



**Department of Veterans Affairs
Office of Inspector General**

Healthcare Inspection

**Evaluation of Nurse Staffing in Veterans
Health Administration Facilities**

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EXECUTIVE SUMMARY

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) evaluated the efforts to manage nursing resources in Veterans Health Administration (VHA) medical facilities in light of the national nursing shortage. The purposes of our evaluation were to determine whether VHA facility managers: (1) effectively allocated and deployed nursing resources; (2) monitored the impact of staffing levels on the quality of care provided to patients; and (3) applied effective recruitment, retention, and deployment strategies to maintain a stable VHA nursing work force. We also solicited employee perceptions on other issues that may affect job satisfaction.

As of August 2003, VA employed more than 36,000 Registered Nurse (RN) full-time equivalents (FTE). In a 1989 report, OIG concluded that: (1) VHA managers needed to better monitor their nurse staffing needs, (2) staffing decisions were based on inaccurate data, (3) wide variations occurred among facilities, and (4) VHA did not have a standardized methodology to determine the appropriate number and mix of nursing personnel. Public Law 107-135, which became effective January 1, 2002, required the VA to establish a nationwide VHA staffing policy to ensure the provision of appropriate high-quality care and services. At the time of this review, VHA had not mandated the use of a national nurse staffing methodology.

Our review focused primarily on fiscal year (FY) 2002 activities. At the 10 medical facilities in our sample, we collected staffing data from 81 inpatient wards. We reviewed data reports and analyzed workload trends, costs, employee vacancy reports, and rates of employee absenteeism and turnover. We interviewed more than 800 VHA personnel and reviewed facility documents, including nurse staffing plans, policies, and trending reports. In addition, we reviewed the recruitment and retention practices employed by facility managers to hire and retain qualified personnel.

The nursing shortage is affecting nurse staffing, patient care, employee morale, and costs at VHA facilities. We found that facility managers frequently had to employ undesirable measures resulting in significant adverse patient access, financial, and job satisfaction consequences to ensure sufficient numbers of staff to provide safe patient care. Some facility managers limited patient access to care by deactivating beds and diverting patients to community hospitals, in part because of lack of nursing personnel. Facility managers might have been able to mitigate these consequences had VHA developed and implemented procedures to ensure: (1) efficient management of nurse staffing resources through the use of consistent staffing methodologies, standards, and data systems; (2) monitoring of the potential impact of nurse staffing issues on patient care; (3) effective use of recruitment and retention strategies; and (4) appropriate management response to issues that influence RN job satisfaction. Despite frequently voiced concerns about staffing shortages, the 10 sites we visited had generally met patient care demands.

Until VHA senior managers develop and fully implement a nurse staffing policy, system-wide monitoring is not possible. Effective policy implementation will require the designation of a national nurse staffing methodology, which facility managers will use to develop measurable staffing standards for all patient care areas.

We found that facility managers had not consistently considered available data, such as employee efficiency, absenteeism, and turnover, when they made nurse staffing decisions. Several VHA data systems, including the nursing computer package and the Decision Support System (DSS), are available to all facility managers and could be used to assist in making staffing decisions. These data systems incur significant maintenance costs and were not being fully used. They need to be evaluated, updated, maintained, and used to achieve greater staffing efficiencies. We believe that better resource management might have reduced limitations to patient access, reliance on overtime and contract labor, and costs.

We found minimal evidence that facility managers had analyzed the impact of nurse staffing variables, such as turnover and vacancy rates, on patient outcomes. Our analyses showed that increases in turnover were associated with suboptimal patient outcomes, which is consistent with published research findings. High-quality patient care and evidence-based practice could be facilitated if managers systematically evaluated the relationship between nurse staffing variables and patient outcomes. Also, the Joint Commission on Accreditation of Healthcare Organization's (JCAHO) staffing effectiveness standards require analyses of relationships between staffing indicators and patient outcomes. We found incomplete compliance with these standards.

Given the many varied opportunities available to RNs, managers need to create incentives for experienced staff nurses to remain in direct patient care assignments. Retention of experienced nurses is extremely important in today's work environment. Turnover is costly and needs to be consistently measured and managed. Aggressive succession planning is needed to address the anticipated losses of retirement-eligible nurses.

Facility managers use only a portion of the numerous recruitment and retention authorities available. VHA managers need to determine which authorities are most effective, secure sufficient funding, and streamline cumbersome administrative procedures to ensure success. The system would benefit if all recommendations submitted by VHA's Office of Nursing Service's (ONS) Future Nursing Workforce Planning Group (FNWPG) were implemented. National education programs have been beneficial in recruitment and retention and should be funded and supported.

VHA and facility managers need to address employee perceptions that influence job satisfaction and retention. Excessive use of overtime and all mandatory overtime cause nurse job dissatisfaction. Safe limits on overtime use need to be established. Floating, tour of duty changes, ancillary staff availability, and staffing mix all impact RN job satisfaction. Staff nurses would like to see evidence that managers support them and to be involved in staffing decisions.

We made recommendations to improve the management of nursing resources, promote high quality patient care, facilitate nursing recruitment and retention efforts, and enhance nurses' job satisfaction. We also identified areas where costs could be reduced or funds better used.

Acting Under Secretary for Health Comments

The Acting Under Secretary for Health concurred in all recommendations, including the estimate for monetary benefits. However, he expressed concerns that this report used perception data from nursing staff as the basis for recommending that VHA monitor the impact of overtime, duty changes, and floating changes on staff recruitment and retention and that VHA assess the need for establishing safe limits on these measures. The full text of the comments and the implementation plans are shown in Appendix A.

Acting Assistant Secretary for Human Resources and Administration Comments

The Acting Assistant Secretary for Human Resources and Administration recommended that the Acting Under Secretary for Health assume the lead for taking actions to ensure that direct patient care assignments offer similar opportunities to non-patient care assignments. The Acting Assistant Secretary for Human Resources and Administration also stated that the Department of Veterans Affairs has considerable discretionary authority to provide additional compensation to licensed practical nurses. The full text of the comments is shown in Appendix B.

Inspector General Comments

The Acting Under Secretary for Health comments and implementation plans are responsive to the recommendations. The Acting Assistant Secretary for Human Resources and Administration comments met the intent of recommendations 3a and 4b. We will continue to follow up until all issues are resolved.

(original signed by:)

JOHN D. DAIGH JR., M.D.
Assistant Inspector General
for Healthcare Inspections

INTRODUCTION

Purpose

We evaluated efforts to manage nursing resources in VHA medical facilities in light of the national nursing shortage. The purposes of our evaluation were to determine whether VHA facility managers: (1) effectively allocated and deployed nursing resources; (2) monitored the impact of staffing levels on the quality of care provided to patients; and (3) applied effective recruitment, retention, and deployment strategies to maintain a stable VHA nursing work force. We also solicited employee perceptions on other issues that may affect job satisfaction.

