Yes, anybody what their salaries are in the current year?

Ms. HORAK. Yes.

Mr. SIMPSON. I mean, I have information in front of me as an example that says the current VA dentist's income before taxes was \$97,500. That doesn't seem too hard to figure out. Also the average private practice in general dentist income in 1998 after taxes was \$133,400. We didn't take 2 years to figure this out. It is not that difficult to get that information, it would seem like.

Ms. HORAK. No, sir. However, the law does specify some very specific kinds of information that VA must go and collect to use in setting nurse pay, and we must comply with those provisions that include collecting starting salaries at very specific types of private sector institutions and making sure that we are collecting information that is correlated to a specific skill level that matches the VA grades.

Mr. SIMPSON. Well, I appreciate that, but it seems to me that when we have got an impending problem, that there ought to be a quicker way of resolving it and finding appropriate pay levels. It almost seems like we are using the excuse of not being able to gather the information as an excuse for not addressing the problem.

I agree with Mr. Filner that it seems like the VA is unwilling to recognize that there is a problem, or at least to address it.

Do other members have further questions?

Thank you for your attendance today, and for your testimony, and we will look forward to the information that you said that you will provide to the committee.

Our next panel is Margaret Kruckemeyer, an R.N. from the Nurses Association of the VA, Mr. Bobby Harnage, the national president of the American Federation of Government Employees, Mr. John Burton, D.D.S., National Association of VA Physicians and Dentists, and Mr. Robert Anderton, D.D.S., president-elect of the American Dental Association.

I thank you all for coming today, and welcome to the committee, and we look forward to your testimony, and we will start with Mrs. Kruckemeyer.

STATEMENTS OF MARGARET KRUCKEMEYER, RN, MA, MSN, CRNH, ARNP, THE NURSES ORGANIZATION OF VETERANS AFFAIRS; BOBBY J. HARNAGE, SR., NATIONAL PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES; ROBERT M. ANDERTON, D.D.S., PRESIDENT-ELECT, AMERICAN DENTAL ASSOCIATION; AND JOHN F. BURTON, JR., D.D.S., NATIONAL ASSOCIATION OF VA PHYSICIANS AND DENTISTS

STATEMENT OF MARGARET KRUCKEMEYER, RN, MA, MSN, CRNH, ARNP

Ms. KRUCKEMEYER. Mr. Chairman and members of the subcommittee, I am Margaret Kruckemeyer, and I'm an advanced practice nurse, and I work in the hospice unit and palliative care unit at the Dayton VA medical center.

The Nurses Organization of NOVA is a professional organization of over 35,000 registered nurses employed by the DVA. I have worn another hat that Members of Congress use to epitomize what NOVA nurses do best, and so I am pleased to present testimony on the 1999 VA Nurse Appreciation Act, H.R. 1216 on behalf of the NOVA Board of Directors and membership.

The DVA Nurse Pay Act of 1990 was a very viable concept. Its purpose was for the salaries of registered nurses to be market driven in order to be competitive with their counterparts in the community.

It has been known since 1993 that this survey process is flawed and inconsistently applied. DVA nurses have become the target of budget juggling, and now perceive the survey process as unfair, inequitable, and discriminatory.

When this law was first introduced, DVA nurses were enticed with the promise of surveys which would provide pay increases based on the local labor market areas. In 1991, 1992 and 1993, it was required that reports be submitted to Congress about pay adjustment increases, as well as the basis for not providing these increases.

Subsequent to 1993, reports were no longer required. The NOVA Board was informed at our 1998 legislative roundtable by congressional staff members that Congress was not even aware of any DVA pay problems.

Many facility directors have refused to implement pay increases that were indicated by a survey process. Increases were being re-

fused due to budget shortfalls and because they are discretionary. Nurses are frequently informed there is no money in the budget for any kind of nurse pay adjustment, and the same facility directors who denied nurse pay raises, annually receive a pay increase.

Registered nurses at DVA hospitals are working harder. As one colleague put it, we have cut past the meat and we are into the bone. Staff downsizing, increased patient acuity, shorter hospital stays, bed closures, fault-line budgets, and realignment to service lines have resulted in work overload and increased adverse events including medication errors and patient and staff injuries.

Double shifts, cross-training and mandatory overtime are causing immeasurable stress. Nurses are constantly worrying about their practice. Most feel the joy of nursing is gone for them, and nurses are finally saying we can't do this anymore.

The VA stands to lose 40 percent of its R.N. workforce by the year 2004. In fact, only 20 percent of our workforce is under the age of 40. Another fact is that the top VA nurse senior executive position still has gone unfilled for 22 months.

NOVA supports the recommendations in October of 1998, the final report of the Hay group, a study of the nurse locality pay system within the Veterans Administration that said these six points.

One, use independent third party surveys; two, acquire data on averages and ranges as opposed to beginning pay only; three, survey hospitals on actual pay rather than published minimums; four, do job analysis and detailed job matching on less than annual basis using standard industry terms and definitions; national adjustment that is in general across-the-board pay adjustment for all nurses; and No. 6, locality pay differential that reflects local market conditions or cost-of-living differences.

Mr. Chairman, NOVA thanks you for the opportunity to present testimony before this subcommittee on this issue. Nurses are at the veterans' side 24 hours a day, 7 days a week. The accomplishment of DVA's mission is integral to the morale of the registered nursing workforce which is impacted by equitable pay systems.

This is necessary in order to attract and retain and improve morale in the DVA's facilities. NOVA believes H.R. 1216 goes a long way in establishing guidelines toward this, and encourages the subcommittee to act on this bill.

This Easter lily for nurses means we will be working that holiday, too. H.R. 1216 is like an Easter lily to us, to bring rebirth and hope for the future of VA nurses.

Thank you.

[The prepared statement of Ms. Kruckemeyer appears on p. 62.]

Mr. SIMPSON. Thank you. Mr. Harnage.

STATEMENT OF BOBBY J. HARNAGE, SR.

Mr. HARNAGE. Chairman Simpson, members of the subcommittee, my name is Bobby Harnage, Sr., and I'm president of the American Federation of Government Employees. AFGFE represents over 600,000 federal employees, including 125,000 Department of Veterans Affairs workers across the Nation.

We appreciate that you're holding this meeting today, and recognize the importance of having experienced DVA healthcare workers

provide veterans with high quality, safe and compassionate health care.

Mr. Chairman, I ask that my written statement be included in the record.

Mr. SIMPSON. Without objection.

Mr. HARNAGE. AFGE supports H.R. 1216, the Department of Veterans Affairs Nurses Appreciation Act, which was introduced by Representative Steve LaTourette from Ohio. I thank him and Representative Jack Quinn for their statements to this subcommittee. I thank the members of this subcommittee who are cosponsoring H.R. 1216 and H.R. 2660. Both bills restore some common sense to the retention and recruitment.

Both would reward healthcare workers who dedicate their careers to treating veterans by ensuring they receive an annual pay increase, when others working side-by-side with them receive one.

It's clear that collecting nurses salary data has been an ongoing problem for the DVA, but even if the DVA were magically able to get the best, most accurate survey data, the current nurses pay system would still be flawed in two respects.

One, medical directors have authority to impose negative pay adjustments, and two, medical directors have the authority to deny nurses any pay increase regardless of the survey data.

Medical Directors are the DVA's officials who have the statutory authority to determine whether to make an adjustment to their staffs' salaries paid. If the medical director determines that no adjustment is necessary, then the nurses at that facility receive no annual pay increases. Under the law, the pay adjustment can be decreased in pay.

DVA's central office reviews all determinations, but the Secretary has no real authority to require that any medical director raise his nurses pay at any facility.

As you know, general schedule employees do not receive COLAs. Under federal pay comparability law, GS employees, including those who work are DVA healthcare workers, receive one, a nationwide increase, and two, a locality increase based on a comparison of a range of non-federal and GS salaries in 32 pay areas across the Nation.

DVA registered nurses do not receive either the nationwide or locality components of annual pay increases under FEPCA. Since FEPCA's enactment, GS workers have received a pay increase every year, although these increases were not as large as required by the full implementation of FEPCA.

Unfortunately, thousands of DVA nurses have not received annual increases. This is possible because under the law, if a medical director simply declares that there is no retention or recruitment problem at that facility, then no pay raise is required.

Even when DVA nurses receive pay increases, these raises lag behind those given to GS workers. From 1996 through 1999, DVA nurses on average were denied a cumulative pay raise equivalent to 4.5 percent because of the current pay system for nurses. This lost of pay affects the pocketbooks of nurses now, and when they retire.

Even worse, some medical directors adjusted nurses' pay negatively. In effect, this is a pay cut. The nurses in Louisville got a

negative pay adjustment of minus 7.7 percent in 1998, and that followed a minus 2.6 pay adjustment in 1997.

These negative adjustments occurred at a time when federal employees were required to pay more for their healthcare benefits.

Even after pay increases in 1999 and 2000, these nurses have yet to see a real dollar increase in their pay. Their retirement benefits have also been eroded as a result of these negative adjustments.

The DVA nurses' pay system should reflect that DVA is a unique and unparalleled healthcare system. It provides care and treatment that is not easily obtainable in the commercial sector. Logically, DVA should be placing a premium on staff who devote their careers, competence, skills and experience. Treating veterans with fewer R.N.'s and fewer support staff caring for sicker veterans who typically have multiple physical and mental illness, patient care can be at risk. With restructuring of the DVA, the need to respect, appreciate and pay fairly seasoned nursing place escalates.

Requiring the DVA to pay nurses the same nationwide and locality pay raise given the GS employees is consistent with the DVA's budget submission for the past several fiscal years.

In fiscal year 2001, the DVA requested \$63.5 million to support pay raises for the R.N.'s under the nurses locality pay system. The fiscal year 2001 request takes for granted that nurses would be receive the same percentage of the combined nationwide and locality increases as was requested for GS employees, therefore requiring the DVA to provide nurses with the same total percentage increase as their GS co-workers and would not undermine or disrupt the DVA's budget.

Mr. Chairman, that concludes my remarks, and I look forward to working with you and your staff and the subcommittee on improving and passing H.R. 1216 and H.R. 2660. I would be happy to answer any questions.

[The prepared statement of Mr. Harnage appears on p. 67.]

Mr. SIMPSON. Thank you. Dr. Anderton.

STATEMENT OF ROBERT M. ANDERTON

Dr. ANDERTON. On behalf of the American Dental Association, I want to thank you, Mr. Chairman, for the opportunity to testify today.

I'm Dr. Robert Anderton, president-elect of the American Dental Association and a practicing dentist in Carrollton, TX. I'm here today to address two areas of concern for VA dentistry—the oral health needs of America's veterans, and the recruitment and retention of VA dentists.

I know the VA is committed to providing comprehensive health care, and that oral health care is an essential component of those comprehensive services. However, difficulties of retaining and attracting dentists to the VA has made keeping this commitment very tenuous, at best.

We submit that this is a serious problem and critical now. A recent study of patients in VA hospital-based home care programs indicates that 65 percent of the patients are in need of dental care; 30 percent cannot chew most foods; 21 percent need help in eating which indicates they also need assistance in their oral hygiene; and 55 percent of the patients have not seen a dentist in over 2 years.

While oral health care is urgently needed in its own right, the failure to adequately treat oral disease can also complicate the patient's medical condition. That's why it's important to eliminate infections in the mouth prior to surgery, chemotherapy or radiation treatment.

Regular dental care is also important because dental exams can provide advanced warnings of the onset and progression of numerous systemic diseases, such as coronary heart disease, diabetes, and strokes. So you see, Mr. Chairman, the evidence indicates a direct link between veterans' oral health and their overall general medical health.

To serve these needs, the demand for dental care has increased over the past 10 years. For example, in 1989, VA dental services received over 95,000 consultation requests from other hospital services. By 1998, 9 years later, there were over 104,000 consultation requests, a 10 percent increase.

Yet while the demand is increasing, the number of VA patients receiving dental care is decreasing. In 1997, VA facilities treated over 3.1 million patients, of whom 330,000 were dental patients, or roughly 10-1/2 percent. By 1999, the total number of VA patients treated grew to 3.4 million, while the number of dental patients fell to 318,000, which is approximately 9 percent, or a drop of a percent and a half.

The Association believes that the primary reason for this reduction in dental care is a shortage of VA dentists. In 1989, there were 850 full-time dentists working at VA dental clinics. By 1999, 10 years later, that number had fallen to 654 dentists, a 23 percent decrease.

Unfortunately the retention and recruitment numbers are projected to get even worse. Within the next 3 years, as you previously noted, Mr. Chairman, almost 70 percent of all VA dentists currently serving will be eligible for retirement. Those who resign from the VA system before they are eligible for retirement stay for only 7.7 years. The turnover rate during the past 2 years has been over 11 percent.

In regard to compensation, Mr. Chairman, not only is the pay for VA dentists well below that of private practice, but it is not even on parity with dentists and physicians in other federal services.

There is a precedent for what is being proposed in H.R. 2660. A similar set of financial incentives was provided to the Department of Defense and the Public Health Service to help them recruit and retain dental officers. These efforts have proven to be successful today.

To help stem this tide of VA dental vacancies, the American Dental Association is proud to support H.R. 2660. This is a VA dental equity bill sponsored by Congressman Filner. H.R. 2660 would increase tenure pay amounts to help to retain VA dentists. It would raise the full-time status component pay from \$3,500 to \$9,000 annually, and it would increase responsibility pay for VA dentists in management positions, to mirror the same range of responsibility pay for physicians.

In conclusion, Mr. Chairman, the ADA recognizes the multitude of funding priorities that our Congress must reconcile this year, but we firmly believe that ensuring the availability of VA dentists to

provide necessary dental care for our country's veterans certainly deserves primary consideration.

The financial incentives described in greater detail in our written statement and provided for in H.R. 2660 will address these concerns. We urge your consideration and support of these proposals and we thank you again for the opportunity to offer this testimony.

[The prepared statement of Dr. Anderton appears on p. 73.]

Mr. SIMPSON. Thank you. Dr. Burton.

STATEMENT OF JOHN F. BURTON

Dr. BURTON. Thank you, Mr. Chairman. Good morning to you and members of the committee. I'm Dr. John Burton, chief of the dental service at the VA in Columbia, SC. I'm also treasurer of the National Association of VA Physicians and Dentists, for whom I testify today.

NAVAPD is the only national organization representing all the doctors who work in VHA. We thank you for holding this important hearing today.

NAVAPD strongly believes there is a serious recruitment and retention problem within VHA. As a result, the quality of patient care is suffering in VA if you measure quality by such fundamental things as continuity of care, access to specialists, availability of a full range of services and reasonable waiting times.

I have been practicing in the VA 27 years. My career commitment and length of service were typical just a few years ago. But that's changing. Long-serving doctors are leaving VA and they are not being replaced. Let me share a few examples.

Right now, many VA's no longer have any surgical subspecialists on staff. Patients needing subspecialty care must be sent to other facilities at great expense to VA, hardship for patients and families, and serious delays in care.

I personally know of one Midwestern VA that had eight cardiologists on staff; three have recently left, three plan to leave, and there are no applications to fill the vacancies.

The problem is not confined to medical and surgical specialties. In one facility I know of, 12 primary care physicians have left in the past 5 years, resulting in virtually no continuity of care. This is a chronic and widespread problem about which patients are rightfully unhappy.

The problem with dentists is even more serious. You have heard the numbers this morning. VA's total full-time dentists is hovering around 650 from a high of 1,000 to 1,100 dating back to the 1980's.

In my own dental service, I had six full-time dentists, four of which have taken early retirement in the past 2½ years. Right now in my clinic, patient waiting times for initiation of treatment range from 6 to 9 months; completion of complex cases may easily take 18 to 36 months.

I know of one other Eastern facility where the number of general dentists has gone from eight to two in the past several years, and only one of these vacated staff positions will be filled.

The picture of oral surgery is even worse. Of the 89 oral and maxillofacial surgeons who were employed by VA in the mid-1990's, 41 had left their jobs by the end of 1999. Nine surgeons have been recruited to replace them. Twenty facilities that previously had an

oral surgeon on staff now have none, including my own VA hospital in Columbia.

NAVAPD believes the VA staffing problem is primarily the result of two factors—compensation and morale. VA doctors' salaries lag far behind those in the private sector. I'm a good example. My salary from the years 1992 to 1996 suffered a 7 percent reduction in buying power, while the salaries of my private practice colleagues increased 15 percent. This is a 22 percent differential.

If Congress is serious about solving the recruitment and retention problems, it can take two steps. The first is to enact H.R. 2660, which is legislation to give dentists practicing in the VA pay parity with our physician colleagues. Currently dental pay ranges and all elements of special pay are drastically lower than those for physicians.

The administration has indicated it may propose changing this for just two elements of special pay, full-time and responsibility. But the leadership in VA headquarters in Washington does not understand the magnitude of the employment crisis in individual hospitals. Recruitment has been designated a local responsibility, and the office of dentistry has admitted that it is not directly involved in the staffing process, and often does not even know when and where vacancies exist.

NAVAPD acknowledges that H.R. 2660 is not a magic bullet, but it is a best first step. We urge the committee to move expeditiously to enact H.R. 2660.

Also it is critically important that the statutory language be constructed in such a way that the administration cannot interpret away either any compensation increases or the basic concept of parity. In the past, the VA has done that. It continues to do so today.

NAVAPD's second recommendation would be to require the VA to implement locality pay for all VA doctors. The law authorizing locality pay recognized the cost of living differences from one area of the country to another, based on the fact that the purchasing power of federal salaries was eroding.

Most VA workers, all general schedule workers get locality pay, but VA doctors are denied it. We have no more control of the economic factors that affect buying power in a particular area than do other employees.

I want to add one more comment about the administration proposal for special pay that is currently being discussed. These two changes alone—namely increasing full-time and responsibility pay—would give the majority of VA dentists only \$5,500 increase. Certainly that's not enough to impact recruitment and retention.

For years, NAVAPD has appealed to VA leadership to make locality pay available to VA doctors. Our requests have been routinely denied. VA's rationale essentially has been that the geographic location component of special pay provides local VA's the flexibility necessary to offer competitive rates. In fact, the flexibility offered has allowed VA's to chose not to offer this proportion of pay at all.

VA's own data indicate that less than one-fourth of all VA doctors receive any geographic location pay. The negative consequences of such salary decisions are being felt in VA today by pa-

tients who have to wait longer for appointments, or whose primary provider regularly changes, or who have to travel long distances to get care, or who simply just do not get care.

Mr. Chairman, if I'm to carry out my responsibility to the veterans who come through the doors of my hospital, then I need a well-qualified staff. Today I don't have the adequate tools to attract them.

NAVAPD strongly supports the enactment of H.R. 2660, and the implementation of locality pay for VA physicians and dentists. Thank you for your time this morning. I would be happy to answer questions.

[The prepared statement of Dr. Burton appears on p. 79.]

Mr. SIMPSON. Thank you, Dr. Burton. We also have with us today, and the Chair would offer the invitation for Dr. Thomas Soliday, from the American Association of Oral and Maxillofacial Surgeons, to come up and present testimony.

Dr. Soliday.

STATEMENT OF J. THOMAS SOLIDAY, D.D.S., AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS

Dr. SOLIDAY. Thank you, Mr. Chairman. I'm an oral surgeon. I'm representing more than 6,000 members of the American Association of Oral and Maxillofacial Surgery. I would like to thank Mr. Filner and this committee for the opportunity to testify.

To provide the members of the subcommittee with a bit of background, I'd like to briefly describe the practice of oral and maxillofacial surgery. Oral and maxillofacial surgeons are dental specialists who treat conditions, defects, injuries, and aesthetic aspects of both the mouth, the teeth, the jaws, and the face. Our training includes at least a 4-year graduate degree in dentistry, plus the completion of a 4 to 6 year post-doctorate hospital surgical residency program.

Oral and maxillofacial surgeons care for patients who experience such conditions as problems with their wisdom teeth, with facial pain, with misaligned jaws. We treat trauma, patients suffering from facial injuries in the hospital emergency rooms.

We offer reconstructive surgery such as cleft palate and cleft lip repairs, dental implant surgery, and surgical care of patients with tumors and cysts of the jaws and the functional and aesthetic conditions of the maxillofacial areas.

Mr. Chairman, we are pleased that the subcommittee is exploring the issues of recruitment and retention and compensation of dentists employed by the Veterans Administration. This is a promising step that brings attention to the disturbing decline in the delivery of dental services to veterans who often have no opportunity to access care other than through the VA.

The crisis concerning the delivery of dental care within the VA is especially critical in my profession, the oral and maxillofacial surgeons. As the only dental specialty designated as having extraordinary difficulties in recruiting, it is imperative for the VA to have the tools necessary to recruit and retain the oral and maxillofacial surgeons.