Background

For the past decade, health care literature has identified concerns about current and future nursing shortages in the U.S.¹ Subject matter experts have attributed the increasing concern about nursing shortages to an aging RN workforce, decreasing numbers of young people entering the profession, and the impending health care needs of the aging baby boom generation.^{2,3}

In July 2001, the General Accounting Office (GAO) issued a report that discussed concerns about emerging nursing shortages. The report concluded that impending demographic changes are widening the gap between the numbers of people needing care and those available to provide care. In addition, GAO stated that job dissatisfaction is crucial in determining the extent of current and future nursing shortages and that efforts must be undertaken to improve the workplace environment.⁴

Studies of VHA's nursing work force reported similar concerns. RNs comprise one of the largest segments of health care workers in the VHA. As of August 2003, VA employed more than 36,000 RN FTE.* In a 1989 report, the OIG concluded that VHA managers needed to better monitor their nurse staffing needs. The OIG audit found that staffing decisions were based on inaccurate data, that wide variations in staffing occurred among facilities, and that VHA did not have a standardized methodology to determine the appropriate number and mix of nursing personnel.⁵ At the time of this review, VHA had not mandated the use of a national standardized nurse staffing methodology as recommended in 1989.

VA stakeholders have identified quality of care implications that warrant attention. The American Legion reported that health care facility managers have been forced to neglect several long-term care programs, close inpatient beds, and postpone elective medical procedures because of insufficient nursing personnel.⁶ Several private sector studies have linked adverse patient consequences, such as medication errors, urinary

* Data extracted from the payroll system as of August 8, 2003.

tract infections, and pneumonia, to care provided in wards inadequately staffed with RNs.^{7,8,9}

Following the 1989 OIG report and in response to stakeholder concerns, VHA developed and endorsed the Expert Panel Staffing Methodology in the early 1990s for facilities to use to manage their nursing resources. This model was intended to assist bedside nurses, in collaboration with their managers, to appraise the adequacy of administrative, clinical, and support services, and to explore opportunities for work redesign. However, not all facility managers embraced the Expert Panel initiative. Objections to the Expert Panel Staffing Methodology included that it was too time consuming to maintain, allowed for improper manipulation, and was budget neutral (staffing adjustments had to be accomplished within existing budgets).

In 2000, VHA's ONS chartered the FNWPG to evaluate issues related to the supply and utilization of nursing resources. Approximately 1 year later, the ONS published its report entitled, "A Call to Action: VA's Response to the National Nursing Shortage." The report concluded that existing human resource and pay authorities did not offer the flexibility required to respond quickly to prevailing market forces. The report made numerous recommendations categorized according to nursing utilization, retention, recruitment, and outreach activities. The report concluded that sufficient funding must accompany any actions to ensure enduring success and that VHA needed to shift from traditional, cumbersome employment practices to more flexible and creative strategies.¹⁰

Also in 2000, VHA established the Hiring Timeline Ad Hoc Group¹¹ to address pre-employment issues affecting RNs. The group identified various barriers that delayed or impeded the hiring process and recommended strategies to improve nursing recruitment. The recommendations included national labor relations negotiations, advertising campaigns, and collaboration between Human Resources (HR) personnel and the VA Nurse Recruiters Association.

In response to prior reports and increasing nurse staffing concerns, the U.S. Congress passed Public Law 107-135, entitled "The Department of Veterans Affairs Health Care Programs Enhancement Act of 2001." The law became effective January 1, 2002, and required the VA Secretary, in collaboration with the Under Secretary for Health, to establish a nationwide VHA staffing policy to ensure the provision of high-quality care and services. The required policy must take into account the staffing levels and mixture of employee skills required for the range of care and services provided. In addition, the law mandated the establishment of the National Commission on VA Nursing to collect information related to legislative and organizational policy changes and to assess the future of the nursing profession in the VA. The law also strengthened some pay and retirement initiatives and required VHA managers to submit reports on several key topics, such as mandatory overtime, nurse managed clinics, and nurse qualification standards.

We will refer to two VA data systems in this report, the nursing computer package and the DSS. The nursing computer package includes a staffing methodology, introduced in 1984, intended to be used by managers to monitor if sufficient nursing personnel were provided to meet patient care needs. The methodology requires that nurses classify inpatients according to their dependencies and needs for direct nursing care (referred to as the patient's acuity level). Nurses classify each patient every day into one of several groups. Average values, in hours, are assigned to each group and serve as measures of staffing needs. The associated values are specific to several clinical specialties, i.e., critical care, extended care, medicine, surgery, behavioral health, and spinal cord injury. The levels of care range from minimal nursing care, acuity level I, to acuity level V. In addition, the methodology requires that the hours worked be entered into the system. Staffing adequacy is determined by comparing the hours provided with those required for each patient's acuity.

DSS is an automated managerial cost accounting system that VHA adopted in 1994. The system associates costs with health care services delivered to patients. In addition, the DSS provides a mechanism to analyze patient outcomes and manage clinical care. By extracting and integrating data from a variety of existing VHA computer packages, the DSS can assist facility managers to make informed decisions, thereby using resources more effectively. The DSS is used by more than 1,400 hospitals and health care systems worldwide.¹²

All detailed data systems require maintenance and validation to achieve maximum functionality. Accurate DSS reports require the individuals who are most familiar with the work produced to maintain the following three factors:

Workload Collection: The amount of work performed within a specific time period by one or more employees.

Labor Mapping: A record of the amount of time and location each employee is available to produce work.

Relative Value Units (RVUs): The weighted units of measure that allow for the relative comparison between different complexities and mixes of procedures, i.e., amount of resources used to produce each work product.

Scope and Methodology

We reviewed VHA's efforts to manage its nurse staffing resources in light of the national nursing shortage and evaluated several issues, such as use of a nurse staffing methodology, use of data to make staffing decisions, and the impact of nurse staffing on patient outcomes. In preparation for this review, we met with VA Central Office program officials. We reviewed prior OIG and GAO reports, as well as extensive literature and research related to nurse staffing. We also reviewed documents related to recruitment and retention authorities.

We selected 10 VA medical facilities, which comprise a mix of facility size, geographic location, and Veterans Integrated Service Networks (VISNs). We visited the facilities from November 1, 2002, through May 15, 2003. Our review focused primarily on FY 2002 activities. At the 10 medical facilities visited, we collected staffing data pertaining to 81 inpatient wards. Some data analyses in this report are based on 78 inpatient wards because of differences in department structures and ward consolidations. The medical facilities we visited had 4,095 authorized inpatient and outpatient nursing positions.

We reviewed employee efficiency statistics from the DSS and analyzed workload trends, employee vacancy reports, and rates of employee absenteeism and turnover. We evaluated the performance of each inpatient ward against both local and available national staffing standards. We also considered the additional costs, such as overtime and contract personnel used to supplement core nurse staffing in order to achieve acceptable staffing levels.

We analyzed nurse staffing data in the context of patient outcomes to determine if there were any trends. We interviewed more than 800 VHA personnel, including senior facility managers (directors and nurse executives), nurse managers, staff nurses, nurse educators, HR specialists, DSS Managers, and Quality Management (QM) personnel. We reviewed facility documents, including nurse staffing plans, policies, trending reports, database statistics, and committee meeting minutes. In addition, we reviewed the recruitment and retention practices employed by facility managers to hire and retain qualified personnel.

We validated all data with the nurse managers, DSS managers, and nurse executives on-site. We communicated our interpretations and suggestions to the responsible managers. When we identified data integrity issues, we recommended corrective actions to ensure that future staffing decisions and resource requirements could be supported by accurate data.

We conducted the evaluation in accordance with the *Quality Standards for Inspections published by the President's Council on Integrity and Efficiency*.

RESULTS AND CONCLUSIONS

The nursing shortage is affecting nurse staffing, patient care, employee morale, and costs at VHA facilities. We found that facility managers frequently had to employ undesirable measures with significant adverse patient access, financial, and job satisfaction consequences to ensure that sufficient numbers of staff were available to provide safe patient care. Some facility managers limited patient access to care by deactivating beds and diverting patients to community hospitals, in part because of lack of nursing personnel. Facility managers might have been able to reduce the use of these measures if VHA had developed, initiated, and validated systems to ensure: (1) efficient management of nurse staffing resources through the use of consistent staffing methodologies, standards, and data systems; (2) measurement of the potential impact of nurse staffing on patient outcomes; (3) effective use of recruitment and retention strategies; and (4) appropriate management responses to issues that influence RN job satisfaction. There are currently no VHA standards for acute care nurse staffing adequacy. Despite frequently voiced concerns about staffing shortages, the 10 sites in our sample had generally met patient care demands.

Issue 1: Management of Nurse Staffing Resources

Nurse Staffing Methodologies and Standards

We found that VHA facility managers did not follow a standardized staffing methodology. In the absence of a national VHA nurse staffing methodology, facility managers used a variety of methods to monitor, allocate, and deploy nursing resources. We found that managers made decisions based on limited and inconsistent information, which resulted in lost opportunities to better monitor and control resource needs. The facility staffing methods varied in their sensitivities to changes in patient acuties and ward activities.

Establishing the optimum mix of nursing personnel with the appropriate qualifications, credentials, and clinical competencies is critical to fulfill patient care requirements. We found that local nurse staffing methodologies were inconsistent and produced staffing standards that did not always differentiate the mix or categories of nursing personnel required to care for the facilities' patient populations. Of the 10 staffing methodologies we reviewed, 3 did not designate the mix or categories of nursing personnel (i.e., RN, Licensed Practical Nurse [LPN], Nursing Assistant [NA]). In addition, methodologies were based on a variety of workload measurements, such as hours per patient day, nurse-to-patient ratios, and patient census data.

We validated facility managers' compliance with their own locally developed staffing standards by comparing the number and categories of nurses provided with the requirements defined by their own local standards. We analyzed 686 tours of duty (day, evening, and night). We found that facility managers met their staffing standards 76 percent (521/686) of the time. Only one medical facility met its staffing standards at all

times. Staffing standards were met more often when methodologies and guidelines were flexible and responsive to changes in patient care requirements, such as admissions, procedures, and acuities.

We concluded that system-wide monitoring was not possible with locally developed methodologies and standards. VHA senior managers need to provide better guidance and oversight to facility managers by developing and implementing a staffing policy as prescribed by Public Law 107-135. They then need to develop an effective national nurse staffing methodology flexible enough to be implemented at all facilities and responsive to the dynamic changes in workload and the availability of nursing and support personnel. Facility managers will need to consistently apply the national methodology to develop measurable staffing standards for all patient care areas and monitor the adequacy and distribution of nursing resources.

Patient Access to Care

Some facility managers limited patient access to care because of staffing shortages. Managers at one facility told us that they had deactivated 28 percent (16/58) of their medical/surgical beds during FY 2002, in part because of their difficulty in recruiting nurses. At this same facility, we found that managers diverted 287 medical/surgical patients to community hospitals during the first 5 months of FY 2003. Unavailability of nursing personnel was identified as a factor in approximately 54 percent (155/287) of these patient diversions. Nurse Executives at 40 percent (4/10) of the facilities we visited stated that bed deactivations, patient diversions, and cancellations of admissions and procedures routinely occurred when nurse staffing was not adequate. Better coordination of resources might have reduced or prevented the need to limit patient access to care.

Additional Staffing Considerations

Facility managers employed other significant interventions to ensure adequate nurse staffing. Interviews with 81 inpatient nurse managers disclosed that all but 2 of them routinely relied upon employees to work overtime in order to ensure that their wards were adequately staffed. One-third of the staff nurses (122/368) told us that they were required or mandated to work overtime in FY 2002 because of inadequate staffing. During the last 6 months of FY 2002, managers in our sample paid over \$2.2 million in overtime compensation for inpatient nursing services only. During the same period, total resources expended to supplement basic nurse staffing at each of the 10 facilities visited ranged from \$24,000 to \$1.4 million, with the total for all facilities at about \$5.5 million. Annualized and projected for all 162 VHA medical facilities, we estimated that these expenditures exceeded \$178.2 million.

Supplemental nursing resources (including overtime, contract, and per diem costs) may be necessary for coverage and may even be the most cost-effective strategy. However, opportunities existed for managers to significantly reduce these expenditures. When we presented our data analyses to the nurse managers in our sample, 45 percent of them

identified interventions, such as redistribution of personnel, that could have been considered as an alternative to the use of overtime or contract nurses. If managers would reduce their reliance on supplemental nursing resources by 10 percent, they would achieve an estimated annual savings of \$17.8 million.

Managers at 80 percent (8/10) of the facilities temporarily reassigned (floated) nurses between units. All facilities (10/10) changed schedules or tours or duty, and half of the facilities (5/10) relied upon intermittent or contract personnel. Current literature clearly identifies concerns associated with these interventions, such as the negative impact on staff satisfaction, absenteeism, clinical competencies, and patient safety.^{13,14,15} These topics are discussed more fully under Issue 4.

We analyzed the rate of employee absences (absenteeism) and found that the inpatient nursing absenteeism rates ranged from 11 to 23 percent for the last 6 months of FY 2002 for all categories of nursing employees. The average for all facilities was 14.4 percent. While managers have little control over unplanned absences due to illness or family emergencies, scheduling of vacation and holiday time lends itself to more control. Facility managers need to monitor the costs associated with excessive absenteeism. Nursing managers agreed that overtime and contract costs could have been reduced if absenteeism had been better controlled. By reducing the average inpatient absenteeism rate in our sample by 1 percentage point, 23.6 FTE could have been saved.[†] If this reduction were achieved by all VHA facilities, the projected annual cost avoidance would be \$17.8 million in salary replacement costs.

In addition, facility managers were inconsistent in collecting and analyzing data when managing nursing resources, even within the same facility. For example, some nurse managers told us that they based their evaluation of nursing workload on the average number of admitted patients, while others considered unit activities, such as admissions, discharges, and patient procedures. We found similar inconsistencies in how managers calculated turnover rates. According to the Veterans Benefits and Health Care Improvement Act of 2000 (Public Law 106-419), turnover rates should be calculated by dividing the facility's losses by the average number on board. During our review, we identified three different methodologies used for calculating the turnover rate. Managers at one facility acknowledged that they had not calculated turnover rates until requested for our review. These inconsistencies were more prevalent in facilities with decentralized nursing services, such as product or service line organizational structures.