I'm going to, as a matter of time, skip a lot of my testimony, Mr. Chairman. You will have a copy of it, I believe.

The situation regarding recruitment of dentists, specifically the oral and maxillofacial surgeons, has reached a critical level. As was testified by Dr. Burton, 20 VA facilities that employ oral and maxillofacial surgeons 3 years ago no longer have one on staff. Even the facilities where oral and maxillofacial surgeons positions have not been eliminated, recruiting to fill a vacant position normally takes more than a year, if a candidate can even be found at all.

In one instance in a VA facility in North Carolina, they had to recruit for more than 4 years to fill a staff oral and maxillofacial surgeon position. A facility in Oregon had recruited two candidates who initially accepted the position, but later declined because of lack of adequate pay.

Even in Florida, the VA cannot find candidates to fill positions as general dentists because of uncompetitive pay scale. Obviously these vacancies, the conditions of overwork, the inability to complete work, create a situation of patient care that is lacking, and the employees' morale is waning. A solution must be found.

Perhaps the most immediate step that can be taken is for Congress to enact the provisions of H.R. 2660, including guarantees that VA administrators follow both the spirit and the letter of the law by strictly re-establishing pay parity between dentists and physicians in the Veterans Administration.

At the time when the income for dentists in private practice is at a high point, it is impossible for the VA to compete with it when it offers the lowest dental salaries among the federally employed dentists. To make the VA competitive requires a comprehensive review and upgrading of the pay schedule for dentists.

The current special pay is simply inadequate to recruit and retain special candidates to serve the veterans of our Nation.

Enactment of H.R. 2660 would provide immediate relief to dentists already employed in the VA, and give them an incentive to continue their career within the federal services. It would also provide the VA with a powerful new recruitment tool to help fill the existing vacancies.

The patients served by the Veterans Administration deserve to receive the health care they have earned. It is time we to provide it for them, therefore the more than 600,000 members of the American Association of Oral & Maxillofacial Surgery requests the subcommittee to support the passage of H.R. 2660.

Mr. Chairman, there are 172 VA hospitals in this country. It's been testified that there are 38, 38 full-time oral and maxillofacial surgeons. Of that 38, 14 are in administration. That leaves 24 full-time oral and maxillofacial surgeons to service 172 facilities.

The Veterans Administration's mission, statement of mission, their code of mission, is for patient care, education, and research. How can 24 oral and maxillofacial surgeons carry out their mission statement with lack of personnel? We need this H.R. 2660 to help recruit more.

I thank you.

[The prepared statement of Dr. Soliday appears on p. 85.]

Mr. SIMPSON. Thank you, Doctor, and your full statement will be entered in the record. I would like to, for the record, enter a paragraph from the report to the President from the VA administration.

This is a report to the President on adequacy of special pay for physicians and dentists. It was offered in 1999.

One paragraph states as follows: "VHA is starting to experience difficulty in recruiting and retaining dentists. Most of this difficulty is focused on the VHA's ability to offer adequate financial incentives due to the limitations of dental special pay. During a 5 year period starting in 1995, VHA has experienced a decline in full-time dentists from 830 to 677, while the annual turnover rate has been running in excess of 11 percent. There are also fewer highly qualified applicants to fill vacant positions, and most vacancies take several months to fill. During this same period, income levels for dentists in the private sector have increased to an average of \$130,000 per year versus an average of \$95,000 per year for VA dentists. In addition, Congress recently passed legislation that provided essentially bonuses of \$30,000 for newly appointed military dentists, while at the same time increasing tenure pay to an amount up to \$18,000 per annum."

Let me ask, and I guess Dr. Burton would be the best one to ask, is pay the only issue that dentists entering the VA, is that the only issue that they are concerned about? Why do dentists choose the VA?

Dr. BURTON. No, sir, that's not the only issue. Certainly it is one that's critical. Since I am in the recruitment process right now myself, I will just share with you that I advertised for 2 months in the Journal of the American Dental Association and also on the Internet. As a result of that advertisement, I got two qualified applications on a national search, which I think was very disappointing.

Working conditions, staff support and clerical support are all issues of concern to VA dentists. If you go in the typical dental office in private practice, you will have somewhere in the neighborhood of 3.7 support personnel per dentist working in a given office. In the VA, we are lucky if we get one to one.

The pressure over the last few years, and the reorganization of the VA—which in my opinion in many respects was long overdue, and I support many of those concepts—has put pressure on clinicians to produce more, but the infrastructure to support them in that endeavor has not been provided.

So it is also a morale issue—there is a lot of pressure to produce more, but the incentive is not there. You have people, like those on my staff with 22, 25, 26 years of service, who say, "I don't like this anymore, I'm just not happy," and they leave. I have a very close friend leaving in July from my staff to go into private practice full-time where he will be easily receiving compensation on about a 2½ day week equivalent to that which he is getting from VA right now on a 5-day week.

Mr. SIMPSON. What about the aspect of teaching and research that the VA—you mentioned, or Dr. Soliday mentioned that the mission of the VA was also in teaching and in research. How has that—has that been also decreasing in the VA?

Mr. BURTON. Well, sir, in a sense it has. In my particular program, for example, we have a training program in affiliation with the local hospital. The difficulty we have now is the balancing be-

tween teaching and production. The pressure is there to see more patients, the demand is certainly there, as I shared with you.

How do we balance that with giving our residents adequate educational experiences, adequate supervision from the staff when at the same time, I have a hundred percent disabled veterans waiting 9 months for me to make a simple set of dentures for them?

You know, it's sad, and literally yesterday in my clinic I told a gentleman and his wife that it was going to be 9 months before we could actually deliver a set of dentures for him. It's a sad state.

Mr. SIMPSON. I had a difficult time when I had to tell patients that it would be 3 weeks. I suspect 9 months, they get a little upset at that.

But I also understand that I have information here that indicates that due to the lack of oral and maxillofacial surgeons, that the largest dental implant study in the history is in jeopardy due to the inability to recruit and retain those surgeons, is that true?

Dr. SOLIDAY. Yes, sir, that is true. You know, the VA could be very, very proud that they instituted this implant study and research many years ago, and because of patient care crisis, these patients need the care, the actual work on this research is having to be downgraded and curtailed.

Mr. SIMPSON. Thank you. Given the statement that I read from the report to the President that the VA made earlier, and then from the comments that were made today where they mentioned that although the VA does not currently have a widespread recruitment and retention problem for dentists, there are some areas where problems exist, some areas.

Almost 70 percent of the VA full-time dentists will be eligible for regular or early retirement in the next 3 years. It would seem to me that that is clearly an indication that you have a problem in recruitment system-wide if the age of the population of your dentists, 70 percent of them are going to retire within the next 3 years, or are eligible for retirement, which means you don't have young dentists coming up in the field, which means that you are not able to recruit those. Wouldn't that indicate that same thing to you?

Dr. BURTON. Yes, sir. We are having great difficulty, and again, I will use my personal situation. I had a general dentist retire in July of 1998, an oral surgeon retire in July of 1999—early retirements, I might add, both gentlemen in their 50s—I have another gentleman that is retiring in July. In fact, he's gone. He is taking some vacation now, and then I have another dentist who has announced his retirement for October 1.

So that's four dentists from July 1998 to October of 2000 who are leaving, and I don't have anybody knocking on the door to come work for me right now.

Mr. SIMPSON. I appreciate that. I should note that I retired from dentistry early, too, and am thinking real seriously about going back. (Laughter.)

Mr. SIMPSON. Mr. Doyle.

Mr. DOYLE. Thank you, Mr. Chairman. Let me say it's refreshing to hear from the people on the front lines or the people representing the people on the front lines. We need to do more of that on the committee.

Mr. Harnage, I think you hit the nail right on the head when you spoke of the problems with the current nurse pay system, and it seems that the problems are stemming more from the manner in which they are being implemented rather than how they were designed. I think VERA is another good example of this.

You know, given your comments, do you think it is productive to presume that if nurses leave the VA, then we should increase nurses' pay, but if they don't quit their jobs, then they should never get a raise? I mean, isn't that sort of the mentality that we seem to be working under?

Mr. HARNAGE. That seems to be the philosophy of the VA right now.

Mr. DOYLE. Let me ask Margaret, the Hay Group report makes several recommendations about nurse executive pay, including using a national rather than local data, and creating a new pay system. Do you support the recommendations in the Hay Group report?

Ms. KRUCKEMEYER. I certainly do, and when you are looking at trying to get your top nurse leaders as your senior nurse executives, I think just looking at what's happening right now with not us having to fill our first position which has got reduce from the Associate Chief of Medical Services to that of a chief nursing consulting position, it is still unfilled for 22 months, and it only pays \$110,000.

Mr. DOYLE. Let me ask anyone on the panel if Representative Filner's bill were to be enacted, what is your level of confidence that it would be implemented in the manner that it is intended, and not in a backwards manner that we seem to have seen in the 1990 Nurse Pay Act implemented?

Dr. BURTON. I'm confident it will not be implemented the way it is intended. (Laughter.)

Mr. DOYLE. Thank you, Mr. Chairman.

Mr. SIMPSON. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman. Thank you for the courtesy extended to Dr. Soliday and for your homework on this issue, and I certainly want to thank Ms. Kruckemeyer, Mr. Harnage for you and your organizations' representation of employees. I see SEIU folks back here also. We thank you all for working to improve the status and pay and working conditions.

People want to help other people. People have a special feeling for veterans and they want to help them, but they need the working conditions also to make that possible. I want to thank the dentists and the surgeons for being here. Where did you all get your data that you used for us, these reports and your testimony?

Dr. BURTON. The particular data that I used was my paycheck for one, and the comparative data was published by the ADA. They publish a—what's it called, Bob? The survey of dental practice. They publish salary data. The most current version ends in 1996, so I took my pay and compared it to average salaries in 1992 to 1996, and that's where I got my data for that.

Mr. FILNER. I read your testimony earlier, and I just, there is a lot of data there, and I would like you to give your sources to the folks who testified earlier because they didn't have a lot of data. (Laughter.)

The data is there. The problem is clear. Our bills are first steps and even for those we are worried about implementation, and this is a no-brainer, as far as I'm concerned. I mean, we ought to take these first steps and then ask what do we have to do for the second step, or the third step.

My own vision of what you all should be doing, and that's the vision I think should be coming from the VA, is we should have the highest quality physicians, nurses and dentists giving the heroes of our country, our veterans, the highest quality service that they should have without waiting times, without having to go through big bureaucracies, and frankly, in terms of dentistry especially, we should be on the offensive.

One-third of the homeless on the streets are veterans. A big part of homeless issues center around dentistry it turns out. People who have had no dental care and have lots of problems literally cannot face the outside world. They cannot apply for jobs. Dentists can do a lot about them. We know they can be dealt with, and that's what our VA should be doing.

I hope somewhat of that message, and I appreciate your efforts here today, and we will continue trying. Mr. Simpson, thank you for your expertise here, and I hope you take the lead—let's take the first step regardless of the fact that the data won't be available to us apparently from the VA for several years, and let's take those first steps.

When I saw the cost estimate for my bill went from \$8 million to \$18 million, that is a hundred and something percent difference. I mean, when you have got 600 folks. You know the pay grade scale. You know what they are going to get if they get a pay raise. Tell me how much that costs. We could all probably do that in 10 minutes. I don't know what the issues are.

I don't mean to simplify something that is complex, but it doesn't seem hard to me right now. Of course, I am not a physician. I'm only a Ph.D. Thank you.

Mr. SIMPSON. Thank you, Mr. Filner.

Mr. SIMPSON. Thank you, Mr. Filner, and I thank you for your leadership on this issue. I would like to ask just a couple of other questions. Mr. Harnage, are you concerned, there was talk about the concern about making the VA pay leader in the area of nurses. Are you concerned that this proposal would make the VA the pay leader in a given area?

Mr. HARNAGE. I'm not concerned with that, because mainly I don't agree with the concept that treatment of veterans should be on the low end of the scale. I think the government ought to be setting a precedent, not following what everybody else does.

The nurses and all health care people within the Veterans Health Administration are dealing with a unique group of patients. You don't find the same out in the private sector, and that has to be taken into consideration, that they are dealing with, on an average, a sicker population, a population requiring more care than you would find in the private sector, and unique care.

I think it's absolutely an insult to the veterans, and I'm a veteran myself, that you have to wait 9 months for dental care, for a set of teeth, when you can get them in 24 hours in the private sector. I just came from Boston, Massachusetts and Jamaica

Plains, where they have got a dialysis unit there that is about to be privatized, not because it is the more economical way to go, and in fact even though the VA doesn't come under A-76 studies, its analysis showed that it was more economical and better for the veteran to do it in-house, they are continuing to privatize it, but in Cincinnati, Ohio, you have a director there who is bragging about his facilities, his dialysis facilities, and what a great service he is providing to the veterans.

We can build an amputee a leg in 48 hours, but we can't give him a set of teeth in 9 months, so I don't think we ought to be looking at the care of our veterans, those people that served our country, as the low end of the scale when it comes to pay. I think we ought to be recognizing this as a unique service, this is a unique, a group of patients that we are trying to serve, and it takes more dedication, more skill, and more experience.

We shouldn't be saying okay, we're going to punish you for staying here so long. We are going to punish you for being so dedicated. We are going to punish you for not leaving, and we are not going to raise the pay until you leave and then we have a problem finding somebody to replace you, and then we will give them the higher pay.

So I don't have a problem if we do become the leader. I think that's where we ought to be. I understand the law says we won't be, but I think the law is flawed.

Mr. SIMPSON. That is an interesting comment. It seems like we always get ourselves in a crisis situation and then we try to address it, and the people that benefit are those that come along after the crisis, instead of those that have stayed around and done the job for many, many years.

So what you are suggesting is that it is okay if the VA becomes a pay leader in a given area.

Mr. HARNAGE. I think it's where it ought to be.

Mr. SIMPSON. Any other questions?

Mr. FILNER. There is no danger of that happening from the bills that are here. (Laughter.)

I think we will worry about that when we get to a decent salary, then we will worry about whether they ought to be leaders. Thank you again, for being here.

Mr. HARNAGE. If I might, on that, yes, you asked a question and the answer, I apologize for your frustration that I have experienced over the last couple of years dealing with the Veterans Administration, but when asked about a particular pay increase, and they said to implement it would have made them the pay leader, just blows my mind because the data that gave them that information indicated that they were underpaying the nurses, not overpaying them. How could they become the pay leader using that same data and giving them the pay increase? I don't understand that, and I hope that you pursue that answer.

Mr. SIMPSON. It's a miracle of science. (Laughter.)

Thank you. You heard this morning that we had some problems with definitions, and you know, so—I thank you for your testimony today and all those that came here. As I said, your full written testimony will be included in the record, and we look forward to working with you as we try to address this issue to make sure that our

veterans receive the health care that they have been promised by this country.

Thank you. The meeting is adjourned.

[Whereupon, at 12:07 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CONGRESSMAN GUTIERREZ

I am pleased that we are here today to discuss the topic of recruitment, retention and compensation of the healthcare personnel that serve our veterans in VA facilities. I thank the witnesses for appearing here today and I look forward to hearing their perspectives on this important subject.

As we all know, the quality of VA healthcare depends on the ability of the VA to recruit and retain individuals who are committed to improving the health and quality of our nation's veterans. Without continuing to recruit men and women, the overall quality of care offered by the VA will surely suffer.

I am concerned that the VA is already losing its ability to attract and retain quality healthcare professionals. VA's inability to retain and recruit medical personnel exists for a number of reasons, and many of our witnesses here today will shed light on this issue. As we will learn, the VA is often unable to offer salaries to its employees that are competitive with the private sector. Many VA employees, even those with tenure, do not receive adequate salary increases on a regular basis.

In many VA hospitals around the country we are seeing reductions in full-time employees. As a result of the cuts in staffing, doctors, nurses and other medical caretakers spend less time with each patient, their patient caseload is increased significantly and they are forced to work doubleshifts and overtime, often to the detriment of their own physical and mental health. Thus, the quality VA healthcare suffers and the likelihood of medical errors increases significantly. In addition, the reduction of full-time employees often results in increased waiting periods for appointments and the elimination of specific medical services. Mr. Chairman, this is unacceptable.

The difficulty of VHA to recruit, retain and compensate medical personnel is a serious matter that deserves our immediate attention. These men and women who served our country honorably deserve the very best care we can give them. If the VA does not take steps to recruit more doctors, nurses, dentists and other medical staff, we will soon be facing a very serious crisis. I urge my colleagues in Congress to support a Fiscal Year 2001 budget for the Department of Veterans Affairs to adequately address these problems and I urge Secretary West and our officials at the Department of Veterans Affairs to implement policies that will improve these troubling conditions.

PREPARED STATEMENT OF CONGRESSMAN DOYLE

As always, I want to thank Chairman Stearns and Ranking Member Gutierrez for bringing the subcommittee together to discuss issues that are of critical importance to the VA Health Care System.

I particularly want to express my thanks in terms of the make-up of this morning's panelists. It will be refreshing to hear directly from those who serve on the frontlines in our VA facilities—the nurses, dentists, and doctors who are ultimately responsible for delivery care to our veterans. Too often I find that we approach healthcare matters in a seemingly indirect manner by way of talking to those who hover around the actual delivery of care or to those who analyze it from afar. So again, I am appreciative that we actually have VA health care personnel here to provide their unique perspective on the issues of recruitment, retention and compensation.

As many of you may be aware, I am a cosponsor of both Representative LaTourette's Nurse Appreciation bill and Representative Filner's Dentist Equity Act. My support for these bills provides a clear indication as to my personal opinion as to the status of recruitment, retention and compensation practices currently in place within the VA—quite frankly they appear to not be working and are in need

of adjustment. I realize that there are those who may view both the LaTourette and Filner bills as not providing the perfect solutions, but these bills at the very least should be credited for recognizing the problems and positing possible approaches. It is my sincere hope that the Committee will look to this morning's hearing as a starting point from which to further refine these two bills and coalesce even greater support for them.

But you know, whether we talk about the process that drives capital asset planning as we did last week in committee or the process that drives recruitment, retention and pay decisions, we can not begin to visualize improvement until we first acknowledge that there are problems that exist. Sticking our heads in the sand is not productive and serves only to impede the delivery and dilute the quality of the health care that our Nation's veterans receive. We must respond to the need to approach VA matters in a more decisive and rational manner and above all else we must get away from always reacting after the fact. We need to respond much more proactively not only in terms of the issues we are discussing today, but a whole host of system-wide concerns.

Thank you Mr. Chairman.

PREPARED STATEMENT OF CONGRESSWOMAN CHENOWETH-HAGE

I would like to thank Chairman Stearns for holding today's hearing. I would also like to thank the panelists for appearing before the Subcommittee, and for providing valuable testimony to improve the quality of life for our VA healthcare workforce.

Chairman Stearns, the Clinton/Gore Administration's blatant neglect of our veterans has compromised VA health care. Last month, we heard from veterans' organizations that the Clinton/Gore Administration began this Congress on a dark note for veterans. The Administration presented to our veterans its fourth consecutive, flat-lined starvation budget for the VA. Under Clinton's FY2000 budget, if the Veterans Administration were to function exactly as it did the previous year, it would be one billion dollars short of what is needed going into Fiscal Year 2001. This at a time when our World War II veterans are in increasing need of healthcare, when healthcare costs are on the rise, and when the number veterans requiring complex healthcare is at an all-time high.

Mr. Chairman, how can this Administration expect to provide health care without a VA workforce? Earlier this year, a group of health care personnel from the Boise VA Medical Center visited me. These dedicated individuals expressed concerns with the Clinton Administration's treatment of VA health care personnel. Under the current Administration cost-of-living proposal, these employees would only receive one-fourth of the increase under the Federal Employees Pay Comparability Act. They have served our veterans so well, and yet the Administration still continues to ignore their needs.

This Administration's policy has driven away qualified medical personnel from our VA health care system. Despite the passage of the DVA Nurse Pay Act of 1990, Public Law 101-366, this Administration has failed to match pay with private sector standards. In fact, VA facility directors, who deny nurses pay raises, routinely give themselves a pay increase and bonus! It is no wonder VA dentists have left in droves—a high of 1100 dentists a few ago have dwindled down to the current figure of 650.

Though the VA engaged a contractor to assess problems under the current pay system, it has been slow to adopt solutions. In June 1998, the VA contracted for study on the current system. In November 1998, Congress in Public Law 105-368 directed the VA to provide recommendations by February 1, 1999 to remedy the problems. This requirement was not met until December 1999, when Secretary West furnished a report reflecting the basis for a totally undeveloped implementation plan.