Staffing Data Systems

We found that most facility managers did not fully use, or were not familiar with, existing data systems that could provide better information to make sound nursing resource management decisions. Data sources, such as the nursing computer package and the

[†] Calculations are based on 2349 inpatient FTE representing 54 percent RNs, 19.4 percent LPNs, and 26.6 percent NAs in our sample as of September 30, 2002. We used average annual national salary costs of \$63,500 for RNs, \$36,934 for LPNs, and \$28,915 for NAs.

DSS, were available to support decisions, but few nursing managers fully used these data systems to monitor and manage nursing resources.

Nursing Computer Package

We found that most nursing personnel were classifying patients in the nursing computer package as expected. Although nurse executives told us that they considered patient classification data when making staffing decisions, they said that the comparison reports had limited value because the nursing time allocated for each patient category was not accurate. The package had no provision to make adjustments. Consequently, not all facilities entered the employee hours worked data into the package. The methodology that could have been used to determine staffing adequacy was not considered to be accurate and therefore, was not being fully utilized.

Since the nursing computer package was available to all facilities (although not all facility managers chose to use it), we used this methodology as one measure of compliance with staffing standards. We analyzed 487 tours of duty. We found that facility managers met the staffing standards embedded in the nursing computer package only 49 percent (239/487) of the time.

We concluded that VHA senior managers needed to evaluate and either eliminate or update the patient classification and employee hours worked components of the nursing computer package as part of a more comprehensive national staffing methodology. If VHA chooses to retain these components, DSS should be integrated into the national staffing methodology to enhance clinical and cost analyses. These actions would result in more efficient use of employee time currently expended to maintain a system that is not fully used to manage nurse staffing resources.

DSS Nursing Data Maintenance

We found that facility managers had not consistently maintained essential nursing data within the DSS database. Specifically, they did not maintain the accuracy of data related to workload collection, labor mapping, and RVUs. We reviewed workload reports for the third and fourth quarters of FY 2002. Reports indicated that 37 percent (29/78) of the inpatient wards' nursing workload was incomplete, primarily because nurses did not classify all their patients' acuity levels. In addition, 89 percent (72/81) of nurse managers told us that they were not expected to report changes in the locations and times that nursing employees were available to work in their areas. Failure to collect all data and to accurately map labor could result in either overstatements or understatements of employees available to provide care to the patients. Similarly, nurse managers did not assure the accuracy of RVUs.

Staffing adequacy is reflected in various DSS efficiency reports.[‡] The three factors of the DSS database (workload collection, labor mapping, and RVUs) are interrelated and can be used to calculate employee efficiency or productivity, which is a useful measure

[‡] DCM 0700 Report and Variable Labor Statistics Report.

of staffing adequacy. DSS program officials suggested that wards operate within an efficiency range of 70 to 110 percent. We reviewed DSS efficiency reports from 78 wards and found a range of 29 to 183 percent. Only 46 percent (36/78) of the wards fell within the acceptable efficiency range. The data suggested that 30 percent (23/78) of the wards were understaffed and that 24 percent (19/78) were overstaffed. This indicated that over half of the inpatient wards were inappropriately staffed with nursing personnel and/or that essential DSS database factors were not maintained. Managers consistently told us that they did not have confidence in the integrity of the DSS data. Nursing leaders did not consistently use the DSS cost data to assist with resource management decisions. Only 15 percent (12/81) of the nurse managers we interviewed told us that they were expected to use any aspect of the DSS, and none of them used the DSS to conduct cost benefit analyses regarding ward staffing.

To illustrate, at one facility we found two behavioral health wards with divergent extreme measures of employee efficiency. The locked psychiatric ward was 158 percent efficient, and the unlocked psychiatric ward was 45 percent efficient. The nurses told us that managers floated personnel from the unlocked ward to the locked ward almost every shift and every day, which adversely affected employee job satisfaction on both wards. We encouraged nursing managers to use the DSS reports to support decisions regarding staffing assignments.

We found that confusion surrounding standardization issues contributed to underutilization of the DSS. Among facility managers, we found inconsistent opinions regarding which aspects of the DSS should be standardized. One facility director told us that the DSS had limited value to support local facility decisions because VISN managers had imposed standardized RVUs for facility comparisons. The facility director expressed frustration that national guidance had not been provided so that the DSS would meet national, VISN, and local objectives. At the time of this review, VHA had not yet published a national DSS directive that clearly addresses DSS utilization by VISN and VHA facility managers.

In 2001, the VA Secretary acknowledged that VHA had made a significant investment in both time and resources in the implementation of the DSS.¹⁶ A 1999 OIG audit evaluated whether DSS implementation was sufficiently standardized to ensure the usefulness of data at local, VISN, and VHA levels. The audit found that VHA had invested approximately \$140 million in the DSS implementation costs through 1998 and that additional actions were needed to ensure maximum usefulness of DSS data.¹⁷ In response to the audit, the Under Secretary for Health stated, "The Offices of the Chief Network Officer, the Chief Financial Officer, and the Chief Information Officer have committed to working in close coordination to ensure that DSS achieves its full potential as a critical management tool." However, our findings from this nurse staffing evaluation indicate that the actions were not successful.

VHA program officials told us that estimated annual DSS maintenance costs are \$58.6 million. Since nursing costs are approximately 14.2 percent of the total VHA budget, we estimated that 14.2 percent of the annual DSS maintenance costs could reasonably be

attributed to managing nursing resources. However, VHA program officials told us that half of these costs are dedicated to managerial cost accounting and should not be attributed to nursing services. Therefore, we estimated that VHA expended at least \$4.1 million in annual maintenance costs for a system that managers had not consistently or fully used to manage nursing resources.

Conclusions

System-wide monitoring of nurse staffing adequacy is not possible using the variety of locally developed methodologies and standards currently in place in VHA facilities. VHA needs to provide more effective oversight to ensure efficient management of facility resources. Once a national nurse staffing policy and methodology are developed and implemented, facility managers need to create staffing standards that will ensure the efficient, appropriate use of nurse staffing resources to provide safe patient care and address pertinent nurse staffing considerations.

Existing data systems need to be evaluated, updated, maintained, and used to achieve greater staffing efficiencies. VHA continues to expend significant funds on DSS maintenance, yet has not effectively addressed utilization, accountability, standardization, and data integrity issues.

Recommendation 1:

The Acting Under Secretary for Health, in conjunction with VISN and facility managers, needs to take actions to:

- a. Develop and oversee the implementation of a national nurse staffing policy that applies a single staffing methodology to generate consistent facility staffing standards.
 - 1) Identify specific data elements and systems that will be used.
 - 2) Ensure appropriate data validation and database maintenance.
 - 3) Ensure that data systems, such as the DSS and the nursing package, are complimentary, consistent, and used by nurse managers in making decisions regarding staffing levels and staffing mix.
- b. Design a process to ensure the efficient and appropriate management of nurse staffing resources.