Mr. Chairman, it has been almost 2 years since the VA's began investigating this situation, yet no solutions have been implemented. Why is this Administration compromising our veterans' health care? This is what we must get to the bottom of here today.

Thank you Chairman Stearns.

**STATEMENT OF LANE EVANS
RANKING DEMOCRATIC MEMBER
HOUSE COMMITTEE ON VETERANS AFFAIRS
HEARING ON THE STATUS OF RECRUITMENT, RETENTION, AND
COMPENSATION OF THE VA HEALTH CARE WORKFORCE
INCLUDING NURSES, PHYSICIANS, AND DENTISTS
APRIL 12, 2000**

Good Morning, Mr. Chairman. I am pleased to be here today as we examine the status of VA's workforce. Mr. Chairman, there is no doubt that VA's greatest resource is its dedicated workforce. In FY 2001, VA estimates it will spend about 55% of its budget on personal services and benefits—it is far and away VA's largest cost center. Accordingly, any discussion of budgets for maintaining a world-class health care system for our veterans appropriately begins and ends with the cost and use of VA's direct care staff.

In this regard a few trends are telling, VA staff treat 20% more enrolled patients with 10% fewer employees than they did just five years ago when staff costs consumed 5% more of the budget. Like other health care providers striving for efficiency, VA's management has greater expectations of its staff than ever before. VA staff is expected to be more autonomous and wellness-oriented; it is expected to be flexible shifting from inpatient to outpatient and home health care settings, and, as VA becomes increasingly focused on third party collections and performance measures, its staff must deal with increasingly weighty documentation requirements.

To meet these new challenges VA is developing new staffing models that rely on fewer, but more highly trained staff who are capable of working independently or as part of a team. Using a managed care approach that has become prominent throughout all of health care, VA makes use of primary care teams that must oversee the health of large numbers of veterans assigned to them. Teams are responsible for screening veterans for age and gender-related risk factors as well as health behaviors that contribute to poor health outcomes. They must diagnose and treat or refer any conditions appropriately. They must educate patients about managing chronic conditions, about the appropriate use of medications, supplies and equipment and about reducing risky behaviors. They must accomplish all of these goals for an extremely complex group of patients within the timeframe of an average 20-minute visit. As you can surmise, these incredibly challenging tasks must be managed by extremely skilled workers who are capable of making informed decisions quickly.

VA's nurses, who comprise almost a third of its health care workforce, are clearly an important part of making this ongoing transition. VA nurses have had to be flexible—many have shifted from inpatient settings where doctors are the primary decision-makers to outpatient settings where they make their own decisions with less time and less guidance. VA's statistics on employment indicate a shift from the use of licensed practical or vocational nurses to more highly trained registered nurses. VA's testimony will indicate that in the last year VA has increased its nurse practitioner workforce by 9.3% while decreasing its registered and licensed nurse workforce. These statistics reflect VA's new uses of nurses and its implementation of new nurse qualifications that require all VA nurses to be working toward at least a baccalaureate degree in nursing.

Unfortunately, at the same time VA is expecting more to be accomplished by its nurses, its pay policy has not reflected this interdependency. We enacted VA's Nurse Locality Pay System in 1990 during a nursing shortage in order to allow hospital directors to recruit and retain this valued part of VA's workforce. The policy, however, created a double-edged sword that allows directors to reduce or eliminate pay raises when their workforce is stable. While VA has, thus far, managed to avert major turnovers or shortages in its workforce, nurses believe that management has balanced its last four years of frozen budgets at their expense. Indeed, since at least FY 1996, at many VA care sites, this appears to be the case. In none of these years, did the average pay raise for nurses either meet or exceed the comparability pay raise for other federal civilian workers. In fact, in most facilities, nurses' pay raises were considerably lower. For example, at the Iowa City VA Medical Center, beginning rates of pay for nurses in each grade did not change in 1996 or 1997, while comparability pay raises increased at 2.4% and 3% for each respective year. In 1998, the rates increased from 1% to 2.29% which was still less than the 2.8% pay raise other federal employees received. This example makes it clear why nurses, including our friends in the American Federation of Government Employees and Nurses of VA whose representatives will testify today are calling for a better deal.

VA has been fortunate, thus far, that, despite this treatment, it has retained its workforce. But this luck may soon run out. Decreases of almost 3% in the nurse anesthetist staff last year may indicate that time is now. Nurses comprise an aging workforce and VA nurses are older, on average, than others. In addition, in the near future, VA nurses must have or be in the process of acquiring baccalaureate training which may greatly curtail VA's supply of eligible nurse candidates. According to the American Nurses Association, in 1996, only about

42% of registered nurses had at least a baccalaureate degree. Unless nurses with less training are willing to commit to continuing their education, this will cut VA's available nursing candidates by more than half.

Certain areas of the country may also experience shortages in workforce before others. West South Central States—Arkansas, Louisiana, Oklahoma and Texas—have almost half the nurses available per 100,000 people than states in New England which has the highest concentration of nurses. But as VA's need for new nurses grow, the nursing profession as a whole may have fewer nurses to offer. First-year enrollments in nursing schools dropped precipitously between 1985 and 1986, and while it began to rebound in the early nineties, it is showing signs of dropping again. As a majority of VA nurses reaches the age of eligibility for retirement, VA will have a greater challenge in finding eligible candidates in a shrinking pool.

We all understand we must have meaningful and reliable data in order to implement VA's nurse pay system accurately. There are a number of challenges that impede this process, but I intend to ensure that we meet them as we work toward getting nurses the pay they deserve.

That's why I am a cosponsor of the Department of Veterans Affairs Nurse Pay Appreciation Act of 1999. By setting a floor on pay raises and mandating increments to accommodate the local nursing market using accurate survey data, it is one response that would give VA a better chance of meeting its recruitment and retention goals in the future.

VA also has an immediate concern in addressing its dentists' compensation needs. VA dentists have shown the greatest signs of attrition with more than 3% leaving the system last year. Almost 70% of VA's dentists are eligible for retirement in the next three years. VA dentists are paid less than Defense dentists, dentists in academia, or dentists in private practice. VA dentists make between 20 to 35% less than dentists working in these settings.

The nation's supply of dental graduates peaked in the early eighties and has gradually declined to a fairly stable level since that time. VA's pay schedules do not accommodate the competition for these scarce health care personnel. VA is noting some troubling trends such as longer recruitment periods for new dentists that reflect the disparities between VA dentists and those dentists who practice elsewhere. As VA faces a peak in retirement eligibility, this troubling trend may lead to significant problems filling vacancies its dentists leave behind. Something

must be done in the near future to address this situation before it becomes a significant problem.

I am an original cosponsor of Bob Filner's bill, H.R. 2660, "Put Your Money Where Your Mouth Is—The VA Dentists Equity Act". This bill would allow VA to offer dentists special rates of pay which are now applicable only to its physician staff. These rates reward full-time status and tenure. They are aimed at creating a stable and loyal workforce of dentists. While this is a relatively small workforce, access to dentistry is critical to an aging population of veterans with service-connected needs for dental care.

A multitude of issues effect recruitment and retention of VA's physician staff. Like other health care providers, VA has problems bringing physicians, and particularly specialists, into its ranks, especially in parts of the country where such specialists are already rare. VA's shift to a primary care focus has affected its educational programs and care duties. These changes, understandably, have been unsettling to VA's physician community.

Physicians' average salaries vary from 114 to 177% above rates for VA physicians in different specialties. Specialists' average salaries are more disparate between VA and other sectors than primary care providers. Still, other factors such as predictable hours, opportunities for research and teaching, and other incentives may be more meaningful for VA physicians. This is still a trend worth monitoring.

Since we are here today to address workforce concerns, I do not want to neglect the opportunity to address a small, but critical need for VA's physicians assistants (PAs). Chairman Stump and I recently asked Deputy Under Secretary for Health, Dr. Tom Garthwaite, to address the need for a consultant for VA PAs. I have been concerned that VA PAs have no one within VA's management hierarchy to voice their views and promote their profession within VHA. I was deeply disappointed with the non-responsive reply we received that referred to the PA's longstanding involvement on a Field Advisory Group. This has clearly not addressed the need. PAs are a small, but vital part of the VA workforce. As physician extenders, they play a critical role in addressing the primary care needs of veterans and yet, at the same time VA increased its nurse practitioner staff by 9.3%, it only marginally increased its physician assistants' staff (.8%). Organized leadership could promote the profession within VA and bring better care to veterans. I would appreciate VA re-examining the need for a consultant for the PAs in the near future.

Pharmacists and certain other allied health professionals are increasingly nearing the caps that are set on their salaries. As an increasingly important part of the primary care team—inside and outside of VA--pharmacists are in high demand. VA pharmacists are not yet leaving the system, but VA is beginning to experience recruiting difficulties—especially in the Western part of the country. VA has already broken the cap applied to physical therapists and certain other providers. The cap problem may limit VA's ability to recruit new pharmacists and must be re-assessed in the near future.

Mr. Chairman, VA's workforce is its most important asset. I am looking forward to working with you to address some of the concerns I and others will raise today. Thank you.



April 11, 2000

The Honorable Lane Evans
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Representative Evans:

I am writing to request that the following statement in support for the provision of specialty pay for nurses and therapists in VA's spinal cord dysfunction programs be included in the record of the House Veterans' Affairs' Subcommittee on Health hearing on April 12, 2000.

Specialty pay for clinical staff in VHA's programs for veterans with spinal cord dysfunction (SCD) would provide incentives for nurses and other non-physician clinicians to seek, qualify for and maintain long term commitments to the difficult and challenging work involved in caring for paralyzed patients.

PVA strongly believes that VHA should use existing authority, as specified in VA Directive 5575.3/1, to implement specialty pay for individuals other than physicians assigned to SCD programs. We also believe that the qualifications specified in the directive should be supplemented by requirements for successful completion of training programs recognized by the Chief Consultant, Strategic Health Care Group for Spinal Cord Injury and Disorders.

Providing recruitment, retention and education incentives under this authority would enhance VHA's ability to comply with the Congressional mandate to maintain capacity in these programs currently experiencing long-standing shortages in trained, experienced personnel. It would not increase base pay and would not continue for employees who leave SCI/D service.

Thank you for your assistance.

Sincerely,

Richard B. Fuller
National Legislative Director

Chartered by the Congress of the United States

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December 8, 1999

Honorable Thomas L. Garthwaite
 Acting Under Secretary for Health
 Department of Veterans Affairs
 Washington, DC 20420

Dear Dr. Garthwaite:

We recently met with representatives of the Veterans Affairs Physician Assistants Association who related a concern that VA has made only limited progress in removing barriers to greater use of these health care professionals.

Dr. Kenneth Kizer, to his credit, convened working groups to identify and help overcome barriers to VA employment of non-physician clinicians. The most recent of those initiatives, the establishment of the Multidisciplinary Practice Advisory Board, was apparently intended to develop strategies for, and oversee implementation of recommendations to address practice barriers faced by physician assistants and other mid level non-physician clinicians. That Board issued a report in June, but the status of its recommendations and implementation plans are unclear.

In that regard, the Association makes what appears to be a very reasonable request in urging the establishment of a Physician Assistant consultant position in the Office of the Under Secretary. Creating a consultant position (whether in Central Office or field-based) would appear to help in formulating policy and in carrying out changes proposed to overcome employment barriers. There can be little doubt that VA has (and has exercised its) broad authority as to the manner in which the Office of the

Honorable Thomas L. Garthwaite

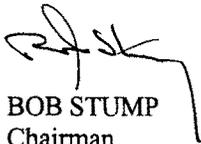
Page 2

Under Secretary for Health is staffed and organized (notwithstanding language which provides that the Office include Directors of specified "Services"). Section 7306 of title 38, United States Code, provides that the Office shall include "[s]uch directors of such other professional or auxiliary services as may be appointed to suit the needs of the Department." In that regard, Congress has recognized the important role for physician assistants in the Veterans Health Administration in providing specifically in section 7302(a)(2) of title 38 for training and employment of veterans with military backgrounds in that occupational specialty.

The Committee would appreciate learning what plans you have for reviewing the advisory board report and acting on its recommendations as well as for establishing a consultant position.

Thank you for your attention to these issues.

Sincerely,



BOB STUMP
Chairman



LANE EVANS
Ranking Democratic Member

BS/alj

cc: Mr. Thomas Zampieri

FEB 10 2000



DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

FEB - 4 2000

In Reply Refer To:

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Evans:

Thank you for your inquiry regarding a consultant position for physician assistants in the Veterans Health Administration (VHA) as well as our plans to respond to the June 1999 Multidisciplinary Practice Advisory Board (MPAB) Final Report.

One of the goals for the Department of Veterans Affairs' (VA) transformation to a national health care system is that it achieve an appropriate mix of primary care providers that includes non-physician clinicians (NPCs). The proposal from the VA Physician Assistants Association that a physician assistant, either in the field or in VA Headquarters, serve as a consultant on behalf of VA's physician assistants has merit. However, this is not a recommendation of the June 1999 Multidisciplinary Practice Advisory Board (MPAB) Report.

This report does recommend the formation of Network level MPAB advisory Boards to assist Networks in addressing critical clinical, resource, and practice issues when utilizing non-physician clinicians (NPCs). The report also recommends a work group be established to rewrite VHA Handbook 1100.19 dated April 4, 1997, Credentialing and Privileging, with specific application to NPCs.

While the plans for implementation of the recommendations of the MPAB are not finalized, the Chief Consultants of the Primary and Ambulatory Care, Nursing and Pharmacy Strategic Health Care Groups are in the process of establishing a permanent standing Multidisciplinary Practice Advisory Council (MPAC). The Council will address implementation of outstanding recommendations of the MPAB. Subsequently, it will provide input and advice to VHA's leadership on all matters of interest and concerns to NPCs, including physician assistants. We anticipate that three physician assistant leaders in VHA will be offered membership on the new MPAC, along with an equal number of pharmacists and advanced practice nurses. We are planning to establish the Council by March 15, 2000.

2.

The Honorable Lane Evans

Physician assistants (PAs) are currently represented in VHA by the Chief Consultant, Primary and Ambulatory Care who is in direct contact with the Physician Assistant Field Advisory Group (PAFAG). The PAFAG is composed of four physician assistants and two physicians. Its chairperson serves as program advisor to the Chief Consultant for Primary and Ambulatory Care.

The current chairperson of the advisory group, Rebecca Goldsmith, PA-C, has served on the Under Secretary for Health's Work Group tasked with Exploring Internal Practice Barriers for Advanced Practice Nurses, Clinical Pharmacy Specialists and Physician Assistants. The work group identified barriers to hiring non-physician health care providers in VHA. Ms. Goldsmith was appointed to the Multidisciplinary Practice Advisory Board as a Co-Chair. This Board was charged with implementing changes to overcome the barriers to hiring non-physician health providers. She authored the "PA Employment Handbook" which has provided guidance to VHA health care facilities when hiring PAs.

Ms. Goldsmith also authored the "PA Practice Issues Handbook" which is an educational tool that assists health care managers to understand the role of physician assistants in VHA. The work of Ms. Goldsmith and others on the PA Field Advisory Group has helped VHA health facilities to recruit and retain PAs. The relationship between the Chief Consultant, Primary and Ambulatory Care and the PA Field Advisory Group has worked well in support of the PA Program.

Thank you for your interest in VHA's Physician Assistant Program and the role of NPCs in providing the best possible care for the Nation's veterans.

A similar letter has been sent to the Chairman, Committee on Veterans' Affairs.

Sincerely,



Thomas A. Garthwaite, MD
Deputy Under Secretary for Health

**Statement of Congressman Jack Quinn (R-NY)
House Committee on Veterans' Affairs
Health Subcommittee**

**Recruitment, Retention and Compensation of the VA Health Care
Workforce
April 12, 2000**

I would like to take this opportunity to thank my colleagues on the Veterans Affairs Committee, Chairman Stearns, Ranking Member Gutierrez, and the members of the Health Subcommittee for holding this hearing today. I appreciate the opportunity to submit a statement for the record.

Mr. Chairmen, in my capacity as Chairmen of the House Veterans' Affairs Benefits Subcommittee I have had the unique opportunity to meet many men and women who work at our VA Medical Centers and outpatient clinics. These men and women who serve our veterans, especially nurses are often not equally compensated as their counterparts. These men and women choose to serve our veterans and they should be paid for their sacrifices.

I am a proud co-sponsor of Congressman LaTourrette's legislation, H.R. 1216, The Department of Veterans' Affairs Nurses Appreciation Act of 1999. As you know, this legislation would amend title 38, United States Codes, to provide that pay adjustments for nurses and certain other healthcare professionals employed by the Department of Veterans Affairs shall be made in the same manner as is applicable to Federal employees generally and to revise the authority for the Secretary of Veterans Affairs to make further locality pay adjustments for those employees.

This legislation would bring pay for VA nurses up to par with other Federal employees. H.R. 1216 would guarantee department of Veterans nurses, as well as any other health care employees for whom the VA Medical Director has discretion whether to pass on annual increases) the same GS increases plus locality pay given to most federal workers.

Many facilities within the Department of Veterans' Affairs Health Care network are experiencing nursing shortages, due in part to the non-competitive salaries being offered. Our sick veterans deserve the highest quality health care and with the outsourcing of nurses they are not always receiving the highest quality care. The intent of this legislation is not to deny Medical Directors or the Secretary of the VA the ability to respond future nurse shortages by offering higher wages, it is to give this workforce some uniformity with the pay of their counterparts within the VA's health care network.

It is imperative that we change the current law, that is why I am a proud co-sponsor of Congressman Latourette's legislation. The pay of our VA Nurses has slowly improved. However, we must pass this legislation to show them how much their work on behalf of veterans is valued.

Mr. Chairman, thank you for allowing me to submit my statement for the record and sharing my views on this legislation with the subcommittee.

Statement of Congressman Steven C. LaTourette (R-OH)
House Committee on Veterans' Affairs
Health Subcommittee

Recruitment, Retention and Compensation of the VA Health Care Workforce
April 12, 2000

I'd like to thank Chairman Stearns, Ranking Member Gutierrez, and the members of the Health Subcommittee for holding this important hearing today. I very much appreciate the opportunity to submit a statement for the record.

Mr. Chairman, the men and women who work at our VA Medical Centers and outpatient clinics care for our nation's ailing veterans with tremendous professionalism and heart. Our VA health care workers provide much needed and highly specialized care with great compassion. Many choose to work with veterans because they enjoy the satisfaction of helping those who have served our country. These health care workers, and VA nurses in particular, find their jobs challenging and rewarding in many, many ways. For thousands of VA nurses, however, their pay is not equally rewarding.

Many VA nurses have come to expect that their pay will not reflect their performance in any given year. VA nurses throughout the country have endured year after year of nominal raises or frozen wages. This has happened as virtually all other federal employees received annual increases — increases that sometimes have been twice those of VA nurses. This is not the way a grateful nation should be treating those responsible for restoring the health of our national heroes.

The law that created a locality survey-based pay system for VA nurses was clearly well intended, and it initially achieved what it sought to do: to recruit and retain a quality nursing force. It beefed up the workforce and made VA nurse salaries competitive with the private sector. Regrettably, however, the same law that initially so dramatically helped VA nurses has since been used as a cowardly tool to avoid giving raises that VA nurses have earned and deserve. Legislation I have introduced, the VA Nurse Appreciation Act of 1999, H.R. 1216, will maintain many of the good provisions of the Nurse Pay Act. It also will update the law to reflect a far different workplace scenario than existed a decade ago. Under my legislation, the 39,000 VA nurses will be assured the same annual increase as their fellow General Schedule (GS) workers, and flexibility will allow the VA to pay nurses more if locality studies show there are retention or recruitment problems.

Not many people would stay in a job where they received no annual raise, or an annual raise of less than one percent. The fact that so many of our VA nurses have remained loyal to their patients and the VA proves that this is a very generous, compassionate and dedicated workforce. VA nurses have specialized skills to deal with the unique needs of veterans — from spinal cord injuries, to veterans suffering from a perplexing array of Gulf War illnesses, to mental illness. Their training and expertise often are not easily matched to nursing jobs in the

private sector, nor is their experience easily transferred to the private sector. The average VA nurse is 47 years old, and I don't think you find many folks in the prime of their career willing to give up their seniority, responsibility or work schedule to start from scratch someplace else.

Chairman Stearns, my legislation has broad bipartisan support, including support from 11 members of the full committee and five members of your subcommittee. It is also supported by full committee Ranking Member Lane Evans and Health Subcommittee Ranking Member Luis V. Gutierrez. In addition, H.R. 1216 has the support of the American Federation of Government Employees (AFGE), the American Nurses Association (ANA), and the National Federation of Federal Employees (NFFE).

I am heartened by the VA's more generous financial stance toward nurses since the introduction of the VA Nurse Appreciation Act last year. After many years of crossing their fingers and praying the pay situation would improve, it appears the leanest, cruelest years of nurse pay have passed. Pay has increased recently for many nurses, and the VA should be commended for that. Still, more work must be done. From 1996-1999, no raises were given to Grade I, II or III nurses (statistically 98% of the VA nurse workforce) at nearly 80 separate VA medical centers around the country. This is unconscionable.

Nurse pay is slowly improving, but until this largely female workforce has parity with its fellow VA health care workers and the men and women in uniform for whom they so lovingly care, the VA nursing workforce will never be as stable as it should be. If our veterans were worthy of a 4.8 percent pay increase this year, shouldn't the very people who care for them be worthy of that increase, too? It's time to change the law and show our VA nurses that their work is appreciated and valued.

VA Nursing Statistics

How VA nurse annual salary increases compare to GS employees	
<p style="text-align: center;">VA Nurse Salary Increases</p> 1996: Average raise was 1.2% 1997: Average raise was 1.2% 1998: Average raise was 2.2% 1999: Average raise was 3.0%	<p style="text-align: center;">GS Employee Salary Increases*</p> 1996: Average raise was 2.4% 1997: Average raise was 3.0% 1998: Average raise was 2.9% 1999: Average raise was 3.6% <i>*Note: The raises can increase significantly if federal workers live in areas with a high cost-of-living, such as New York, Houston or San Francisco.</i>

From 1996 to 1999, GS federal workers received raises of 2.4% to 3.6% or more. VA nurses at the following facilities had their pay rates cut by as much as	
Fayetteville, NC (-2.7%) Louisville, KY (-7.7%) Wichita, KS (-8.0%) Chillicothe, OH (-0.7%) Cleveland, OH (-0.4%) Columbus, OH (-2.8%) Danville, IN (-1.7%) Indianapolis, IN (-4.6%)	Iron Mountain, MI (-3.5%) Bay Pines, FL (-0.3%) Des Moines, IA (-1.4%) Iowa City, IA (-0.3%) Biloxi, MS (-1.1%) Denver, CO (-2.7%) St. Louis, MO (-1.4%) Sheridan, WY (-4.6%)

Sometimes VA nurses are given minuscule raises
<ul style="list-style-type: none"> • Grade I nurses in Fargo, ND, received a 0.1% increase in 1996 • Grade II nurses in Tucson, AZ, received a 0.1% increase in 1997 • Grade I nurses in Central Texas received a 0.1% increase in 1998 • Grade I nurses in Charleston, SC, received a 0.1% increase in 1999

While GS federal workers got raises of at least 2.4% in 1996, no raises were given to Grade I, II and III nurses (typically 98% of the workforce) at these facilities	While GS federal workers got raises of at least 3.0% in 1997, no raises were given to Grade I, II and III nurses (typically 98% of the workforce) at these facilities	While GS federal workers got raises of at least 2.9% in 1998, no raises were given to Grade I, II and III nurses (typically 98% of workforce) at these facilities	While GS federal workers got raises of at least 3.6% in 1999, NO raises were given to Grade I, II and III nurses (typically 98% of the workforce) at these facilities
Bedford, MA Boston, MA Brockton, MA Connecticut Northampton, MA	Bedford, MA Boston, MA Brockton, MA Connecticut Manchester, NH	Connecticut Richmond, VA Minneapolis, MN Sioux Falls, SD Muskogee, OK	Boston, MA Mountain Home, TN Iowa City, IA Long Beach, CA

Togus, ME	Northampton, MA	New Orleans, LA
Batavia, NY	Providence, RI	Albuquerque, NM
Bronx, NY	Togus, ME	El Paso, TX
Brooklyn, NY	White River	Grand Junction, CO
Castle Point, NY	Junction, VT	Fresno, CA
East Orange/Lyons,	Batavia, NY	Honolulu, HA
NJ	Buffalo, NY	Palo Alto, CA
Montrose, NY	Bronx, NY	VANCHCS (No.
New York, NY	Brooklyn, NY	CA)
Northport, NY	Castle Point, NY	Long Beach, CA
Lebanon, PA	East Orange/Lyons,	Los Angeles, CA
Fort Howard, MD	NJ	Sepulveda, CA
Durham, NC	Montrose, NY	West Los Angeles,
Richmond, VA	New York, NY	CA
Birmingham, AL	Northport, NY	
Columbia, SC	Butler, PA	
Montgomery, AL	Clarksburg, WV	
Fort Wayne, IN	Coatesville, PA	
Marion, IN	Philadelphia, PA	
Minneapolis, MN	Pittsburgh, PA	
Lincoln, NE	Wilkes-Barre, PA	
Leavenworth, KS	Durham, NC	
St. Louis, MO	Fayetteville, NC	
Alexandria, LA	West Palm Beach,	
Bonham, TX	FL	
Kerrville, TX	Memphis, TN	
Amarillo, TX	Murfreesboro, TN	
Big Spring, TX	Nashville, TN	
Tucson, AZ	Fort Wayne, IN	
Grand Junction, CO	Chicago, IL	
American Lake,	Hines, IL	
WA	Madison, WI	
Palo Alto, CA	Milwaukee, WI	
San Francisco, CA	North Chicago, IL	
VANCHCS	Tomah, WI	
(Northern CA)	Minneapolis, MN	
Loma Linda, CA	Iowa City, IA	
Long Beach, CA	Columbia, MO	
Los Angeles, CA	Poplar Bluff, AR	
San Diego, CA	Muskogee, OK	
Sepulveda, CA	New Orleans, LA	
West Los Angeles,	Phoenix, AZ	
CA	Prescott, AZ	
	Denver, CO	
	VANCHCS (No.	
	CA)	
	Loma Linda, CA	
	Long Beach, CA	
	Los Angeles, CA	
	San Diego, CA	
	Sepulveda, CA	

West Los Angeles, CA	
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VA Nurses – Additional Statistics	
<p><i>Number of VA Nurses:</i></p> <ul style="list-style-type: none"> • 39,209 nurses nationwide <p><i>Employment Status:</i></p> <ul style="list-style-type: none"> • 88.9% work full time <p><i>Gender:</i></p> <ul style="list-style-type: none"> • 87.3% are female <p><i>Average VA Nurse is:</i></p> <ul style="list-style-type: none"> • 47-year-old female with 11 years tenure and earns \$48,000 <p><i>Length of Service:</i></p> <ul style="list-style-type: none"> • 35.7% have worked for the VA between 1 and 5 years • 29.1% have worked for the VA between 5 and 10 years • 33.2% have worked for the VA between 10 and 20 years 	<p><i>Age of Nursing Staff:</i></p> <ul style="list-style-type: none"> • 5% are under age 30 (1,956 nurses nationwide) • 19% are ages 30 to 40 (7,450 nurses nationwide) • 41.1% are ages 40 to 50 (16,119 nurses nationwide) • 34.9% are over age 50 (13,684 nurses nationwide) <p><i>Grade Level:</i></p> <ul style="list-style-type: none"> • 98.1% of all VA nurses are Grade I, II or III (only 749 nurses fall within Grade IV or V) • 18.7% are Grade I • 59.4% are Grade II • 20.1% are Grade III <p><i>Retention of Nurses:</i></p> <ul style="list-style-type: none"> • 4.8% voluntarily quit

Sources: Department of Veterans Affairs: *A Study of the Nurse Locality Pay System within the Veterans Health Administration*; Congressional Research Service Report to Congress: *Pay and Retirement Benefits for Federal Civil Service and Military Personnel: Increases from 1969 to 1999*.

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**STATEMENT OF
 KENNETH J. CLARK
 CHIEF NETWORK OFFICER
 VETERANS HEALTH ADMINISTRATION
 DEPARTMENT OF VETERANS AFFAIRS
 BEFORE THE
 SUBCOMMITTEE ON HEALTH
 COMMITTEE ON VETERANS AFFAIRS
 U. S. HOUSE OF REPRESENTATIVES**

April 12, 2000

Mr. Chairman and members of the subcommittee,

I am pleased to appear before the committee to discuss the recruitment, retention, and compensation of health care professionals and to present the Department's views on H.R. 1216 and H.R. 2660.

VA's health care providers are its most important resource in delivering high-quality, compassionate care to our Nation's veterans. We must maintain the ability to recruit and retain well-qualified individuals in health care and related occupations. Compensation, employment benefits and workplace factors affect our ability to recruit and retain employees, particularly in highly competitive labor markets and for hard-to-fill occupations. Thanks to the efforts of this Committee and the Senate Veterans' Affairs Committee, VA is able to offer generally competitive pay in most markets. VA continuously monitors the recruitment of health care workers, trends in private sector employment, and workforce projections for the health care industry. At the present time, health care staffing in the VA health care system is relatively stable and we are not currently experiencing any widespread or critical staffing shortage for our health care occupations.

However, there are some specific problem areas – individual locations that are experiencing some difficulties for some occupations and non-VA pay trends for dentists and pharmacists are beginning to create difficulties.

VA Nurse Pay

Under the authority of the "Department of Veterans Affairs (VA) Nurse Pay Act of 1990," VA established the Nurse Locality Pay System (LPS) covering Registered Nurses and Nurse Anesthetists. The purpose of the LPS is to ensure that pay rates at VA facilities are sufficient to be competitive with those at local non-VA health care facilities for the recruitment and retention of nurses and nurse anesthetists. Under the Act, officials of VA medical centers throughout the country establish nurse pay schedules based on the results of local salary surveys.

Pay Adjustments for VA Nurses under the Locality Pay System

An analysis of the average full-time nurse salary in VA, as compared to the average nurse salary in the United States over the past ten years shows a close linkage between VA's salary trends and those for the U.S. nursing population. Over the past 5 years, average increase for VA's LPS schedules increased from 1.67 percent in January 1996 to 4.27 percent in January 2000.

Recruitment and Retention of VA Nurses

Recruitment and turnover data for VA full-time nurses for the past 15 years show that VA nurse employment trends have remained relatively stable.

VA's Study of the Locality Pay System

In 1998, the Department hired an outside contractor to conduct a comprehensive review of the Nurse Locality Pay System (LPS). The results of that study were reviewed by an implementation group of management and employee representatives, which reached consensus on a number of recommendations.

Among the key recommendations the group presented to the Under Secretary for Health and the Secretary of Veterans Affairs were:

- ◆ To develop a third party source for survey data. The group strongly recommended that the Bureau of Labor Statistics (BLS) be selected as the source for this information.
- ◆ To collect data on actual pay rates and ranges, rather than just published minimum rates. The group was concerned that the current survey methodology could result in an underestimating of actual starting salaries.
- ◆ To improve communications with nurses regarding the locality pay process.
- ◆ To separate nurse executives from the locality survey processes and establish a separate pay setting process for them. This recommendation was intended to deal with the unavailability of survey data for key nursing positions.
- ◆ To establish a system to assure that nurses receive equitable treatment vis-à-vis the market in which they work.

The Secretary accepted the group's recommendations and forwarded the complete report to Congress on November 29, 1999.

The key conclusion of the contractor and the implementation group was that the current survey process is flawed and that another methodology is needed for pay adjustments to ensure more equitable pay adjustments for nurses.

VA has accomplished or is working on a number of the Report's recommendations that can be acted on without legislative action. For instance, VA is working with BLS to develop a survey methodology for them to collect nurse pay data for the LPS. Those surveys would use re-described survey jobs to find private sector pay data, and would collect rate ranges, average salaries, and actual hiring rates. VA has provided guidance and instruction to managers and nurse executives on the use of LPS and other pay flexibility to advance recruitment and retention goals. In addition, for the last three years, the Under Secretary has strongly encouraged all facilities to grant pay adjustments to nurses in January to coincide with the timing of pay increases in other different pay systems.

The Department's Views on H.R. 1216

H.R. 1216 would expand the VA occupations covered by the LPS, would require that the pay rates of covered employees be adjusted annually under Title 5, revise the LPS survey process, and retain VA's authority to make local pay adjustments in addition to the Title 5 annual adjustment. The Department supports the goal of H.R. 1216 – equitable pay adjustments for nurses – however, we have concerns with the bill as currently drafted.

Coverage of H.R. 1216 -- H.R. 1216 would expand the Locality Pay System (LPS) beyond the current coverage of nurses and nurse anesthetists to include all Title 38 occupations (except for physicians and dentists), hybrid occupations, and some Title 5 occupations. This would require VA to use BLS surveys, where available, for the Title 38 occupations of optometrists, podiatrists, physician assistants, and expanded-function dental auxiliaries; the hybrid occupations of occupational therapists, physical therapists, pharmacists, certified or registered respiratory therapists, and licensed/vocational nurses; and, the Title 5 occupations of dietitians, psychologists, and other scientific

personnel (such as microbiologists, chemists, biostatisticians, and medical and dental technologists).

The costs for BLS locality surveys for these additional occupations would be significant, and the resulting data could be of limited validity, accuracy, and value, given the small population numbers of individuals in some of the occupations, the difficulty of surveying in small geographic areas, and the lack of pay-related national staffing problems. These occupations currently are paid from national pay schedules linked to or under the General Schedule, and already receive annual increases in the same manner and at the same time as General Schedule employees under 5 U.S.C. 5303 and 5304. In addition, the Department currently has the flexibility to adjust rates using the special salary rate mechanism if nationwide rates are not sufficient to recruit and retain well-qualified individuals. We do not believe that bringing these additional occupations under the LPS is necessary, practical, or even beneficial.

Annual Pay Adjustment Mechanism – H.R. 1216 would provide that covered positions, which are currently paid under the Locality Pay System (LPS) and receive rates of pay based directly on the community rates for comparable positions, would be adjusted annually in accordance with the provisions of 5 U.S.C. 5303, which provides for general comparability increases to basic pay, and 5 U.S.C. 5304, which provides for locality-based comparability payments (LCP). Because the LPS system is part of VA's independent title 38 personnel system, changes should be accomplished solely in title 38. Title 5 should not be applied to title 38 employees.

LCP works as an add-on to General Schedule pay, based on the difference between the General Schedule (GS) basic pay rates and local prevailing rates of pay at private employers, as measured by the Bureau of Labor Statistics. The statute provides for a graduated increase in the locality payment over a number of years to bring Federal pay to within 5 percent of the community. Those increases have been accumulating every year since 1994, and now vary from just under 7 percent in many parts of the country to a high of just over 15 percent in San Francisco.

LCP add-ons are paid at the full amount for the locality in which the individual works. There is no provision in Title 5 to pay only a portion of the LCP accumulated percentage. VA is concerned that, as a result of this legislation, nurses, whose salaries have been adjusted to reflect locality rates, would become entitled to the full LCP percentage, on top of their LPS rates. VA does not believe that this would be the intent of the legislation, and is concerned that the language be carefully crafted to avoid such an unintended consequence.

A key concern about such a possible outcome is that many VA facilities would become community pay leaders if starting salaries were increased by 7 percent or more throughout the continental United States. A comparison of VA starting rates for nurses at grades I through III to the community pay leader shows that one-third of the VA starting rates are at or within about 5 percent of the highest community rate found. For these VA locations, then, mandated LCP adjustments would result in VA becoming the community pay leader.

A second concern is that the proposed bill provides that the LCP adjustment would become part of the nurses' basic pay. Because LCP is tied to where employees work, it is not portable and is not part of employees' basic pay. LCP serves to offer competitive salaries with the private sector in a given locale; it serves, then, as a recruitment and retention tool for the community where it is paid. If the LCP increase were to become part of nurses' basic pay, it would have the effect of making permanent a conditional locality payment. Thus, making LCP a part of nurses' basic pay would create an advantage not accorded to General Schedule and other employees. Another disparity that would result from adding the LCP to a nurse's basic pay is that it would be compounded (magnified) by future increases in basic pay, whether due to future pay increases, promotions, etc.

If LCP is to be granted to nurses, the Department believes that the LCP increase should not be granted until the valid, accurate, and sufficiently detailed locality survey data

collected by the Bureau of Labor Statistics is available. In addition, VA nurses should not receive the full accumulated LCP add-on, but only the current year adjustment. Until such time, adjustments should continue to be made under the current VA LPS statute.

Use of BLS Survey Data to Set VA Nurse Pay Rates – Another of our concerns with H.R. 1216 relates to the proposed mechanism for use of Bureau of Labor Statistics (BLS) data. The proposed language would provide for use of BLS data in lieu of facility-conducted salary surveys. The proposed bill, unlike the current VA statute, does not provide for any alternative mechanism. We are very concerned that under this rigid mechanism the Department will not be able to respond to certain situations, such as instances where BLS data are not available or not yet validated, where BLS data are not available for specialty assignments or qualifications, where, for technical reasons, BLS surveys must cover an area too large to be useful in meeting local nurse salary competition, or where BLS data do not support higher rates for a facility, even when it is documented by recruitment and retention data that an increase is necessary.

We believe that the Department needs the flexibility to consider salary information beyond and in addition to the BLS results if we are to retain the ability to adjust pay rates when justified and necessary to maintain a competitive stance with the community, whether it be to set rates for remote locations, for specialized groups of nurses, or for pay comparability, should the BLS survey data not be adequate to VA's staffing needs. Thus, VA favors retention of its current authority to conduct local surveys where BLS data are inadequate, not yet validated, for too large an area, or offer insufficient detail on specialties. It is important that H.R. 1216, if it is adopted, make clear that any adjustment in pay for nurses not be mandatory.

Availability of BLS Data – We understand that BLS data would not be available until 2002 at the earliest. The initial cost estimate from BLS to provide survey data for nurses alone ranges up to \$10 million per year. The cost would increase significantly if VA were to include additional occupations, such as those proposed for inclusion by H.R. 1216.

Other Concerns – The bill does not continue the provision to use contractor salary data for pay setting for nurse anesthetists. The flexibility to survey rates paid to contract employees is one that the Department believes should be retained.

Amendment Concerning Annual Pay Adjustment for Employees on Special Salary Rates – We understand that a proposal has been submitted that would amend HR 1216 to provide for a change in the annual pay adjustment process for employees with special salary rates set under 38 U.S.C. 7455. It is unclear how this alternative proposal might work. We are concerned that it would mandate that the annual comparability increase under 5 U.S.C. 5303 and the locality increase under 5 U.S.C. 5304 be granted to employees receiving special salary rates. This provision could result in VA becoming a community pay leader or could cause VA facilities to delay adjusting rates when warranted. For example, if a facility increases pay rates for a healthcare occupation in October to maintain comparability with the community, and then is required to pass on the comparability increase the following January, the VA's rates could exceed community rates. Alternatively, a facility might defer a warranted increase in the latter half of a year, knowing that a mandated increase was coming the next January. This second possibility could result in VA losing pace with the community and adversely affect our recruitment and retention.

It should be noted that other Executive agencies have been delegated authority to use section 7455 to establish special salary rates for health care workers in their agencies. Any change to the language in 38 U.S.C. 7455 would also affect other agencies.

Title 5 special rate employees, including VA's, are not currently guaranteed an annual increase. VA employees in the hybrid occupations are treated similarly. VA's Title 38 special salary rates are adjusted as needed.

Cost Estimate for H.R. 1216 – The Department has not formulated a comprehensive cost estimate for H.R. 1216, due to the potential for changes to coverage and scope, however, we believe the cost could be substantial.

VA Dentist Pay

Public Law 102-40, "The Department of Veterans Affairs Healthcare Personnel Act of 1991," provided an enhanced program of special pay for VA physicians and dentists. Special pay is paid in addition to rates of basic pay to assist in the recruitment and retention of well-qualified practitioners. This law significantly increased the amounts of special pay available to compensate VA physicians, with smaller increases authorized for dentists.

Special pay for VA physicians and dentists may be authorized locally for six of the seven components established in statute; one requires the express approval of the Under Secretary on a case-by-case basis. Some components are entitlements for employees; others are discretionary and approved on a local basis according to the recruitment and retention needs, as well as the levels needed to be generally competitive with the community.

Employees receive special pay to the extent that they qualify for the mandatory components, work in a designated clinical category, and provide hands-on patient care. The amounts approved for each individual are based on their entitlements to certain components, as well as their personal qualifications, experience, and training. These mandatory and discretionary components resulted in average pay for dentists of \$104,959 as of September 30, 1999.

Recruitment and Retention of VA Dentists – The turnover rate for dentists has paralleled that for other health care occupations. It has remained relatively stable over the past 5 years. We note, however, that the rate is increasing slightly, primarily due to the aging of VA dentists, who are reaching retirement age in increasing numbers.