Acting Under Secretary for Health Comments:

The Acting Under Secretary for Health concurred with the findings and recommendation and made plans for improvement, which are acceptable.

Inspector General Comments:

We will follow up on the planned actions until they are completed.

Issue 2: Nurse Staffing and Potential Impact on Quality of Care

We found that only one facility's staffing policy included a comprehensive analysis of the relationships between patient outcomes and nurse staffing issues, such as vacancy and turnover rates. In 2001, the Health Resources Services Administration contracted with the Harvard School of Public Health to study nurse staffing and patient outcomes in hospitals.¹⁸ The study assessed patient outcomes that were potentially sensitive to nurse staffing. Researchers used 1997 discharge data from 799 hospitals in 11 states. Strong and consistent inverse relationships were found between nurse staffing and numerous undesirable patient outcomes, including urinary tract infections, pneumonia, and upper gastrointestinal bleeding. We collected FY 2002 data from all patient discharges at the 10 facilities in our sample using selected patient diagnoses included in the Harvard study. Our analyses did not produce results that were inconsistent with those in the study.

In addition, we interviewed 369 inpatient RNs to obtain perceptions of staffing adequacy and patient outcomes. While we recognize that nurses generally think that more staff is the solution to all problems, we provide these perceptions as one perspective on issues surrounding the nursing shortage. Thirty-eight percent (141/369) of the RNs believed that their wards were inadequately staffed. Seventy-four percent of these nurses (105/141) perceived that patient care was compromised as a result of inadequate staffing. These nurses identified patient falls (67 percent), increased lengths of stay (64 percent), and skin breakdown (60 percent) as factors most commonly associated with inadequate staffing. In addition, over 70 percent of these nurses told us that staff injuries occurred more often because of short staffing. The nurses interviewed were unable to provide us with specific patient incidents that could be directly related to inadequate nurse staffing. We referred general concerns brought to our attention to the facilities' QM program coordinators for follow-up.

In 2002, the JCAHO implemented new staffing effectiveness standards that require facility managers to analyze the relationships between staffing indicators and patient outcomes. Managers are expected to select at least two clinical indicators, such as medication errors, patient complaints, and increased length-of-stay, and two HR indicators, such as staff vacancy rates, overtime use, and sick leave trends.¹⁹ Although the standards were effective July 2002, we found that the 10 VA medical facilities we visited were in varying stages of compliance with the new standards. Several facilities' managers had selected indicators related to nurse staffing, yet only one facility had fully integrated the results of their analysis into their nursing resource planning process.

Conclusions

We found minimal evidence that facility managers had analyzed the impact of nurse staffing issues with diagnoses potentially sensitive to those issues. Facility managers need to systematically review the relationship between nurse staffing issues and patient outcomes. VHA managers need to ensure that all facility managers comply with the JCAHO's staffing effectiveness standards.

Recommendation 2:

The Acting Under Secretary for Health, in conjunction with VHA facility managers, needs to take actions to design a process to systematically measure the impact of nurse staffing issues on patient care outcomes.

Acting Under Secretary for Health Comments:

The Acting Under Secretary for Health concurred with the findings and recommendation and made plans for improvement, which are acceptable.

Inspector General Comments:

We will follow up on the planned actions until they are completed.

Issue 3: Recruitment and Retention

Alternative Career Options and Promotion Opportunities

Nurses today have career alternatives available to them that do not require direct patient care, such as utilization management, information technology, and QM. We found that these alternatives were attractive to nurses because they provided opportunities to seek interesting challenges with more stable schedules and promotion options.

We interviewed 153 RNs who spent three quarters or more of their time performing assignments that did not involve direct patient care. We asked these nurses to identify the most significant factors that influenced their decisions to leave bedside nursing. Seventy-three percent (112/153) told us that they pursued their current positions for increased responsibility and challenge, and 58 percent (88/153) wanted more stable work schedules. Thirty-five percent (53/153) reported that they would not have achieved their current salaries or grades had they remained in direct patient care assignments. VHA program officials acknowledged the widespread perception that bedside nurses were less likely to attain promotions than non-direct care nurses. As a result, VHA officials told us that they were considering developing a career track specifically for direct care nurses.

Turnover

Retention of experienced nurses is extremely important in today's work environment. One measure of retention is the employee turnover rate. VHA reported an average turnover rate of 9.4 percent among all VHA facilities as of June 30, 2002. Based on the information provided to us by facility managers, the average turnover rate for RNs in our sample during FY 2002 was 11.7 percent, with a range from 6 to 26 percent. Five of the 10 facilities exceeded the VHA national average of 9.4 percent. According to the Acute Care Hospital Survey of RN Vacancies and Turnover Rates in 2000, the average RN turnover rate was 21.3 percent.²⁰ Although the VHA turnover rates remain below the reported national average, VHA officials acknowledged that the overall vacancy and turnover trends and continuing staffing difficulties at many locations remain causes for concern.

The financial impact of turnover is significant. An organization incurs costs related to direct and indirect recruiting, reduced productivity, training, and termination. According to a recent report from the Voluntary Hospitals of America,²¹ it costs approximately 100 percent of a nurse's annual salary to fill a vacated nursing position. The following illustrates one method to determine costs associated with turnover. The average annual VHA RN salary was \$63,500. If the five facilities in our sample that exceeded the VHA national average had set a goal to attain an annual turnover rate of 9.4 percent, the estimated annual savings would be over \$2.7 million.

We also looked at the reported turnover rates of ancillary nursing personnel, such as LPNs and NAs. We found that the average rates in our sample were higher than RN rates. The turnover rates for LPNs and NAs were 18 and 14 percent, respectively. Clearly, effective strategic solutions need to involve all categories of nursing personnel.

Retirement-Eligible RNs

At the facilities we visited, 19 to 51 percent of the RNs were eligible for retirement within the next 5 years. Nursing managers at all facilities expressed grave concern regarding the potential mass departure of these experienced nurses. Most of the nursing managers predicted that the current budget allocation methodology and the recruitment and retention initiatives will not be adequate to respond to this impending crisis. In addition, most believed that without dramatic changes, patient care will be compromised, and restricted access to care will be widespread and unavoidable.

Recruitment and Retention Authorities

While VHA had been granted the authority to implement a number of strategies to become more competitive in recruitment and retention, we found that facility managers had not fully implemented many of the strategies. Our findings were consistent with the ONS's FNWPG report. Managers informed us that the reasons for not exercising these

authorities included the inability to obtain local funding, the perceived ineffectiveness of some authorities, and cumbersome processes to obtain required approvals.

During our visits to the medical facilities, we collected information on the use and effectiveness of 23 recruitment and retention authorities, including incentive awards, recruitment bonuses, and retention allowances. We interviewed senior managers and HR specialists to determine whether these authorities were used to recruit and retain qualified nursing employees and to what extent employees benefited from these initiatives. The two authorities managers used frequently were incentive awards and specialty pay for hard to fill positions.