An analysis of the VA dentist workforce shows that almost 7 in 10 will be eligible for regular or early retirement by 2003. Of the 131 full-time VA dentists who left since January 1997:

- ◆ 103 (78.6%) were retirements.
- ◆ 21 (16 percent) resigned to pursue other employment opportunities and 1 left dental practice to pursue research. These dentists had an average of 10.6 years of service. If the 6 new hires who left after only 1 year are excluded, the average seniority at departure was 14.7 years.
- ◆ 6 (4.5%) were deaths while in service.
- ◆ 56 (42.7 percent) of those who left employment, were Service Chiefs. While this offers advancement opportunities to dentists on staff, it indicates a significant loss in the leadership cadre in a short period of time.
- ◆ 32 (31.1 percent) of the retirements indicated that they were entering private practice, academia, or other employment opportunities in the dental profession.
- ◆ 4 additional full-time employees converted to part-time employment, reducing their availability to care for veterans.

The Department's Views on H.R. 2660

H.R. 2660 would increase dentists' special pay so that it would be identical to the amounts authorized in statute for physicians.

When the amounts of special pay for dentists were established in P.L. 102-40, the Department was not experiencing significant turnover or retention difficulties for dentists. For that reason, special pay increases at the level of those for physicians were not put in place.

Although VA does not currently have a widespread recruitment and retention problem for dentists, there are some areas where problems exist. Almost 70 percent of VA full-time dentists will be eligible for regular or early retirement in the next three years. Therefore, we are concerned that as VA dentists retire, it will be difficult to attract the best qualified dentists to work in the VA, given the gap that exists between VA and non-VA compensation packages. VA is currently reviewing legislative options that would mitigate these potential problems.

VA's preliminary estimate for the cost of H.R. 2660 ranges from \$8.2 to \$18.9 million per year, based on current approval rates for some discretionary components.

Other Health Care Occupations

At the present time, health care staffing in the VA health care system is relatively stable. However, efforts are continually underway to maintain this stability. Staffing problems typically occur in cycles and vary considerably from one locale to another.

One occupation for which VA is currently experiencing increased recruitment and retention difficulties is pharmacist. Currently, VA pharmacists are not leaving their jobs to pursue private sector opportunities (most losses are due to retirements); rather VA is experiencing some increased difficulty recruiting new pharmacists.

There is a significant increase in the number of special salary rate authorizations for pharmacists. The Department is receiving requests for new or increased special rates on almost a daily basis. VA will continue to monitor the ceiling on special rates contained in 38 U.S.C. 7455(c) to ensure that restrictions in salary adjustments do not become problematic.

An analysis of special salary rates for all occupations subject to the ceiling (excludes nurse anesthetists and licensed physical therapists) contained in 38 U.S.C. 7455(c) shows:

- ◆ Of the 638 special salary rate authorizations in effect as of March 28, 1999, 178, or 28 percent, are at or within 6 percent of the ceiling.
- ◆ The 178 authorizations within 6 percent of the ceiling cover 19 different occupations. 75 of the authorizations, or 42 percent, are for pharmacists alone.

VA salaries for certain occupations in certain locations could fall behind those in the private sector, and create recruitment and retention difficulties although this has not happened. We will continue to carefully monitor the situation. VA will also continue to use the tools that are currently available to address any incipient recruitment and retention problems. These authorities include recruitment, relocation, and retention bonuses; advanced in-hire rates for high quality candidates; special advancements within the rate range and cash awards for exceptional achievements and contributions; and educational assistance.

Educational assistance provided through the recently implemented Employee Incentive Scholarship program and the soon-to-be-implemented Education Debt Reduction Program will undoubtedly have a positive impact on our ability to recruit and retain a well qualified health care workforce.

VA Physician Pay

VA is generally able to recruit all clinical specialties in all areas of the country. Although facilities do encounter problems from time to time for particular clinical specialties, we find the current pay flexibility in P.L. 102-40 to be generally adequate to meet our needs. However, P.L. 102-40 was enacted 10 years ago and the limits established at that time may not prove to be sufficient to respond to all recruitment situations in the future – particularly for scarce specialties.

VA will continue to closely monitor physician pay trends and recruitment experience, and will evaluate whether any action is necessary to maintain our ability to recruit and retain well-qualified physicians.

Summary

VA has been diligent in its use of the special authorities that Congress has provided for recruiting and retaining health care occupations. As noted earlier, VA monitors the current staffing needs, and the effects of changing demographics on both the veteran population and the labor force of health care professionals available to serve them.

The average age of the VA workforce is increasing. A significant number of VA employees will be eligible to retire in the next few years. As a result VA likely will experience significant turnover. VA is studying this phenomenon in order to maintain our ability to maintain the highest quality health care workforce.

We look forward to continuing to work with the Committee to ensure that VA is able to recruit and retain well-qualified health care professionals to meet VA's obligation to care for the Nation's veterans.



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STATEMENT OF

THE NURSES ORGANIZATION OF VETERANS AFFAIRS
(NOVA)

BEFORE THE HOUSE COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON HEALTH

STATUS OF RECRUITMENT, RETENTION AND COMPENSATION
OF VA HEALTH CARE WORKFORCE

BY
MARGARET KRUCKEMEYER, RN, MA, MSN, CRNH, ARNP

APRIL 12, 2000

Mr. Chairman and members of the Subcommittee on Health, I am Margaret Kruckemeyer, RN, MA, MSN, CRNH, ARNP, an Advanced Practice Nurse in the Hospice/Palliative Care Unit of the Dayton Veterans Affairs Medical Center. The Nurses Organization of Veterans Affairs (NOVA) is the professional organization of the over 35,000 registered nurses employed by the Department of Veterans Affairs (DVA). As President of NOVA and a disabled, Vietnam-era nurse, I am pleased to present testimony on the 1999 VA Nurse Appreciation Act, H.R. 1216, on behalf of the NOVA Board of Directors and membership. I would also like to thank NOVA's Legislative Committee for their efforts in the preparation of this testimony.

The DVA Nurse Pay Act of 1990, PL 101-366 and amended in 1992 as PL 102-585, was a viable concept. Its purpose was for the salaries of registered nurses to be market driven in order to be competitive with their counterparts in the community. Although the Nurse Locality Pay System (NLPS) is functioning properly at some facilities, at most facilities it has been applied in a discriminatory and inconsistent manner. It has been known since 1993 that the NLPS survey process is flawed and inconsistently applied. Since its inception, the goal of matching DVA nurse pay to the private sector has grown difficult and has not achieved the goal of maintaining the community average. DVA nurses have become the target of budget juggling, and now perceive the survey process as unfair, inequitable, and discriminatory.

When this law was first introduced, DVA nurses were enticed with the promise of surveys which would provide pay increases based on the local labor market area wages. In 1991, 1992 and 1993, the law required reports be submitted to Congress about pay adjustment increases or the basis for not providing an increase. Subsequent to 1993, reports were no longer required. The NOVA Board was informed during the 1998 Legislative Roundtable by Congressional staff members that Congress was not aware of any DVA nurse pay problems.

In 1997 and 1998, the unfairness and inequality of the NLPS was brought to the attention of Secretary Jesse Brown and Under Secretary for Health Dr. Kenneth Kizer by frustrated nurses around the country. Many facility directors had refused to implement pay increases which were indicated by the survey process. Increases were being refused due to budget shortfalls and because they are discretionary. Medical centers do not have to be experiencing recruitment or retention problems in order to adjust nurse pay rates. The primary purpose of the NLPS was to give increased authority to facility directors to address salary needs before recruitment and retention problems developed.

The NLPS was designed to allow the DVA to adjust nurse pay and be competitive with the private sector, thus, easing severe retention and recruitment issues facing the DVA. The prior system of adjusting nurse pay was cumbersome and untimely with submissions to DVA Central Office for approval. Action for better pay adjustments could have taken six months or longer

with many staff leaving for jobs in the private sector. Now despite a law to facilitate a timely response to nurse pay issues, because of budget shortfalls and directors' discretion, a problem still exists. Nurses are frequently informed there is no money in the budget for any kind of nurse pay adjustment. The same facility directors, who denied nurse pay raises annually, receive a pay increase as well as locality pay and pay bonuses.

NOVA applauds the Honorable Representative Steven C. La Tourette (R-OH) for introducing the VA Nurse Appreciation Pay Act of 1999, HR 1216, to rectify pay injustices DVA nurses have suffered. Even with legislative changes, however, the basic inability to obtain accurate pay information from local labor markets will not be solved unless the NLPS survey data can be collected by the Bureau of Labor Statistics or another third party without time frame limits. Additional changes in the law or all of the recommendations of the Hay Report should be taken into consideration.

Job matches are extremely difficult and only starting salaries are currently surveyed. When competing facilities do participate, published pay schedules are not indicative of the actual beginning salaries offered to new hires and published scales do not reflect the rates of pay for continuing employees. Since 98 percent of VA nurses are in steps I, II, and III, survey data needs to include mean salary rates. Facilities are hesitant to provide accurate information and some have refused to provide any information at all. The DVA cannot be the pay leader in any area. The VA Nurse Appreciation Pay Act of 1999 would help ensure DVA Registered Nurses receive fair annual pay increases and will reinforce the NLPS to assure nurse salaries are based on accurate and timely salary survey data collection by a third party.

Registered nurses at DVA hospitals are working harder. As one nursing colleague put it, "we have cut past the meat into the bone". Staff downsizing, increased patient acuity, shorter hospital stays, bed closures, flat-line budgets, and realignment into service lines have resulted in work overload and increased adverse events, including medication errors, and patient and staff injuries. DVA nurses are functioning in roles not envisioned when the NLPS was created. This is very disheartening to registered nurses who are managing nurse run clinics and improving quality care outcomes daily.

Nurses are essential to the delivery of high quality health care to veterans and research proves that an hour of care provided by a registered nurse improves patient outcomes significantly. Studies show when nurses are present, there are lower mortality rates, shorter lengths of stay, lower cost, and fewer complications. More than a decade of research demonstrate that nurse staffing levels and skill mix make a difference in the outcomes of hospitalized and ambulatory care patients. Ensuring quality patient care is a priority, and appropriate nurse staffing is a critical component to achieving quality of care. Nurses are the best value in health care.

The Hay Report noted research and technology-based organizations, those affiliated with universities, as well as those with specialty needs, tend to pay toward the upper end of the scale. DVA is noted for research, technological advances, and developing programs for special needs populations, such as those with spinal cord injuries, PTSD, geriatrics, and long-term care. DVA nurses are involved in every aspect of the research process. A critical shortage of nurses across the nation has arrived. It is more imperative than ever to retain as well as recruit a competent nursing staff. DVA nurses work harder than their counterparts in the private sector, as staffing levels and diminishing support services are consistently less than in the private sector.

A recent study funded by the American Nurses Association found that the aging nursing workforce, combined with declining enrollment in nursing programs, has fueled this nursing shortage. Research by the American Association of Colleges of Nursing demonstrated enrollments of nursing students in entry-level Bachelor Degree programs fell by 4.6 percent in the fall of 1999 which was the fifth consecutive drop. Additionally, enrollment in Masters Degree programs decreased by 1.9 percent.

Double shifts, cross-training and mandatory overtime are causing immeasurable stress. Nurses are constantly worrying about their practice, and most feel the joy of nursing is gone for them. Nurses are finally saying, "We can't do this anymore." Some DVA nurses have had to revert to buying answering machines to prevent punitive actions against them, if they are called at home to work extra shifts. Recently, at a VAMC, the evening nurses refused to accept their assignments at shift change because of unsafe staffing levels which would put their patients and licenses in jeopardy. This issue was resolved when the supervisor found two nurses willing to work overtime to safely staff the unit for the evening.

Benefits that once made the DVA an attractive place to work are gone. Some examples include:

- Funds for continuing education have become more restricted due to budget constraints. With many non-nurse service line managers, the dissemination of funds is not proportionately reaching nurses.
- Authorized Absences have been cut back or staffing has been reduced so significantly, nurses, are unable to attend educational programs without using annual leave.
- Incentive awards are no longer given. Most nurses are told there is no money for them even before their proficiency is due.
- Incentive award funds for specialty certification or re-certification is no longer given.
- Nurse managers are told not to submit any requests for advancements for nursing staff due to budget constraints, and to find other methods of rewarding staff.
- Adequate staffing levels are gone, causing dangerous working conditions that deter new hires from staying at the DVA.

- Overtime pay is also restricted with a *push* to utilize compensatory time. With downsized staffing levels, much compensatory time is being forfeited because it must be utilized within six pay periods.

NOVA supports the recommendations in the October 1998 Final Report of the Hay Group, *A Study of the Nurse Locality Pay System within the Veterans Health Administration*.

- Use independent third party surveys.
- Acquire data on averages and ranges, as opposed to beginning pay only.
- Survey hospitals on actual pay rather than published minimums.
- Do job analysis and detailed job matching on a less than annual basis, using standard industry terms and definitions.
- National adjustment that is a general across-the-board pay adjustment for all VA nurses.
- Locality-based differential that reflects local market conditions or cost-of-living differences.

NOVA also believes the issue of locality pay is only one issue affecting the DVA nursing workforce. Solving this inequity will help with the low morale problem but will not solve it.

NOVA recommends the following as retention strategies:

- Reduce workplace stress by giving nurses the time they need to do their jobs effectively.
- Provide nurses with educational and career opportunities.
- Ensure appropriate staffing levels.
- Offer more flexible schedules.
- Build mentoring programs.

Mr. Chairman, NOVA thanks you for the opportunity to present testimony before the Subcommittee on this important issue. The accomplishment of the DVA's mission is integral to the morale of the registered nursing workforce which is impacted by an equitable pay system. This is necessary in order to attract, retain and improve morale in DVA facilities. Nurses are at the veterans side 24 hours a day, seven days a week. NOVA believes H.R. 1216 goes a long way in establishing guidelines toward this and encourages the Subcommittee to act on this bill.

STATEMENT BY ROBERT L. HARNAGE, SR., NATIONAL PRESIDENT, AMERICAN
FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

Mr. Chairman, Ranking Member Guitierrez, members of the Subcommittee: my name is Bobby L. Harnage, Sr. I am President of the American Federation of Government Employees, AFL-CIO (AFGE). As the largest federal employees union, AFGE represents over 600,000 federal employees, including roughly 125,000 Department of Veterans' Affairs (DVA) workers across the nation.

We appreciate your recognition of the importance of having experienced DVA health care workers provide veterans with high quality, safe and compassionate health care. Unquestionably, DVA's ability to recruit, retain and pay fairly and adequately these health care professionals is key to operating a unique health care system for veterans.

The primary focus of this Subcommittee's hearing is on Veterans Health Administration (VHA) clinicians and Registered Nurses (RNs). AFGE would be remiss, however, if we did not call to your attention the many other DVA employees who also are indispensable to providing veterans with specialized health care and ensuring that veterans are treated with respect and dignity. Like RNs and MDs, these employees care for and about veterans. They also do the sometimes dirty, difficult and hazardous work that is essential to the delivery of high quality medical care. Support staff, who clean the wards, transport patients, enter medical record transcriptions, monitor and restock medical supplies, prepare and deliver food, or perform a multitude of administrative tasks, allow nurses and other clinical staff to spend more of their time on direct patient care. Adequate pay and respect for these workers, who are no less professional or dedicated, is also extremely important.

Overall, pay and benefits for federal employees need considerable improvement. Our remarks for this hearing, however, will focus on the bills that have been referred to this Subcommittee for review and appropriate action, and how they would positively affect the recruitment, retention and pay of VHA health care workers.

AFGE supports H.R. 1216, the Department of Veterans Affairs Nurse Appreciation Act and H.R. 2660, which addresses pay parity for dentists.

A decade ago this Subcommittee responded to a national nursing shortage by replacing DVA's national salary schedule for RNs and Certified Registered Nurse Anesthetists (CRNAs) with a locality-pay system. Under the Nurses' Locality Pay Act medical facility directors were granted the discretion to make locality pay adjustments based upon a local pay survey.

Collecting valid salary data has been a continuous challenge for DVA. Unlike Bureau of Labor Statistics (BLS) employees, Medical facility staff are not experts in detecting sample bias or error, or collecting and validating salary data. Comparing the jobs of DVA nurses to non-DVA counterparts has inherent difficulties because nursing duties at the DVA are not interchangeable with the commercial sector. DVA nurses have higher

educational requirements and are routinely responsible for care activities not usually required of nurses in the non-DVA facilities. Job matching also requires technical expertise and skills. Another basic problem with the survey process is that it requires DVA to focus on published beginning rates of pay, which may not reflect actual pay rates or middle rates of pay for more experienced nurses.

The challenges confronting DVA in obtaining accurate and complete survey data are significant and troubling. These issues, however, are secondary to the problems that arise in the next stage of the process. Medical Directors are the DVA officials who have the statutory authority to determine whether to make an adjustment to their staff nurses' pay. If the Medical Director determines that no adjustment is necessary then the nurses at that facility receive no annual pay increase. Under the law, the pay adjustment can be a decrease in pay. DVA Central Office reviews all determinations but the Secretary has no real authority to require that any Medical Director raise nurses' pay at any facility.

The purpose of the nurse locality pay system was to enable Medical Directors to act quickly and effectively to prevent nurse pay problems so that each DVA medical facility could recruit and retain the highest caliber of nursing staff. Directors were expected to use their broad authority to provide fair and adequate salaries for nursing staff. In addition, Congress gave the Secretary the authority to place other health care workers under this locality-pay based system.

This change for Title 38 employees occurred at the same time Congress was considering broader pay reform for General Schedule (GS) federal employees. In 1990, President George Bush signed into law the Federal Employees Pay Comparability Act (FEPCA) to close the pay gap between private and public sector counterparts over a nine-year period.

FEPCA did not create cost-of-living adjustments or COLAs. Under FEPCA, GS employees, including those who work as DVA health care workers, receive (1) a nationwide increase linked to the Bureau of Labor Statistics' Employment Cost Index (ECI), which measures the change in private sector wages and salaries; and (2) a locality increase, based on a comparison of a range of non-federal and GS salaries in 32 pay areas across the nation.

The current Nurse Locality Pay system has some positive features but it also has some flaws, which have not been amenable to redress. This pay system was designed before the Veterans Health Administration (VHA) reorganized into integrated networks, initiated formula changes to resource allocations, and tried to survive years of flat line budgets. AFGE believes these changes exacerbated the inherent problems in the nurse pay system and have contributed to a crisis in the legitimacy of this pay system.

Problem: Medical Directors Have Broad Authority to Deny Nurses a Pay Increase

Under the nurse locality-pay system, DVA Registered Nurses do not receive either the nationwide or locality component of the annual pay raise under FEPCA. Since FEPCA's enactment, GS workers have received a pay increase every year (although these increases were not as large as required by the full implementation of FEPCA). Unfortunately, thousands of DVA nurses have not received annual increases.

Medical Directors have wide latitude in deciding whether an adjustment is necessary to prevent a recruitment or retention problem. Indeed, even when a local survey indicates a significant gap in the rates of pay between DVA nurses and their private sector counterparts, a Medical Director has the authority to deny nurses any annual pay increase. This is possible because under the law if a Medical Director simply declares that there is "no retention or recruitment problem at the facility" then no pay raise is required.

Both the DVA nurse pay system and FEPCA as federal employee pay systems are designed to balance the desire of federal managers to be able to compete for applicants in all labor markets and front line workers' needs to maintain a fair and adequate standard of living. Permitting Medical Directors to have unfettered discretion to deny nurses a pay increases when survey data indicates that the facility is not offering competitive pay calls into question the fairness and legitimacy of this pay system. It also deprives nurses of annual increases that are necessary to maintain their economic purchasing power.

Even when DVA nurses received pay increases, these raises lagged behind those given to GS workers. For example, in 1996, the average pay raise for nurses was 1.2 percent; compared to the 2.4 percent average increase received by their GS co-workers. In 1997, the average pay raise for nurses was again 1.2 percent, compared to the 3.0 percent average increase received by their GS co-workers. In 1998, the average pay raise for nurses was 2.2 percent, compared to the 2.9 percent average increase received by their GS co-workers. In 1999, the average pay raise for nurses was 3.0 percent, compared to the 3.6 percent average increase received by their GS co-workers. From 1996 through 1999, DVA nurses on average were denied a cumulative pay raise equivalent to 4.5 percent because of the current pay system for nurses. This loss of pay affects the pocketbooks of nurses now and when they retire.

The VHA's nurses' pay system should reflect that VHA is a unique and unparalleled health care system. It provides care and treatment that is not easily obtainable in the commercial sector. This subcommittee has prompted and supported VHA preeminence in the treatment and rehabilitation of disabled veterans (including those with spinal cord dysfunction, blindness, amputations, mental illness), care for homeless veterans, and treatment of Hepatitis C Virus. VHA needs employees whose training and career focus is dedicated to serving *only* veterans and providing them with specialized treatment for

their distinctive injuries, disabilities, illnesses and medical conditions. Accordingly, the VHA particular pay system should not only attract talented health care workers entering their profession but also continue to give them repeated incentives to develop their nursing and medical expertise in treating veterans.

Logically, VHA should be placing a premium on staff who devote their careers, competence, skills and experience to treating veterans. Denying experienced nurses any annual pay increase flies in the face of this logic.

The rationale for an annual increase for valued employees is more compelling as VHA undergoes restructuring. VHA is reducing beds, downsizing its staff who provide acute, subacute and psychiatric inpatient care, putting greater emphasis on cost-cutting measures and increasing outpatient surgery and treatment. At the same time the medical needs of the aging veteran population have intensified and are more complex, even as the overall population declines. With fewer RNs and fewer support staff caring for frailer, sicker veterans (who typically have multiple physical and mental illnesses), patient care can be at risk. Thus, the need to respect, appreciate and pay fairly seasoned nursing staff escalates. Unfortunately, many Medical Directors have exercised their discretionary authority to deny dedicated nurses a pay increase.

To their credit, when AFGE called attention to this problem, the VHA leadership and Central Office staff tried to address it. For the past few years the Under Secretary for Health has used his bully pulpit to issue information letters to Medical Directors urging them to pass along the GS increase. We appreciate these efforts and they have made some improvement. But even this year Medical Directors denied nurses in Lake City, Florida and Gainesville, Florida any pay increase, even after the Under Secretary sent out his most strongly worded letter. Unfortunately, these persuasive letters are of limited value because by law it is the Medical Director – and not the Secretary or Under Secretary for Health – who is vested with the authority to determine whether and how much of a raise will be given.

How would H.R. 1216 address this problem?

The intent of H.R. 1216 is to guarantee DVA nurses (and any other health care employees for whom a Medical Director has discretion over whether or not to pass on an annual increase) the same GS increase plus locality pay given to virtually all other federal workers. It is to create a floor for nurses' pay.

This change would not restrict the ability of Medical Directors to increase salaries more than the GS percentage. Under H.R. 1216, the Secretary would still have authority to increase nurses' pay above the GS nationwide and locality pay raise *if needed*. This authority could be delegated to Medical Directors but, as with other delegations of authority, the Secretary would retain ultimate authority.

H.R. 1216 restores common sense to "recruitment and retention." The current law provides a perverse opportunity for medical directors to cut costs by not rewarding its most experienced nurses. It is unfair and inexcusable that nurses should be penalized for their loyalty as employees and willingness to devote years of service to caring for veterans. Nurses, like their GS co-workers, deserve an annual pay increase.

Requiring the DVA to pay nurses the same nationwide and locality pay raise given to GS employees is consistent with the DVA's budget submissions for the past several fiscal years. In FY 2001, the DVA requested \$63.5 to support pay raises for RNs under the nurse locality pay system. The FY 2001 request takes for granted that nurses would be receiving that same percentage of the combined nationwide and locality increase as was requested for GS employees. Therefore, requiring the DVA to provide nurses with the same total percentage increase as their GS co-workers will not undermine or disrupt the DVA's budget.

Problem: Medical Directors Have Authority to Impose Negative Pay Adjustments

By law DVA is prohibited from being the "pay leader" in the community. As such when Medical Directors review the survey data they have obtained and they determine that it is valid and shows that DVA is paying nurses more than their non-DVA counterparts, Medical Directors adjust nurses pay *negatively*. In effect this is a pay cut. The nurses in Louisville got a negative pay adjustment of -7.7% in 1998. That followed a -2.6% pay adjustment in 1997. These negative adjustments occurred at a time when federal employees were required to pay more for their own health care benefits under FEHBP. Even after two years of increases (in 1999 and 2000) after these negative adjustments, these nurses have yet to see a real dollar increase in their pay. Their retirement benefits have also been eroded as a result of these negative adjustments.

I have written to Secretary West urging him to take action to address this egregious problem. We have worked with DVA headquarters staff and at the local level to remedy such negative pay adjustments. AFGE members and staff have tried to identify legitimate ways for DVA to revise its regulations to prohibit negative pay adjustments. But at each turn we are confronted by two facts. The law does not allow the DVA to be the leader in pay. And, DVA regards the law as vesting all discretion over pay determinations for nurses with the Medical Director and the Secretary has virtually no authority to overturn such drastic pay decisions.

The contractor hired by DVA to study the nurse pay system also was troubled by negative pay adjustments because of the significant potential for errors and bias in the survey data and the fact that pay cuts are "very rare in non-government organizations, except in widespread economic depressions." The negative pay adjustments to the nurses in Louisville, and in Bay Pines, and Danville, occurred in recent years during times of sustained economic growth for our nation.

The contractor urged the DVA to provide "guidance" to medical directors to discourage negative pay adjustments unless very convincing statistical evidence can demonstrate that such a drastic measure is required. We are concerned that "guidance" will not be sufficient to rectify this problem as long as law gives the Secretary no meaningful authority to overturn negative pay decisions.

How would H.R. 1216 correct this problem?

By guaranteeing nurses the full percentage of the GS pay increase negative pay adjustments will be prohibited in reality and under the law.

The Need to Maintain Flexibility to Pay Nurses Higher Percentage Increases than the GS Pay Raise

The intent of H.R. 1216 is not to deny Medical Directors or the Secretary the flexibility to respond to current or future demands to recruit nurses at higher salaries. Many facilities are experiencing nursing shortages, as evidenced by their regular use of fee-basis or agency nurses to fill shifts for extended periods. According to the Division of Nursing of the U.S. Department of Health and Human Services, if current trends continue, rising demand will outstrip the supply of RNs beginning approximately 2010. DVA will shortly be competing in an even tighter national nursing labor market.

H.R. 1216 gives BLS needed lead time to take over the collecting of salary survey data that has proven so difficult for DVA.

Conclusion

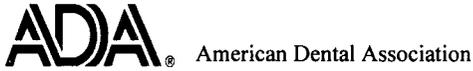
The intent of H.R. 1216 is to create a floor – not a ceiling – for nurses' pay raises.

We realize that the technical drafting of this bill may not fully meet this intent and we would welcome the opportunity to work with the subcommittee and your staff to ensure that H.R. 1216 is modified in markup to address these unintended problems.

The value and respect given to DVA's health care workers ultimately reflects on and comes back to the commitment, value and concern the agency has for veterans. When DVA fails to acknowledge and enormous contributions of nurses, physicians and other health care workers make to high quality medical research and care for veterans it also does a disservice to the veterans under their care.

AFGE urges this subcommittee to support H.R. 1216 and H.R. 2660.

Thank you. This concludes my remarks. I will be happy to answer any questions.



STATEMENT OF THE
AMERICAN DENTAL ASSOCIATION
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
VETERANS HEALTH CARE WORKFORCE

SUBMITTED BY

DR. ROBERT M. ANDERTON

APRIL 12, 2000

On behalf of the American Dental Association (ADA), thank you Mr. Chairman for the opportunity to testify on the status of recruitment, retention, and compensation of dentists in the Department of Veterans Affairs. I am Dr. Robert M. Anderton, President-elect of the ADA and a practicing dentist in Carrollton, Texas.

The ADA is a professional organization that represents 144,000 licensed dentists (73% of the profession) in the United States. The ADA seeks to advance the art and science of dentistry, and to promote high-quality dental care and the oral health care of the public.

Over the years, the ADA has maintained a close liaison with the federal dental services, which include all three Service branches, the U.S. Public Health Service (PHS), and the Department of Veterans Affairs (VA). Just yesterday, the Association testified on behalf of the Indian Health Service's Fiscal Year 2001 appropriations, seeking improved oral health services for the American Indian and Alaska Native communities. The Association is proud to represent the needs of our nation's federal dental officers.

Mr. Chairman, I am here today to address two areas of concern for VA dentistry:

- the oral health needs of America's veterans, and
- the recruitment and retention of VA dentists.

Oral Health Needs of Veterans

As you know, Mr. Chairman, outpatient dental benefits are provided by the VA pursuant to law. In some instances this dental care can be extensive, while in other cases treatment may be limited. Veterans are eligible for dental treatment if they meet one of the following criteria:

- a service-connected compensable dental disability or condition,
- former prisoners of war for 90 days or more and those whose service-connected disabilities have been rated at 100%,
- participating in a VA rehabilitation program for which dental care is needed to complete the program,
- service-connected noncompensable dental condition or disability resulting from combat wounds or service trauma,
- a service-connected noncompensable dental condition or disability within 180 days of discharge or release from active duty (on a one time basis),
- a dental condition clinically determined by the VA to be currently aggravating a service-connected medical condition, and
- enrolled in a VA treatment program and receiving outpatient care or scheduled for inpatient care to repair a dental condition that has been clinically determined to be complicating a medical condition currently under treatment.

For those veterans who are eligible for dental care, I am certain the VA is committed to providing comprehensive health care and that oral health care is an essential component of those comprehensive services. However, difficulty in retaining and attracting dentists to the VA have made keeping this commitment to oral health care tenuous.

While oral health care is urgently needed in its own right, in some instances the failure to adequately treat oral disease can also complicate the patient's medical condition and compromise effective medical treatment. That is why it is so important to eliminate infections in the mouth prior to surgery, chemotherapy or radiation treatment.

Regular dental care is also important because dental exams can provide advance warnings of the onset and progression of numerous systemic diseases manifested in the mouth. For instance, studies suggest a link between the presence and severity of periodontal disease and risk of coronary heart disease and stroke. Gum problems, or periodontal diseases,

occur when mouth bacteria grow unchecked, causing swelling, bleeding and bone loss around teeth.

For years, we have known that people with diabetes are more likely to have periodontal disease than people without diabetes. Recently, research has suggested that periodontal disease may make it more difficult for people who have diabetes to control their blood sugar. In a study by the National Institute of Dental and Craniofacial Research (NIDCR), dental researchers learned that by controlling a diabetic's periodontal disease, the overall diabetic condition of the patient improved.

So you see, Mr. Chairman, there may be a direct link between veterans' oral health and their overall general medical health. To ignore the patient's oral health status is to invite more serious medical illness in an already aging and sicker patient population.

Of course, access to dental services is important to remedy dental disease as well, some of it potentially life threatening. The Veterans Affairs Medical Center (VAMC) in Togus, Maine was downsized from five to three dentists in 1992 at which time routine oral exams, given to veterans as part of their incoming physicals, were phased out. This occurred despite that fact that for the preceding five years, dentists at the Togus VAMC found an unusually high number of oral cancers in veterans during those routine exams. Only after the veteran community complained did the Togus VAMC add another dentist. The facility once again provides oral exams.

To address the oral health needs of VA patients in hospitals, the demand for dentists has increased in the area of providing needed consultations with their medical colleagues. For example, in 1989, VA dental services received over 95,000 consultation requests from other hospital services. By 1998, this number increased to over 104,000, a ten percent increase. With the demand for more hospital-based consultations, it appears to be counter intuitive that over the last three years 18 fewer VA hospitals have an oral surgeon on staff.

Oral Health Care Services for VA Patients

The number of VA patients receiving dental care is decreasing at the same time the number of total VA patients has increased. As discussed above, given the demand for dental services and oral health needs of the VA patient population, this trend presents a troubling picture. In 1997, the VA system treated over 3.1 million patients of whom 330,000 were dental patients, or roughly 10.5 percent. By 1999, the total number of VA patients treated grew to 3.4 million, while the number of dental patients fell to 318,000, or 9 percent.

Significantly, the overall amount of dental services provided is declining at an alarming rate not only because of the fact that fewer dental patients are being treated, but also because the average amount of dental treatment provided per patient is also declining. And this is occurring in an environment in which the need for dental services is high due to an aging population.

A recent study of patients in VA Hospital Based Home Care (HBHC) Programs indicates the following:

- 65% are in need of dental care,
- 30% cannot chew most foods,
- 21% need help in eating, indicating that they also need assistance with their oral hygiene, and
- 55% of HBHC patients had not seen a dentist in over two years.

These statistics are alarming and indicate that most veterans in HBHC programs have oral health care needs that could affect their health and quality of life. When combined with

the previous numbers indicating declining dental care for eligible veterans, these statistics become even more alarming.

Recruiting and Retention of VA dentists

The Association believes the primary reason for the reduction in dental care for eligible veterans is the shortage of VA dentists. In 1989 there were 850 full-time dentists working at VA dental clinics. By 1999, that number had fallen to 654 dentists, a 23 percent decrease. This occurred, as stated above, in an environment in which the oral health needs of the VA patients and the demands for more dental services increased.

Unfortunately, the retention and recruitment numbers are projected to get even worse. Within the next three years, almost 70 percent of all VA dentists will be eligible for retirement. Recent statistics also show that those who resign from the VA system before they are eligible for retirement stay in the VA system for only 7.7 years. These are distressing statistics and require immediate attention by senior VA officials.

The VA has become less competitive in recruiting and retaining full-time dentists because of inadequate financial incentives. The turnover rate during the past two years has been over 11 percent. An increasing number of young and mid-career dentists are leaving due to financial reasons. There are few highly qualified applicants applying to fill over 150 vacant, full-time positions and many vacancies take several months to fill.

To help stem this tide of VA dental vacancies, the ADA is proud to support HR 2660, the "Put Your Money Where Your Mouth Is - The VA Dentists Equity Act" that calls for increases in tenure pay, full-time specialty pay, and responsibility pay for VA dentists. HR 2660 would amend Public Law 102-40 to increase tenure pay amounts to help retain VA dentists, raise the full time status component pay from \$3500 to \$9000 annually, and increase responsibility pay for VA dentists in management positions to mirror the same range of responsibility pay for physicians.

Tenure Pay

Section 7439 of Public Law 102-40 (The Department of Veterans Affairs Health Care Personnel Act of 1991) states:

"it is the policy of Congress to ensure that the levels of total pay for physicians and dentists of the Veterans Health Administration are fixed at levels reasonably comparable--

(1) with the levels of total pay of physicians and dentists employed by or serving in other departments and agencies of the Federal Government; and

(2) with the income of non-Federal physicians and dentists for the performance of services of physicians and dentists."

Mr. Chairman, in recent years Congress has authorized additional pays for the Department of Defense (DoD) and PHS in the form of a \$30,000 accession bonus, increased specialty pay up to \$15,000, and multi-year contracts ranging from \$4,000 to \$14,000 in an effort to assist those departments' efforts to recruit and retain dental officers. These efforts are proving to be successful for DoD and the PHS.

These additional pays are needed as incentives to attract new dentists to work for the federal services as opposed to entering private practice. Recent studies have shown that independent private practice general dentists earn over \$133,400 and specialists earn over \$197,000. Given that education debt can amount to well over \$80,000 for a new dentist, it is critical that the VA, DoD, and the PHS be provided these financial incentive tools to attract and retain dentists to serve their respective populations.

HR 2660 would increase tenure pay for VA dentists based upon their length of service as demonstrated by the following table:

<u>Length of Service</u>	<u>Minimum</u>	<u>Maximum</u>
2 years but less than 4 years	\$4,000	\$6,000
4 years but less than 8 years	\$6,000	\$12,000
8 years but less than 12 years	\$12,000	\$18,000
12 years or more	\$12,000	\$25,000

As previously stated dentists who leave the VA system without retiring do so after 7.7 years. These tenure pay increases would help ensure that mid-grade dentists continue their VA service.

Full Time Pay

Since the implementation of the incentive pay program for physicians and dentists as a result of Public Law 102-40 in 1991, most VA dentists have experienced a steady decline in their income as compared to other dentists in the federal and private sectors. Under Public Law 102-40, the "full time status" component of special pay for physicians and dentists were established as \$9,000 for physicians and \$3,500 for dentists.

Because VA dentists have been denied the opportunity to receive locality pay, many dentists currently receive less pay than Title 5 civilians who are employed at the same GS pay grades. For example, when the current incentive pay plan was implemented in 1991, a VA staff dentist in Houston, Texas with 20 years of federal service received \$7,500 more than their Title 5 counterparts.

That difference has been eroded over time and VA dentists now receive over \$5,000 less than their Title 5 counterpart. Congress implemented the incentive pay plan to help the VA remain competitive in recruiting and retaining a viable dental staff. This proposal would help to address the inequity caused by that fact that VA dentists do not receive locality pay and it would be instrumental in providing high quality dental care for our nation's veterans.

Responsibility Pay

The 1994 Department of Veterans' Affairs Quadrennial Report was submitted in accordance with Section 7439 of Public Law 102-40 (38 U.S.C. 7439). A VHA task force reviewed the findings of the report and recommended that the VA develop a legislative proposal to amend Public Law 102-40. The Report stated that the Assistant Chief Medical Director of Dentistry, dental directors, dentists serving as chiefs of staff, and dentists who are clinical service chiefs receive the same range of responsibility pay as currently authorized for physicians serving in similar positions. The Under Secretary of Health and the Secretary for the Department of Veterans Affairs concurred with this recommendation.

Responsibility pay for dentists is several thousand dollars less than the amounts paid to their physician counterparts in similar positions. The lack of financial incentive for dentists to seek service chief positions and the recent resignations of several dental service chiefs, who linked their resignations directly to the lack of adequate compensation, have hindered recruitment.

Conclusion

Mr. Chairman, the ADA believes that good oral healthcare is an essential component of comprehensive health care. Failing to adequately treat oral disease can complicate the medical condition of the veteran population. As we have shown, fewer veterans are

receiving needed dental care each year. This is a dangerous trend and must be addressed by senior VA health officials.

The ADA recognizes the multitude of funding priorities Congress must reconcile this year but believes that the financial incentives detailed in this statement are urgently needed to recruit and retain an adequate supply of VA dentists who are vital to ensure the oral health of America's veterans. The ADA strongly urges this Committee to give serious consideration to our proposals.

Testimony of John F. Burton, Jr., D.D.S.
on behalf of the
National Association of VA Physicians and Dentists (NAVAPD)
before the Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives
April 12, 2000

Mr. Chairman and Members of the Committee, I am Dr. John Burton, Chief of the Dental Service at the William Jennings Bryan Dorn VA Medical Center in Columbia, South Carolina, where I have also served as Acting Chief of Staff on several occasions in the past. Additionally, I am a Member of the Executive Board and Treasurer of the National Association of VA Physicians and Dentists (NAVAPD), on whose behalf I present testimony today. NAVAPD is the only national organization representing all the physicians and dentists who work in the Veterans Health Administration (VHA). I am proud to represent these dedicated men and women who are committed to improving the health of America's veterans. On behalf of NAVAPD and the patients we treat, let me thank you for holding this important hearing today. In NAVAPD's view, the issue of retention and recruitment of VA clinicians is a critical one. Without qualified physicians and dentists and other health professionals, the VHA cannot provide America's veterans the quality health care they deserve. It is as simple as that. The sad fact is, that is already the case. The quality of patient care is suffering in the VA, if quality is measured by such things as continuity of care, access to specialists, availability of a full range of medical and dental services, and reasonable waiting times for appointments -- those standards by which patient care is traditionally assessed in the private sector.

You have invited us to address the question of recruitment and retention from our perspective. Let me state from the outset that NAVAPD strongly believes that there is a serious recruitment and retention problem within the Veterans Health Administration. Our conclusion is based on our daily experiences, experiences that in most cases have the benefit of a long view. I have been practicing dentistry in the VA for 27 years, since I was a General Practice Resident in 1973. My career commitment and length of service was typical just a few years ago. But that is rapidly changing. Long-serving physicians and dentists are leaving the VA in what seems to their colleagues to be record numbers, and they are not being replaced. I say "seems," Mr. Chairman, because this Association does not have ready access to the latest employment data, nor did we have time to conduct a formal survey of our entire membership before this hearing. But we did poll a number of individuals from VA facilities around the country. They speak firsthand about the staffing situation in their own services, facilities and clinics. They describe, not from data but from personal experience, the impact that the current recruitment and retention situation is having on the provision of care. Please permit me to share some examples with the Committee to illustrate the situation. Then I will explain why NAVAPD believes that the retention and recruitment problem exists. And, finally, I will suggest some straightforward actions that NAVAPD suggests Congress and the Administration take to remedy, or at least ameliorate, the problem.