Nursing and HR managers report that many of the existing HR and pay authorities did not offer the flexibility required to respond quickly to facility needs. For example, lengthy hiring procedures hindered their ability to quickly hire new employees, particularly NAs. Managers stated that a significant barrier to the hiring process involved requiring RN candidates to submit original school transcripts before they could be offered permanent positions. Managers reported that they had lost many qualified candidates since most private facilities required only a valid nursing license and had the ability to offer candidates permanent positions within days after receipt of applications for employment.

Some facility managers were not aware that the authority to implement certain strategies had been granted and was available for their use. For example, while it was easier to recruit for Title 38 RNs than for Title 5 NAs, only one facility applied the Title 38 special recruitment authority for hard-to-fill NA positions in lieu of the designated recruitment regulations.[§] Managers at other facilities were not aware of this option. Managers would like direct hire authority for hard-to-fill Title 5 positions.

We also found that certain authorities had not been exercised because of the perceived difficulty in obtaining required approvals. For example, facility managers would benefit by reemploying civilian retirees, such as former VHA nurses; however, only one facility had used this authority. Managers at several facilities had not exercised this option because they erroneously considered it “double-dipping.” Other managers told us that the process of requesting approval to waive the dual compensation restrictions was too cumbersome and time consuming. However, all managers acknowledged the value of this authority since it potentially expands the pool of qualified and experienced nurses, minimizes the costs associated with new employee orientation and training, and may reduce dependency on supplemental staffing, such as overtime or contract labor.

We concurred with the conclusions and recommendations in the ONS’s FNWPG report. However, we found that VHA had not fully implemented its recommendations. In addition, we found that nurses had limited knowledge of the work accomplished and solutions proposed by the FNWPG.

[§] VA has a separate employment system under 38 U.S.C. for appointment of physicians, dentists, podiatrists, optometrists, nurses, nurse anesthetists, physician assistants, and expanded-function dental auxiliaries.

National Education Support Programs

National education support programs sponsored by VHA can serve as powerful recruitment and retention tools. All of the education managers we interviewed told us that employees from their facilities had benefited from these national programs, such as the National Nurse Education Initiative, Education Debt Reduction Program, and VA Learning Opportunities Residency Program. They acknowledged that these programs facilitated nurse retention, and most of them stated that they promoted these opportunities through advertisements and job fairs. While managers and employees were encouraged that VHA had accepted nearly all submitted applications, there were significant concerns regarding the timeliness of educational reimbursements.

All of the nurse executives we interviewed told us that they would like to see the VA Health Professional Scholarship Program reinstated and funded. This program was successful in recruiting some of the highest caliber individuals to the VA system. They told us that it had been legislatively authorized but that current appropriations had not been obligated.

Conclusions

We concluded that VHA managers need to create more incentives for staff nurses to remain in assignments that involve direct patient care. Turnover rates of all nursing personnel need to be monitored consistently and attempts made to reduce them. Aggressive succession planning is needed to address the anticipated losses of retirement-eligible nurses.

VHA managers need to determine which recruitment and retention authorities are the most effective to meet the increasing demands for nursing personnel and then secure sufficient funding to ensure success. Facility managers and employees need appropriate education about the available initiatives to maximize exposure to existing opportunities. HR guidelines and practices need to be flexible and meet the needs of facility managers in a competitive marketplace. VHA needs to streamline cumbersome administrative procedures and ensure more aggressive contingency planning. The system would benefit if all recommendations submitted by the FNWPG were implemented. National education programs have been beneficial in recruitment and retention and should be funded and supported.

Recommendation 3:

- a. The Acting Under Secretary for Health, in conjunction with the Acting Assistant Secretary for Human Resources and Administration, needs to take actions to develop and implement a process to ensure that direct patient care assignments offer opportunities similar to non-patient care assignments.
- b. The Acting Under Secretary for Health, in conjunction with VHA facility managers, needs to take actions to:

- i. Implement a process to ensure aggressive succession and contingency planning.
- ii. Evaluate the effectiveness of recruitment and retention practices.

Acting Under Secretary for Health Comments:

The Acting Under Secretary for Health concurred with the findings and recommendation and made plans for improvement, which are acceptable.

Acting Assistant Secretary for Human Resources and Administration Comments:

The Acting Assistant Secretary for Human Resources and Administration concurred with the findings and recommendation (a) and proposed that the Acting Under Secretary for Health assume the lead in addressing this issue.

Inspector General Comments:

We will follow up on the planned actions until they are completed.

Issue 4: Impact of Management Practices on RN Job Satisfaction

Mandatory Overtime

We found that nurse managers relied heavily on employee overtime to compensate for inadequate staffing. We found that time and attendance records did not distinguish between regular and mandatory overtime, and none of the facilities we visited tracked mandatory overtime separately from regular overtime. Nearly all of the nurse managers we interviewed (79/81) told us that they routinely authorized overtime when staffing was not adequate but that mandatory overtime was employed only when all other staffing options had been exhausted. However, 33 percent (122/368) of the staff RNs we interviewed told us that they were required, or mandated, to work overtime during the past year. They expressed concerns about the frequency of overtime hours because factors, such as fatigue and low morale, affect the quality of care provided to patients. The American Nurses Association reported similar findings regarding the effects of working overtime on patient and employee safety.²²

Staff nurses were emphatic that mandatory overtime was not an acceptable staffing alternative. Nurses did not have a clear understanding of their rights and responsibilities related to mandatory overtime. For example, some nurses stated that although they were not *required* to work overtime, their supervisors pressured them until they agreed. Others feared that they would be counseled or disciplined for abandoning their patients or believed that it was their professional responsibility to remain on duty. RNs need to have a clear understanding of the definition and implications of mandatory overtime.

Mandatory overtime continues to be a concern of nursing unions, professional associations, and Congress. Public Law 107-135 required the VA Secretary to submit a report on mandatory overtime worked by licensed nurses and NAs providing direct care at all VHA medical facilities. VHA managers acknowledged that VA does not maintain an automated database that distinguishes between mandatory and discretionary overtime. Therefore, VHA managers reported total overtime hours per employee. For 2001, full and part-time licensed nurses and nursing assistants worked an average of 43 hours of overtime per employee. Full-time registered nurses worked an average of 37.7 hours of overtime in 2001, which equates to an average of less than 1 hour per week per RN.²³ Even though this number is small, VHA managers need to monitor overtime use and develop clear reporting criteria on mandatory overtime.

Unstable Work Assignments

Inpatient nurses are generally assigned and oriented to primary work locations and tours of duty where they achieve familiarity with the patient population, ward routines, and team dynamics. Eight of the 10 facilities we visited floated RNs between patient care units as a means to temporarily compensate for inadequate staffing. Sixty-four percent (286/449) of the staff nurses and nurse managers we interviewed told us that nurses were routinely floated from wards with adequate staffing to areas that lacked sufficient nursing personnel. Historically, nursing managers have relied upon floating nurses between wards and changing tours of duty to meet staffing standards.