First, I will offer some specific examples that NAVAPD believes are representative of the VA healthcare system as a whole. At several VAMCs throughout the country, there is not one neurosurgeon on staff. Emergency neurosurgery is referred to local hospitals at VA expense. Non-emergent cases are sometimes sent area hospitals and are sometimes transferred to other VA facilities,

which may be many miles away or even in neighboring states. This is unacceptable, an unnecessary expense to the VA and, most important, an inexcusable hardship for patients and their families. One VAMC has no rheumatologist and no dermatologist. The situation is not confined to specialists and subspecialists. In the same facility, 12 primary care physicians have left in the past five years. This has resulted in a significant lack of continuity of care, which the physicians who remain describe as a "chronic problem" about which patients are rightfully unhappy.

For approximately five years the caseload in radiology at a West Coast VAMC has remained relatively stable. The physicians there perform about 75,000 examinations each year. While the number of examinations has been level, the number of staff expected to perform them has been reduced. Previously there were 8 ½ FTE radiologists. Now there are 7. Efforts to recruit an individual to fill the vacancy have been unsuccessful. The remaining doctors have been expected to "pick up the load." But they do not and cannot work alone. At the same time that fewer physicians are being asked to do more work, the number of radiology technicians who assist them has dwindled significantly. The service has lost 9 technicians in the last year, 30 percent of the technician workforce. Potential replacements are reluctant to work under these conditions. The result has been longer waits for appointments. Patients have suffered. In addition, the radiology technicians that remain must be shared with the cardiology service, which currently has only one technician. Recently, when the one cardiology technician applied for and was granted leave for vacation, the facility administration had to make a decision that had a significant impact on patient care. It was a decision that should not have had to be made. They could close the cardiac catheterization lab for two weeks or "lend" a technician from radiology. If the technician was reassigned, physicians in radiology would be even more short-handed, and scheduled patient appointments would have to be cancelled. But closing the cardiac lab was really no option, so patients with radiology appointments were cancelled. That, Mr. Chairman, is tantamount to rationing health care to veterans who rely on the system.

In at least one facility in the Midwest, doctors report that they are unable to care adequately for patients because X rays frequently are either unavailable or are delayed in reading by radiologists. The radiology department is extraordinarily short-staffed and has been unable to hire. There are eight cardiologists on staff, including both full and part-time. Three cardiologists have left recently and three more have plans to leave within the next few years. The VA plans to fill two of the three vacancies with foreign medical graduates needing visas. This may be only a temporary solution as the recruits are likely to seek employment elsewhere once their temporary visas become permanent. Advertisements to fill all the vacancies have been run in the U.S., but there have been no applicants.

Mr. Chairman, the recruitment and retention problem for VA physicians is real. The problem with dentists is even more serious, and is quickly approaching the critical stage --if it has not already reached that point. Please allow me a few more examples.

In another large Northeastern facility, the number of general practice dentists has gone from 8 to 2 in the past several years. Of the six who left, two took early retirement and two others opted to go into private practice. Only one of these vacated staff positions will be filled, and that by a recently graduated resident. This neophyte can fill the slot, but not the shoes, of an experienced practitioner of 20 years. In addition, staff dentists clearly cannot perform complex prosthodontic/reconstructive work

when they are pressured to see two or three patients an hour. The number of dental technicians has also been reduced by fifty percent and dentists report that they are doing technicians' work and even answering phones and scheduling appointments. I need not tell you that this too takes valuable time away from patient care and turns dentistry on its head.

We believe that the total number of dentists serving within the VA today numbers less than 650 – a significant drop from the approximately 1100 who were employed just a few years ago. We know – from our daily experiences in the dental suite – that this number is not adequate to provide quality dental care. Something must be done.

My own dental service is a great example of the severity of VA's recruitment and retention problems. In just a two and one half year time frame, 4 of 6 full-time dentists have taken early retirement. A national advertisement with broad distribution for a two month period has generated only 2 minimally qualified applications for the positions available. Patient waiting times for treatment are extraordinarily long, ranging from 6 to 9 months.

The picture in oral surgery is particularly grim. Private surveys, conducted by clinicians in the field, painted this picture at the end of 1999. Of the 89 oral and maxillofacial surgeons who were employed by the VA in the mid-1990's, 41 had left their jobs. Only 9 surgeons had been recruited to replace them. Eighteen facilities that previously had an oral surgeon on staff now have none. Consequently care is being rationed. Obviously that is detrimental to the veteran patients who rely on the VHA for their medical and dental care.

What about the veteran patient population? I know that the Members of this Committee are as committed to ensuring that veterans receive quality care as are the clinicians who attend to them. These men and women have earned their right to care through their service to this country. We must not forget that. We also must not forget what this veteran patient population we serve is like. It is aging. You have doubtless heard the phrase "older and sicker," and I am here to tell you that it is accurate. Many of our patients have multiple chronic conditions, are homeless, are disabled, are compromised psychiatrically, or are substance abusers. When they come to us for dental care, they are not the typical man or woman on the street coming in for a cleaning. They may be stroke victims, or suffer from dementia, or require reconstructive surgery, or need dental care in concert with complex medical procedures. Typical private practitioners are not adequately trained to deal with this type of patient. But long-serving and mid-career VA dentists are. So VA must retain these dedicated professionals and must provide adequate training programs in the VA to prepare others.

Solving the problem requires understanding its cause. NAVAPD believes that the physician and dentist retention and recruitment problem is primarily the result of two related factors, namely, compensation and morale. VA medical and dental specialists' salaries lag far behind those of our colleagues in the private sector. If the VA honestly wants to provide veterans with the best quality health care available, then it must employ highly qualified clinicians. And if the VA hopes to attract and keep outstanding doctors, professionals of the caliber who have served veterans in the past, then VA must provide compensation that is comparable to that received by other clinicians practicing within the community.

If Congress is serious about solving the retention and recruitment problem, it can take a couple of steps. One is to enact H.R. 2660, legislation that would give dentists practicing in the VA pay parity with physician colleagues. Currently dental pay ranges in all the elements of "special pay" are lower than those for physicians, even when the two may hold the same position, such as Chief of a service or even Chief of Staff. We are aware that the Administration has indicated it may propose changing this for two of the elements – full-time and responsibility pay. We have yet to see a formal legislative proposal to accomplish this, and we do not believe that would go far enough. The full-time element would increase from \$3,500 to \$9,000 annually. But, Mr. Chairman, while an improvement, I can tell you honestly that \$5,500 in pre-tax income is not sufficient to retain a topnotch oral surgeon or general dentist. The Administration's proposal does not go far enough. My own personal situation is a good example. According to comparability data compiled by the American Dental Association, when you factor in cost-of-living adjustments, my salary has suffered a 7 percent reduction in buying power over the last year, while the salaries of my private practice colleagues have increased 27 percent over the same period.

While NAVAPD acknowledges that H.R. 2660 is not a magic bullet we believe it is just, fair, long overdue, and a best first step in addressing the retention problem. So we urge the Committee to move expeditiously to enact it. It is important, as well, that Congress construct the statutory language in such a way that the Administration cannot "interpret away" either any compensation increases or the basis concept of parity. In the past, VA has done that, and it continues to do so today.

We do not believe that the leadership in VA headquarters in Washington completely understands the magnitude of the employment crisis in individual hospitals. Recruitment has been designated a "local responsibility" and the Office of Dentistry has even admitted that it is not directly involved in the staffing process and often do not even know when or where vacancies exist. Let me repeat that, Mr. Chairman. VHA administrators in Washington do not know the extent of vacancies in the field. That being the case, NAVAPD questions VA headquarters' ability to propose appropriate solutions to remedy the situation.

That brings me to NAVAPD's second recommendation. Require the VA to implement locality pay for all VA physicians and dentists. The purpose of locality pay generally is to equalize the value of incomes for the various geographic areas of the country. When Congress passed the law authorizing locality pay, it recognized that the cost-of-living varies significantly from one area of the country to another and that in high-cost areas, the purchasing power of federal salaries was eroding. Without locality pay, federal employees of the same pay grade were not receiving salaries of the same value.

Doctors have no more control of these regional economic differences than do other employees. Their dollars have no more or less purchasing power than those of other federal employees working in the same community. For years, NAVAPD has appealed to the VA leadership to make "locality pay" available to VA doctors. Our requests that VA make locality pay available to VA doctors have been routinely denied. We asked formally in 1994. We did so again in 1997. In its 1998 response, the Under Secretary for Health gave the following rationale for denying locality pay to VA doctors: the "...geographic location and scarce specialty pay components [of special pay] are intended to provide the flexibility necessary to offer competitive rates within geographic areas." In fact and in practice, the

"flexibility" offered has allowed VA to choose NOT to offer these elements consistently. The result is not competitive salaries but unacceptably low ones. At the same time VA was providing that rationale, there own data indicated that less than one fourth of all VA doctors received any geographic location pay. In 1993, only about 26% of VA doctors received any geographic pay. By 1996, the number had slipped below 25%. We believe there are even fewer receiving that today. Meanwhile, other federal employees, even other VA employees, working in the same region do receive locality pay.

The negative consequences of such salary decisions are being felt in the VA today. They are being felt by the committed VA doctors who have chosen to stay at the VA. But more important, they are being felt by veterans themselves – by patients who have to wait longer for appointments, or whose primary provider regularly changes, or who have to travel long distances to get care. Without enough doctors to serve the patient population and without the best qualified doctors, no system, however well-intentioned, can provide the best care. We VA doctors want to provide the best care. But we are not immune to the same financial responsibilities that our colleagues and our friends bear. We have family to support, to house, clothe, feed and educate. Those are issues we must consider when we make decisions about employment.

In closing I want to make a comment that echoes a sentiment that my colleagues who have testified before you in the past have made. NAVAPD thinks it bears repeating. It is tempting to focus on the "VA healthcare system" and to discuss ways to restructure, or streamline or improve it. I acknowledge that we do deliver care within a system. But systems don't provide care, people do – one patient at a time. People are the VHA's most valuable resource. The "system" and those of you in Congress whose responsibility it is to oversee it need to demonstrate that it values its resources; or it will lose them.

The rhetoric in Washington and in the media these days is once again turning to the issues of "patients' rights" and this Congress is considering legislation to ensure it. Those proposals focus on patients within the private sector. But what of veterans? Don't they who have risked their lives in service to their country deserve rights as well? Don't they deserve continuity of care, a full spectrum of services, access to specialists, reasonable waits for appointments? NAVAPD believes the answer is "yes." In fact, NAVAPD believes that it is the solemn responsibility of the Veterans Health Administration to ensure that the patients entrusted to its care are being diagnosed and treated from the top rung of the professional health care ladder.

Again, NAVAPD strongly supports enactment of H.R. 2660 and the implementation of locality pay for VA physicians and dentists. We ask you to take that action before more VA physicians and dentists choose to leave the institution to which they have dedicated the better part of their professional lives. And before one more patient appointment is cancelled or one more test or procedure delayed.

Mr. Chairman, if I am to carry out my responsibility to the veterans who come through the doors of my hospital, then I need well-qualified staff. Today, I do not have the adequate tools to attract them. If I and my colleagues are to perform well, we need qualified colleagues to work with us. We are committed to providing quality care. We ask your assistance in ensuring that VA provides the best to those men and women who were willing to risk their lives for us.

Thank you, Mr. Chairman. I would be happy to answer any questions you or your colleagues might have.

* * *

Neither the National Association of VA Physicians and Dentists (NAVAPD) nor the witness representing the Association have received any Federal grants or contracts during the current or two previous fiscal years.



**American Association of Oral
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AAOMS Testimony – H.R. 2660

Statement of the American Association of Oral & Maxillofacial Surgeons to the Health Subcommittee, Committee on Veterans' Affairs, United States House of Representatives, on Support of H.R. 2660 – recruitment, retention and compensation of VA dentists

Submitted by J. Thomas Soliday, DDS – Speaker, House of Delegates

April 12, 2000

Mr. Chairman and members of the Subcommittee:

I am Dr. Thomas Soliday, Speaker of the House of Delegates of the American Association of Oral & Maxillofacial Surgeons and a practicing oral and maxillofacial surgeon in Gaithersburg, MD. As the representative of the more than 6000 fellows and members of the AAOMS, I would like to thank the Health Subcommittee for the opportunity to testify.

To provide the members of the Subcommittee with a bit of background, I'd like to briefly describe the practice of oral & maxillofacial surgery. Oral and maxillofacial surgeons are dental specialists who treat conditions, defects, injuries, and esthetic aspects of the mouth, teeth, jaws and face. Our training includes at least a four-year graduate degree in dentistry plus the completion of a minimum four-year postdoctorate hospital surgical residency program.

Oral and maxillofacial surgeons care for patients who experience such conditions as problems with wisdom teeth, facial pain and misaligned jaws. We treat trauma patients suffering from facial injuries in hospital emergency rooms, offer reconstructive surgery such as cleft palate and cleft lip repairs, dental implant surgery, and surgical care for patients with tumors and cysts of the jaws and functional and esthetic conditions of the maxillofacial areas.

Mr. Chairman, we are very pleased the Subcommittee is exploring the issues of recruitment, retention and compensation of dentists employed by the Veterans' Administration. This is a promising step that brings attention to the disturbing decline in the delivery of dental services to veterans who often have no opportunity to access care other than through the VA.

The crisis concerning the delivery of dental care within the VA is especially critical among the specialty of oral & maxillofacial surgery. As the only dental specialty

designated as having "extraordinary difficulties" in recruiting, it is imperative for the VA to have the tools necessary to recruit and retain oral & maxillofacial surgeons. Recent data published by the ADA reveal the average after-tax income of a dental specialist in private practice was almost \$192,000 in 1995. When you consider the maximum scale for a full-time oral & maxillofacial surgeon within the VA is \$130,397 before taxes, the handicaps faced by VA recruiters quickly becomes evident.

The chasm of inequity between dental pay scales offered by the Veterans' Administration and the private sector has only exacerbated the challenges encountered by the VA in delivering dental care to it's patients. From a high of approximately 1100 dentists working for the VA, as of the end of 1999, that number stood at approximately 650.

The crisis is demonstrated even more clearly within the specialty of oral & maxillofacial surgery. Three years ago 89 OMSes were employed by the VA on either a full-time or part-time basis. At the end of 1999, that number was 66, only 9 of whom were newly recruited to the position. Of those 66 oral & maxillofacial surgeons, only 38 were full-time. Of those 38, 14 were administrators. Current estimates by the VA are even more dire with only 64 OMSes working to provide care to veterans.

The importance of maintaining a vital dental component within the VA can not be overstated. Many observers have stated the VA has the nation's largest group of hospital-based dentists. The patient population served by those dentists is not only in need of dental care, but is often compromised with a medical or psychiatric condition or a physical handicap. As the VA patient base grows older and sicker, the preponderance of special needs patients makes this a population that is not always easily absorbed by private sector practitioners. At a time when more and more research demonstrates the link between oral health and the preservation of overall systemic health, the importance of providing dental care to patients within the VA can not be ignored.

Perhaps the patient population served by the VA dentists is best described in a passage from a letter sent last December by an oral & maxillofacial surgeon working for the VA to Secretary West. It reads:

"It is common in any given week for my patient population to include a stroke victim who has no rational contact with his world and is sitting in a wheelchair drooling in his lap with facial swelling from an acutely abscessed tooth. The next patient may need his remaining dentition removed because his heart valve has failed, he is oxygen dependent, he is awaiting an artificial heart valve replacement and he is in grave danger of sudden death. The following veteran in my practice may be homeless, may have sustained multiple facial fractures which are now infected because he is not psychiatrically stable enough to adequately care for himself and protect himself in



the streets. Another patient may have sustained a spinal cord injury and require special postural positioning which necessitates that I treat him while I am in a stooped, bent-over stance for an hour or more. Through no fault of their own, very few of my veterans are straightforward healthy, cooperative, interested patients."

Because of the preponderance of special needs patients served by dentists within the Veterans' Administration, the cut backs in VA residency programs that train oral & maxillofacial surgeons and the decline in the number of private training programs in dental schools is especially disconcerting. During a time when OMSes are already in short supply within the VA, this circumstance only compounds the difficulty faced in recruiting and retaining an adequate number of oral & maxillofacial surgeons.

When these multiple factors of low pay, a special needs patient population and the shuttering of training programs are combined, the natural result is a steady decline in the number of oral & maxillofacial surgeons working for the Veterans' Administration. While that fact alone is distressing enough, what is really troubling is what this decreased access to service means for veterans.

With an insufficient number of OMSes in place to treat them, veterans are experiencing more pain, longer times to make appointments and longer waits for appointments once they are secured. Too often non-surgeon dentists are forced to treat patients for whom they don't have the training, experience or facilities to treat. Those conditions are exactly what the OMS has spent years learning to care for.

Additionally, because veterans don't have adequate access to the services of an oral & maxillofacial surgeon, less trauma care is being provided; less cancer care is being provided; less patient education is occurring; and practitioners have less time to take continuing education courses. Treatment plans are only partially completed, as the doctor only has the time to deal with acute pain. A prime example is that it's common for a patient to have teeth removed and then be told they have to go outside the VA to find dentures or other prosthetic devices.

Also disturbing is that less research is occurring. For example, the largest research study to date on dental implants was done in the VA. Continuation of that research is now in jeopardy because too few qualified dentists are available to continue the study.

Naturally, this has led to open patient dissatisfaction. Perhaps more insidious is an overall decline in patient and staff morale because of the diminished quantity and quality of available care. Even more distressing is that some patients just fall through the cracks and don't receive any treatment at all.

The situation regarding recruitment of dentists and specifically, oral & maxillofacial surgeons has reached a critical point. Twenty VA facilities that employed an OMS three years ago no longer have one on staff. Even in facilities where the OMS



position hasn't been eliminated, recruiting to fill a vacant position normally takes more than a year, if a candidate can be successfully recruited at all. In one instance a VA facility in North Carolina had to recruit for more than four years to fill a staff OMS position. A facility in Oregon has recruited two candidates who after initially accepting the OMS position, later declined because of the lack of adequate pay. Even in Florida, the VA can not find candidates to fill positions as general dentists, because of the uncompetitive pay scale. Obviously, these vacancies, the conditions of overwork and inability to do complete work, create a situation of patient care that is lacking and employee morale that is waning. A solution must be found.

Perhaps the most immediate step that can be taken is for Congress to enact the provisions of H.R. 2660, including guarantees that VA administrators follow both the spirit and the letter of the law by strictly re-establishing pay parity between dentists and physicians in the Veterans' Administration. At a time when income for dentists in private practice is at a high point, it is impossible for the VA to compete when it offers the lowest dental salaries, even among federally employed dentists. To make the VA competitive requires a comprehensive review and upgrading of the special pay scales for dentists. The current special pay is simply inadequate to recruit and retain quality candidates to serve the veterans of our nation.

Enactment of H.R. 2660 would provide immediate relief to dentists already employed by the VA, giving them an incentive to continue their career within the federal service. It would also provide the VA with a powerful new recruitment tool to help fill the existing vacancies. The patients served by the Veterans' Administration deserve to receive the health care they've earned. It's time we provide it for them. Therefore, the more than 6000 fellows and members of the American Association of Oral & Maxillofacial Surgeons request the Subcommittee to support and work for passage of H.R. 2660.

Thank you Mr. Chairman and members of the Subcommittee for your thoughtful consideration of the recommendations of the American Association of Oral & Maxillofacial Surgeons. I would be pleased to take any questions at this time.



Highlights Concerning H.R. 2660

- **Access to and quality of dental care has declined in recent years for patients who rely on the VA to provide that care.**
 - A high of approximately 1100 dentists in the service of the VA to approximately 650 now.
 - That decline is especially exacerbated among the specialty of OMS. Three years ago 89 OMS employed by VA on either a FT (50) or PT (39) basis. At the end of 1999 that number stood at only 66. Of that number only 9 were newly recruited surgeons. Current estimates by the VA place that at 64 – 22 FT, 28 PT and 14 administrators.
 - Not only are OMSes of retirement age leaving, so are mid-career and young doctors.

- **VA has the nation's largest group of hospital based dentists.**
 - Not only is the patient population in need of dental care, but they are also compromised with medical or psychiatric conditions or physical handicaps.
 - Patient base growing both older & sicker.
 - Because of the special needs of this population, the private sector is not always equipped to handle them.

- **During the last few years, both VA & private training programs have disappeared.**
 - While the VA is closing residency programs for OMS, dental schools in the private sector are closing at the same time.
 - This makes recruitment and training of OMSes even more difficult during a time of a specialty shortage within the VA. OMS is the only designated scarce specialty within VA dentistry.

- **The result of the decline in the number of OMSes within the VA is veterans are experiencing more pain, longer times to get appointments and longer waits for appointments once they are secured.**
 - Often non-surgeon dentists are forced to treat patients, which they don't have the training, experience or facilities to treat.
 - Less trauma care is being provided.
 - Less cancer care is being provided.
 - Less education is occurring.
 - Less research is being conducted.
 - Patients are openly dissatisfied.
 - Patient and staff morale has declined because of the diminished quantity and quality of available care.
 - Some patients simply fall through the cracks and don't even receive care.
 - Treatment plans are often only partially completed, only dealing with acute pain – not long term need.
 - It's common for a patient to have teeth removed and then told they have to seek prosthetics outside the VA.

- **The situation is reaching a critical point.**
 - 20 VA facilities that employed an OMS three years ago no longer have one on staff.
 - Even where the OMS position hasn't been cut, recruiting to fill the position normally takes over a year – if a recruit can be found at all. In one instance a VA facility had to recruit for more than 4 years to fill an OMS position on staff.

- **To correct the critical shortage of dentists and OMSes within the VA, one of the most important steps is to enact H.R. 2660.**
 - Current data demonstrate that private sector incomes for dentists are much more competitive than those of the federal service. ADA data shows average income for a dental specialist in private practice to be \$191,890 as of 1995.
 - Even among federally employed dentists, those in the service of the VA are the lowest paid.
 - To make the VA competitive in the marketplace it is essential to recognize the change in pay scales since last updated in 1991. Current special pay is simply inadequate.
 - It is critical to enact H.R. 2660 to retain and recruit the dentists and OMSes necessary to provide the highest quality care to deserving veterans.



American Academy of Physician Assistants

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TESTIMONY OF
THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS
SUBMITTED TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

REGARDING THE RECRUITMENT, RETENTION AND PAY
OF THE VA HEALTH CARE WORKFORCE

May 4, 2000

On behalf of the nearly 38,000 clinically practicing physician assistants in the United States, the American Academy of Physician Assistants is pleased to submit comments on issues affecting the working conditions of physician assistants (PAs) employed within the Department of Veterans Affairs (VA).

The first physician assistants to graduate from PA educational programs were veterans, former medical corpsmen who had served in Vietnam and wanted to use their medical knowledge and experience in civilian life. Dr. Eugene Stead of the Duke University Medical Center in North Carolina put together the first class of PAs in 1965, selecting Navy corpsmen who had considerable medical training during their military experience as his students. Dr. Stead based the curriculum of the PA program in part on his knowledge of the fast-track training of doctors during World War II. Today, there are more than 120 accredited PA educational programs across the United States, and PAs work in all segments of the health care system providing high quality, cost-effective, medical care. Nearly 1,200 PAs are employed by the Department of Veterans Affairs, making the VA the largest single employer of physician assistants. These PAs work in a wide variety of medical centers and outpatient clinics, providing medical care to thousands of veterans each year. Many are veterans themselves.

PAs within the VA have experienced a number of long-standing problems. Despite employing PAs for nearly 30 years, the VA does not have a representative within the Veterans Health Administration with sufficient knowledge of the PA profession to advise the Administration on the optimal utilization of PAs. This lack of knowledge has resulted in an inconsistent approach toward PA practice, unnecessary restrictions on the ability of VA physicians to effectively use PAs, and an under-utilization of PA skills and abilities.

For instance, the PA profession's scope of practice is not uniformly understood in all VA medical facilities and clinics, and unnecessary confusion exists regarding such issues as

privileging, supervision, and physician countersignature. Some facilities unnecessarily restrict PAs' ability to provide medical care, and some facilities will not hire PAs at all. These restrictions hinder PA employment within the VA as well as deprive veterans of the skills and experience PAs have to offer.

Additionally, misinformation regarding PAs' ability to sign patient charts and eligibility for third party coverage leads to unnecessary coding and billing problems in some local clinics and facilities. This misinformation creates unnecessary administrative burden and, by creating the mistaken impression that PA practice is burdensome, negatively influences employment opportunities for PAs.

Furthermore, despite the VA's role as a federal agency, VA medical centers currently use a patchwork of different methods to address PA prescriptive authority. Some VA medical centers follow state laws while others use local guidelines or federal authority. Some facilities simply do not allow PAs to prescribe medications at all. These varying standards create hardship for PAs who wish to move within the system. They also prevent PAs from fully utilizing their pharmacological and diagnostic knowledge to benefit their patients. A system-wide standard could eliminate these problems and enhance the productivity of the physician-physician assistant team, but such a system has never been implemented because of the lack of a knowledgeable PA advisor within the VA.

In June 1999 the VA's Multidisciplinary Field Advisory Group sent a report to the Office of the Under Secretary for Health describing these and other barriers to mid-level clinician practice within the VA system. Establishing a PA advisor within the VA would provide essential support in implementing the recommendations of this group. Other professions, such as social workers, nurses, dentists and nutritionists, already have such representation. However, despite years of attempted persuasion on the part of PAs within the agency, the Veterans Administration has not yet created such a position.

To remedy these and other problems, the Academy recommends the passage of legislation requiring the VA to establish a position of Advisor on Physician Assistants, directed by a physician assistant, within the Office of the Under Secretary for Health, Veterans Health Administration. This position would provide guidance on the full implementation of physician assistant services within the VA system. On March 21, Senator Rockefeller introduced a bill in the Senate that meets these criteria, S. 2264, the "Recognition of Physician Assistants in the Department of Veterans Affairs Act of 2000." It is worth noting that each branch of the Armed Services has a PA in a consultant position similar to one the Academy proposes for the VA, and PAs in the Armed Services have managed to avoid problems similar to those faced by PAs in the VA. With appropriate guidance on the needs and abilities of the PA profession, the VA should be able to achieve the same smooth integration of physician assistants into its own health care system.

Thank you for this opportunity to present the American Academy of Physician Assistants' views on issues facing physician assistants within the VA health care system.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES
 CONGRESSMAN SIMPSON TO DEPARTMENT OF VETERANS AFFAIRS

**Question Submitted by
 Congressman Mike Simpson
 on behalf of Congressman Christopher Smith**

**Concerning the April 12, 2000, Hearing on the
 Status of Recruitment, Retention, and Compensation
 of the Department of Veterans Affairs Health Care Workforce**

Question: What has been the impact of the Health Professionals Educational Assistance Program on recruitment of nurses, dentists, and other healthcare professionals within the VA? How many people have taken advantage of the program in each year of its existence? What has been the retention rate of these critical healthcare professionals in the VA after their required time of service expired?

Answer: In August 1990, Public Law 101-366 established the Reserve Member Stipend Program (RMSP) as the third component of The Health Professionals Educational Assistance Program. The other two programs were the Health Professional Scholarship Program and the Tuition Reimbursement Program.

The RMSP was a competitive program open to members of the Selected Ready Reserve who are eligible for the Selected Reserve Educational Assistance Program (GI Bill). Awardees were selected from among applicants who are full-time students in the final year of an associate degree nursing program; or in the final year or two of an entry-level professional degree program in nursing, occupational therapy or physical therapy.

The RMSP recipients received a \$400 stipend for each month of full-time study. In addition, participants received GI Bill benefits. In exchange, they agreed to become employed as full-time professionals in VA healthcare facilities for two years following completion of their educational program and licensure/certification. The basic eligibility criteria used for the RMSP were the same as for the Scholarship Program. Selection factors were identical to the Scholarship Program, with one exception: a recommendation was needed from the Unit Commander of the applicant's Reserve Unit, in which the Commander indicated that the reservist scored 50% or higher on the Armed Forces Qualification Test.

The number of RMSP applicants, eligible applicants, awards and discipline of the awardees by Award Year are as follows:

Award Year	No. of Applicants	No. of Eligible Applicants	No. of Awards	Disciplines of the Awardees
1991	59	33	17	16 Nursing 1 Occupational Therapy
1992	60	34	9	9 Nursing
1993	52	40	7	6 Nursing 1 Occupational Therapy
1994	61	28	1	1 Nursing
Totals	232	135	34	32 Nursing 2 Occupational Therapy

Although extensive circulation of program materials was provided to the various branches of the Armed Services, to colleges and universities, VA medical centers, professional and armed services publications, the RMSP had minimal success in attracting qualified applicants. Other scholarship programs, including the VA Scholarship Program, U.S. Public Health Service, and various Armed Forces educational programs, offered greater benefits for students. Therefore, when given the choice, many qualified students selected programs that offered more.

Due to the low number of eligible applicants and awards given, the RMSP was not offered after 1994.

All of the awardees completed their educational programs. VA does not have a record of the employment status of the awardees after they completed their two-year service obligation.

CONGRESSMAN EVANS TO DEPARTMENT OF VETERANS AFFAIRS

**Post-Hearing Questions
Concerning the April 12, 2000, Hearing**

**on the
Status of Recruitment, Retention, and Compensation
of the Department of Veterans Affairs Health Care Workforce**

**from
The Honorable Lane Evans
Ranking Democratic Member, Veterans Affairs' Committee
U.S. House of Representatives**

1. In the hearing, Mr. Doyle asked if VA would consider extending its existing authority to implement specialty pay and education incentives to enhance its ability to recruit and retain nurses and therapists in the field of spinal cord dysfunction medicine, to which you responded, "yes." Please describe current VA plans to apply these authorities to address the problems of recruitment and retention in spinal cord medicine?

Answer: The Department encourages the use of existing flexibilities to enhance recruitment and retention of healthcare professionals in Spinal Cord Injury/Dysfunction (SCI&D) medicine. This is being accomplished by communications with facility managers, program managers, and employees regarding tools available to provide for competitive pay.

As recently as February of this year, SCI Service Chiefs were advised in writing and on conference calls by the Office of the SCI&D Chief Consultant of the Department's policy on paying retention allowances. They were provided a copy of the policy along with a statement from Dr. Garthwaite indicating his support of using retention allowances when criteria are met.

Additionally, the Chief Network Officer has sent information memoranda to Network Directors and facility directors on the use of recruitment and retention tools to compensate professionals in these and other scarce categories. Information on recruitment and retention strategies is also available to Human Resources professionals, as well as managers and employees, through VA's Intranet. Managers have been briefed on the use of recruitment and retention incentives, including cash bonuses, flexible work arrangements, and performance recognition awards.

VA has implemented two new educational assistance programs to enhance recruitment and retention of health professionals - the Employee Incentive Scholarship Program (EISP) and the Educational Debt Reduction Program (EDRP). The EISP, already in place, allows VA to provide its employees, who agree to serve a period of obligated service, scholarships to pursue education in selected healthcare disciplines. The EDRP will help VA recruit health professionals with educational loan obligations. The program will allow VA to make payments to new appointees in certain healthcare positions over a specified period of time to help them reduce or pay off the balances on loans used for healthcare education. The EDRP policy is under development and should be implemented within the next few months.

An internal education program currently under development is the Veterans Health Initiative, which will include in its syllabus a module devoted to Spinal Cord Injury/Dysfunction. This course will be offered to health care professionals to ensure their comprehensive knowledge of certain health conditions and the clinical ramifications of military service.

2. VA's budget of FY 2001 requests \$63.5 million to support pay raises for nurses. You agreed that this funding request was based upon an assumption that nurses would receive the equivalent of the nationwide and locality pay raise requested for GS employees. What assurance can you give Congress that these funds will be used for this purpose (particularly since hospital directors have discretion about offering such a pay raise)?

Answer: VHA headquarters will continue to encourage local facility directors to exercise their authority to set nurse pay rates so as to maintain competitive pay for recruitment and retention of nurses and will monitor their actions. In evidence of this increased focus, all facilities did authorize pay increases for their nursing staff last year. VHA headquarters will send a letter to each Network and Facility director urging them to carefully consider current and future staffing problems and the trend in community rates in determining the size of a pay adjustment in January 2001.

3. Will VA be able to meet the challenge of implementing its new nurse qualification standards while also confronting a projected nursing shortage without making serious adjustments to its nurse pay salary structure? If so, how?

Answer: The new Nurse Qualification Standard allows VHA to continue to hire nurses from all education programs (associate degree and diploma to doctoral). The emphasis of the new Nurse Qualification Standard is to allow VHA to continually improve the range of skills of its nursing personnel, in this case particularly as it relates to ability to more independently provide care in outpatient, home and community settings. The nurse Locality Pay System has mechanisms and flexibilities to allow VAMCs to locally determine pay schedules necessary to address their specific needs, allowing them to remain competitive with agencies within their Local Labor Market.

While there are projected nurse shortages, the potential impact within VHA has yet to be fully determined. VA is constantly monitoring nurse staffing and plans to meet VHA projected staffing needs.

4. How has VA addressed the need for dental care over the past five years when it has lost more than 11% of its dentists' workforce and simultaneously gained 20% new veteran patients? Describe delays in scheduling of delivery of dental care.

Answer: During the last five years, the number of patients receiving VA care has increased by 20.9%, while the percentage of VA patients receiving dental care has declined by 11.4%. Also, the average amount of dental treatment provided per patient has declined.

Because of the dental staffing reductions, most VA Dental Services are directing their clinical efforts to provide care to veterans who have 100 per cent service-connected ratings, veterans with service-connected, compensable dental conditions, recently discharged veterans, and former prisoners of war. Thus, VA currently provides less dental care for veterans in vocational rehabilitation programs, inpatients, and long term patients, such as nursing home, domiciliary and extended care patients.

There has been an increase in waiting times for dental services. A March 2000 survey of 64 VA dental clinics across the country showed waiting times for examinations and first treatment appointment to range from 10-340 working days, with average waiting times of 46 working days.

Our goal is to provide the appropriate level of quality dental care to all veterans who are eligible, in a timely manner, and with the best possible utilization of our resources. We are working to meet this goal through the following actions:

- (1) Improve the recruitment and retention of dentists by developing a legislative proposal seeking increased salary support.
- (2) Develop a better information and educational process to clarify some of the misconceptions that exist regarding dental eligibility.
- (3) Provide guidance from Headquarters regarding dental care, staffing, space, and eligibility to VISNs and individual VA facilities as needed.

(4) Develop policy recommendations for oral care of patients assigned to nursing home care units.

(5) Re-emphasize policy concerning eligibility and dental care to support vocational rehabilitation program patients.

(6) Implement the electronic Dental Record Manager (DRM). This step will improve the quality of data by reducing "human errors" and will cut down the administrative time clinicians spend in data entry and records management. It will also make data on quality of care more readily available. A Government Performance Results Act (GPRA)-based performance plan will be implemented following implementation of the DRM. The plan will track performance directly from the data entered into the dentistry database.

(7) Establish a simulation modeling pilot to more effectively manage dental operations. It is in the early stages of development. Some of the specific goals of the initial pilot are to monitor dental care capacity and demand for services, to identify variables that impact performance, and ultimately to effectively reengineer the system to serve patients better.

In addition, VA's goal of increasing access and decreasing waiting time is focused to address waiting times in all clinics.

5. Does VA HQ maintain a floor or ceiling for health professions – registered nurses, physicians, dentists? Why or why not?

Answer: VA HQ has not established staffing levels for health professionals, except for certain nurse staffing levels in SCI centers. VHA does not believe that comprehensive national staffing levels would be in the best interests of quality care.

Set numbers of staff and specific types of positions mandated by a central authority would not be responsive to changing patient and staffing needs, evolving patient census, or variations in practice patterns around the country. Instead, Network and facility managers exercise their professional judgment in considering these and other factors to best assure safe staffing levels and quality care for veterans.

6. How does VA gauge recruitment and retention problems? Do local efforts to recruit and retain staff make the picture of turnover based on listings maintained in the Health Care Staff Development & Retention Center inaccurate? Please explain.

Answer: VA gauges recruitment and retention problems by a number of factors including analysis of turnover rates, the quit rate, the number of declinations of job offers, the overall staffing success ratio, community pay disparities, the number of special salary rate requests, and the number and duration of vacancies both for an occupation and at individual facilities.

In addition, we have a number of periodic reports that capture this information, along with reports on gains and losses. These reports give detailed information on quits and other separations by occupation, location, type of action, reason, age and length of service, etc. They also identify gains, whether by new hire, transfer, promotion, etc. They also report historical and current turnover rates, average age of employees, and retirement eligibility. In addition, the Health Care Staff Development & Retention Office (HCSURO) monitors industry trends and employment levels within VHA.

Local control of recruitment efforts enables facilities to quickly fill vacancies as they occur or are anticipated. Many recruitment efforts are focused on local efforts only. Thus, not all vacancies are known to the HCSURO. When facilities initiate regional or national recruitment efforts, they will contact the HCSURO for assistance in publicizing the vacancy. In addition to the recruitment assistance, the Center also serves as a clearinghouse for information on VA employment, and is responsible for outreach efforts and some education funding.

7. How are vacancies tracked at VA's Headquarters? Are VA service chiefs and consultants aware of vacancies that would allow them to monitor trends in retention and recruitment? Would that information be helpful to them in developing national strategies to address problems?

Answer: The overall staffing situation in VA is monitored at headquarters by Human Resources, and VHA officials. In the Office of Patient Care Services, chief consultants and other program managers monitor the operations of their programs at VA facilities throughout the system. This is accomplished by regular status reports from the field, along with automated reports that can track an occupation, location, or region. These reports on separations and hires, on retirement eligibility, and on historical staffing data provide snapshots of the staffing situation, as well as trends.

This information is helpful to the chief consultants and program managers, as well as, field managers. It enables them to identify potential areas of concern and develop strategies to address problems.

8. What impact does both the aging population and the aging workforce have on work-related injuries? It is my understanding that many private facilities have standard operating procedures that prohibit staff from lifting patients and have incorporated state of the art ergonomic lifts and devices into all patient areas. How is VA addressing this issue?

Answer: Both VHA's workforce and veteran populations are in fact aging; VHA has been tracking this issue formally through its Nursing Service. VHA recognizes that patient outcomes of care depend on the working conditions of its employees and views the occupational health of nurses as a "patient safety" issue, with implications for its responsibilities to the veteran population.

Aging workers are at greater risk of acute injuries and of repetitive strain injuries to the musculoskeletal system. An aging veteran patient population is less mobile and more dependent on caregiver patient-transfer activities than a younger, more mobile population.

Two major intervention strategies have been considered and explored. One has proven far superior to the other and has had a focus on technology and training. An administrative focus on developing lifting teams appears to have less suitability for the VA Medical Centers, nursing homes, and domiciliaries.

The two initial approaches:

New technology and training – A nursing researcher at VAMC Tampa reviewed VHA's workers' compensation experience in 1995 and identified the twelve tasks most clearly associated with back injuries. A review of devices existing on the market suggested that these did not appear to resolve the excess risk issues. The researcher convened an expert panel to characterize the task components contributing to the injury and developed technology and training based solutions. The researcher then led a laboratory-based research project that has just finished the data collection phase to examine the scientific validity of the expert panel's task analysis and redesign.

Lifting team approach – VHA experimented with assigning multiple nurses to patient transfers, in an attempt to solve the transfer injuries. This approach was not as successful, as the hospitalized veteran population is generally older and sicker, and double-teaming patient transfers merely appeared to drain resources from other tasks on the same units.

Implementation:

Promising research on technology and training has led to two actions. First, the VA Patient Safety Center of Inquiry at VAMC Tampa is working with a manufacturer to develop and evaluate a safe patient room of the future. Second, two VISNs will be

using the techniques developed in response to the task analysis to change the practice of how nurses handle patients using an innovative "communities of practice" based approach with a back resource coordinator on each patient unit. A brainstorming session is planned for July 2000 to identify possible barriers and solutions, with the goals of implementing these techniques in the next year in 10 percent of VA Medical Centers and evaluating the effectiveness before implementing this approach nationwide.

VA occupational safety and health policy requires that ergonomics programs be developed and implemented at all VA facilities based upon an ergonomics assessment of tasks that pose a significant risk for injury. VHA has reviewed existing ergonomics programs and established an Ergonomics Technical Advisory Group (TAG) to develop a model program that will improve the effectiveness of existing programs and guide the development of new programs to meet ergonomics goals. A major proposal for a pilot / demonstration ergonomics project related to back injury is planned for implementation in FY 2001.

From the April 14, 2000, letter from Rep. Lane Evans to Mr. Dennis Duffy, requesting VA's technical assistance in drafting legislation, VA was asked the following question:

****** Explain if there is any "value added" from OPM's current examining/ certification process?

Answer: Special salary rates approved under the provisions of 38 U.S.C. 7455 for General Schedule occupations must be submitted to the Office of Personnel Management (OPM) for concurrence. The increased rates may not take effect until OPM concurs. If OPM takes no action within 45 days of receiving the case, the increase takes effect automatically.

The effect of this review is to delay implementation of the increased rates. Although OPM has delayed action on some requests, they have never prevented a VA special rate authorization under Title 38 authority from taking effect.

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