Nurses told us that they were concerned about patient safety when they floated to unfamiliar areas. Nurses also told us that they expected nursing managers to implement more permanent staffing adjustments to reduce the frequency of floating. Recent literature identifies concerns associated with floating and tour of duty changes, such as the negative affect on staff satisfaction, absenteeism, and patient safety.^{24,25,26} Research has also shown that more stable work schedules reduce work stress, lower turnover, and improve group cohesion.²⁷

Some of the nurses expressed interest in alternative scheduling practices, such as the Baylor plan.^{**} Use of this provision may enable facilities to staff undesirable weekend tours. Facility directors may request authorization to use the Baylor Plan, if justified, for recruitment and retention purposes.²⁸ We found that not all facility managers knew that this plan was an available option.

Employee Perceptions of Management Support

We found that the perceived level of management support significantly impacted RNs' job satisfaction. The majority of the RNs we interviewed told us that caring for patients was the most rewarding aspect of their roles. However, 20 percent (74/369) of the RNs we interviewed told us that they were considering leaving their facilities, and 93 percent of these (69/74) identified reasons other than retirement. The most frequent reason

^{**} Nurses on the Baylor Plan receive full-time (40 hours) pay for working two regularly scheduled 12-hour tours of duty within the period commencing at midnight Friday and ending at midnight Sunday.

identified was lack of management support. Staff nurses most frequently perceived a lack of management support when managers did not involve them in staffing decisions.

In 2000, the Nursing Executive Center reported that 35 percent of the RNs surveyed stated that they were dissatisfied with their levels of participation in general decision-making.²⁹ We asked staff nurses if they were involved in decisions related to nurse staffing. Almost one quarter (89/369) of the nurses we interviewed reported that they did not have input into staffing decisions. Some of the nurses told us that managers did not respect or value their opinions. Thirty-eight percent (141/369) of the staff nurses told us that their wards did not have adequate staffing, and of those, approximately 30 percent (42/141) reported that facility managers did not agree with their assessments of staffing requirements.

Availability of Support Personnel

Staff nurses consistently expressed concerns regarding the decreasing availability of non-nursing employees, such as clerks, housekeepers, and patient transporters, who are necessary to support patient care activities. Some facilities had difficulty recruiting and retaining ancillary nursing employees who provide direct patient care, such as LPNs and NAs.

In 2001, Aiken, et al.,³⁰ reported that 34 to 69 percent of U.S. nurses surveyed performed non-nursing functions that did not require an RN's professional expertise, such as delivering and retrieving food trays, housekeeping duties, and transporting patients. In our sample, 78 percent (376/479) of the RNs told us that they performed such non-nursing duties because of insufficient support personnel. We found large variations in the extent that ancillary nursing support personnel, such as LPNs and NAs, were available to assist the RNs. In facilities with high NA vacancies, the RNs performed NA duties, such as taking vital signs, delivering specimens, and transporting patients. These duties are typically performed by less skilled workers at lower rates of pay. This issue adversely affected RN job satisfaction.

The number of ancillary nursing support personnel varied by facility and reflected the climate of the local job market. It appears that there was a wider than necessary mix in labor categories and that no cost or outcomes analyses were used to determine the optimum mix. Managers at one facility with a low percentage of NAs told us that they were not successful in recruiting NAs because the local nursing homes paid more than the VA could offer. The table below shows the three labor categories and the percent of total authorized nursing positions as of September 30, 2002, for each facility we visited. The percent of RNs ranged from 28 to 73 percent.^{††} The average for all 10 facilities was 55 percent RNs, 20 percent LPNs, and 25 percent NAs.

^{††} The facility with the 28 percent RN ratio did not have acute medical or surgical inpatient wards.

Distribution of Nursing Personnel

Facility	RNs (percent)	LPNs (percent)	NAs (percent)
1	73	24	3
2	72	11	17
3	72	26	2
4	66	19	15
5	59	16	25
6	51	16	33
7	47	20	33
8	44	23	33
9	42	18	40
10	28	29	43

Nursing managers shared with us their frustrations regarding the difficulty recruiting and retaining LPNs. For example, a new graduate LPN was typically hired at the GS-3 grade level. Until recently, the highest grade an LPN could achieve was GS-6. Considering that many of the NAs employed at these facilities worked at the GS-5 salary level, the perceived pay disparity between these two labor categories discouraged recruitment and retention of LPNs. Currently, experienced LPNs are eligible for GS-7 positions; however, facility managers told us that the majority of LPNs would not qualify and that this initiative will apply only to those in specialized positions, such as procedure areas with less supervision than wards.

Conclusions

Excessive use of overtime and all mandatory overtime cause nurse job dissatisfaction. Overtime use needs to be monitored in accordance with PL 107-135. VHA managers need to study the use of overtime, floating, and tour of duty changes to evaluate the impact on nurse job satisfaction, recruitment, and retention. VHA officials told us that they have requested modifications to the VHA pay system that would allow automated tracking of work schedules to include mandatory overtime and floating. The OIG agrees with this enhancement. However, until these modifications are developed and implemented, facility managers need to monitor the impact of these variables at the local level. Facility managers could use these data to assist with staffing decisions and to implement more permanent staffing adjustments (see Issue 1).

VHA and facility managers need to monitor and address employee perceptions that influence job satisfaction and retention. Staff nurses would like to see evidence that managers support them and involve them in staffing decisions. The impact of ancillary staff availability and staffing mix on nurses' job satisfaction also needs to be monitored. VHA managers need to continue to address LPN compensation issues.

Recommendation 4:

- a. The Acting Under Secretary for Health, in conjunction with VHA facility managers, needs to take actions to:
 - i. Monitor overtime use in accordance with PL 107-135. VHA will need to rely on data collected at the facility level until enhancements to the pay system are accomplished.
 - ii. Conduct a study to assess the impact of overtime, floating, and tour of duty changes on nurse job satisfaction, recruitment, and retention. In the course of study, determine whether safe limits on the use of these measures should be set and monitored.
 - iii. Involve staff nurses in staffing decisions.

- b. The Acting Under Secretary for Health, in conjunction with the Acting Assistant Secretary for Human Resources and Administration, needs to pursue opportunities to compensate LPNs according to local market standards.

Acting Under Secretary for Health Comments:

The Acting Under Secretary for Health concurred with the findings and recommendation and made plans for improvement, which are acceptable.

Acting Assistant Secretary for Human Resources and Administration Comments:

The Acting Assistant Secretary for Human Resources and Administration concurred with the findings and recommendation (b) and stated that the Department of Veterans Affairs has considerable discretionary authority to provide additional compensation to licensed practical nurses.

Inspector General Comments:

We will follow up on the planned actions until they are completed.

ENDNOTES

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- ² Peter I. Buerhaus, Douglas O. Staiger, and David I. Auerbach, "Implications of an Aging Registered Nurse Workforce," *JAMA*, 2000; 283 (June 14, 2000): 2948-2954.
- ³ JCAHO, August 7, 2002.
- ⁴ United States General Accounting Office, "Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors," report no. GAO-01-944 (July 10, 2001).
- ⁵ VA Office of Inspector General, "Audit of Nurse Staffing at VA Medical Centers," report no. 9AB-A99-082, June 19, 1989.
- ⁶ Mark Reagan, statement before the U.S. Senate Committee on Veterans Affairs regarding the nursing shortage and the potential effect on VA health care, Washington D.C., June 2001.
- ⁷ Health Resources and Services Administration, "HHS Study Finds Strong Link Between Patient Outcomes and Nurse Staffing in Hospitals," *HRSA Online* [website]; available at: <http://newsroom.hrsa.gov/releases/2001%20Releases/nursestudy.htm>; April 20, 2001.
- ⁸ Jack Needleman, et al., "Nurse Staffing Levels and the Quality of Care in Hospitals," *The New England Journal of Medicine*, vol. 346, no. 22 (May 30, 2002): 1715-1722.
- ⁹ Linda H. Aiken, et al., "Nurses' Reports on Hospital Care in Five Countries," *Health Affairs*, (May/June 2001): 43-53.
- ¹⁰ Department of Veterans Affairs, Veterans Health Administration, "A Call to Action: VA's Response to the National Nursing Shortage," (November 2001): 1-2.
- ¹¹ Department of Veterans Affairs, Veterans Health Administration, "Final Report: Hiring Timeline Ad Hoc Group," February 2, 2001.
- ¹² House Committee on Veterans' Affairs, *Testimony of Howard H. Green, M.D., Concerning the Veterans Health Administration Decision Support System (DSS), to the Subcommittee on Oversight and Investigations*, Washington, D.C., September 21, 2000.
- ¹³ Institute of Medicine, *Statement of the American Nurses Association for the Institute of Medicine's Committee on Work Environment for Nurses and Patient Safety*, Washington, D.C., September 24, 2002.
- ¹⁴ Jackson, P. (2003, July 11). Per Diem Work Benefits Weary Nurses, Hospitals Short on Staff. *Times Leader.com*.
- ¹⁵ International Council of Nurses, "Nurses and Shift Work," (Position Statements 2000), *ICN Online* [website]; available at: <http://www.icn.ch/psshiftwork00.htm>.
- ¹⁶ U.S. House of Representatives, *Testimony of Anthony J. Principi, Secretary Department of Veterans Affairs, Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs*, Washington, D.C., April 4, 2001.
- ¹⁷ Office of Inspector General, "Audit of Veterans Health Administration Decision Support System Standardization," report no. 9R4-A19-075, March 31, 1999.
- ¹⁸ Jack Needleman, et al., "Nurse Staffing and Patient Outcomes in Hospitals," Final Report for Health Resources Administration, Contract #230-99-0021, February 28, 2001.
- ¹⁹ JCAHO, Standard HR.1.30.
- ²⁰ The HSM Group, Ltd., "Acute Care Hospital Survey of RN Vacancy and Turnover Rates in 2000," (February 2002): 7.
- ²¹ Keith C. Kosel and Tom Olivo, "The Business Case for Work Force Stability," Voluntary Hospitals of America, April 2002.
- ²² U.S. Senate Committee on Veterans' Affairs, *Statement of the American Nurses Association Before Senate Committee on Veteran's Affairs on Looming Nurse Shortage: Impact on the Department of Veteran's Affairs*, Washington, D.C., June 14, 2001.
- ²³ Report to Congress, "Report on Mandatory Overtime for Nurses and Nursing Assistants in Department of Veterans Affairs Facilities," September 2002.
- ²⁴ Institute of Medicine, *Statement of the American Nurses Association for the Institute of Medicine's Committee on Work Environment for Nurses and Patient Safety*, Washington, D.C., September 24, 2002.

²⁵ Jackson, P. (2003, July 11). Per Diem Work Benefits Weary Nurses, Hospitals Short on Staff. *Times Leader.com*.

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²⁹ The Nursing Executive Center, *The Nurse Perspective: Drivers of Nurse Job Satisfaction and Turnover*, (Washington, D.C.: The Advisory Board Company, 2000).

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Acting Under Secretary for Health Comments

**Department of
Veterans Affairs****Memorandum**

Date: July 15, 2004

From: Acting Under Secretary for Health (10/10B5)

Subj.: OIG Draft Report, *Healthcare Inspection, Evaluation of Nurse Staffing in Veterans Health Administration Facilities*, Project Number 2003-00079-HI-0007 (EDMS Folder 266964)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the draft report. The appropriate program offices have reviewed it and we provide the following comments and clarifications to the report's findings. We appreciate the collaboration your staff provided VHA in addressing the issues in this report, which resulted in revisions to the original draft received on April 5, 2004. We are pleased your report notes that despite nursing shortages, VHA generally met patient care demands at the sites reviewed. We concur with the recommendations, since we believe that actions have already been taken or are planned to implement them. We concur with the estimate for monetary benefits as well. The attached action plan details the steps we are taking to address the recommendations and enhance an overall well functioning program.

2. VHA shares your concern about the consistency and predictability of the deployment and allocation of nursing resources. A draft policy requiring the medical centers to develop and implement formal plans linking staffing levels and staff mix with patient outcomes and other performance measures is currently in concurrence. Publication of the policy is expected in July 2004. An Office of Nursing Service (ONS) workgroup is also establishing guidance and defining the essential information for VHA-wide nursing administration information management that will ensure that data used in nursing administrative decision-making is consistent.

3. VHA is also developing reliable data collection methods for quality indicators that impact patient outcomes through the VA Nursing Outcomes Database (VANOD) project. To date, seven indicators have been developed as nursing sensitive quality indicators and other indicators will be added as the project expands.

2. Assistant Inspector General for Healthcare Inspections (54)

4. For the past four years, VA has had succession and contingency plans in place to ensure the use of effective recruitment, retention, and deployment strategies by facility managers. The plans cover aggressive recruitment, leadership development, employee morale, and satisfaction issues, as well as numerous legislative and policy initiatives. Plans are in place at each network, and are a major component of each network director's annual performance contract.

5. Finally, we are concerned that the report uses perception data from nursing staff as the basis for recommending that VHA monitor the impact of overtime, duty changes, and floating changes on staff recruitment and retention, and that VHA assess the need for establishing safe limits on these measures. We plan to conduct studies to more objectively evaluate these issues. Once completed, an executive review of the studies' findings will be used to develop reasonable strategies and timelines to address the issues as appropriate.

6. Thank you again for the opportunity to review the draft report. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at (202) 273-8360.

(Original signed by:)

Jonathan B. Perlin, MD, PhD, MSHA, FACP
(Signed July 15, 2004)

Attachments

Acting Under Secretary for Health Comments

Action Plan for draft OIG report, “Evaluation of Nurse Staffing in Veterans Health Administration Facilities”, Project No. 2003-00079-HI-0007.

Recommendation 1: The Acting Under Secretary for Health, in conjunction with VISN and facility managers, needs to take actions to: a) Develop and oversee the implementation of a national nurse staffing policy that applies a single staffing methodology to generate consistent facility staffing standards. Policy should: 1) Identify specific data elements that will be used, 2) Ensure appropriate data validation and database maintenance, and 3) Ensure that the data systems, such as DSS and the nursing package, are complimentary, consistent, and used by nurse managers in making decisions regarding staffing levels and staff mix. b) Design a process to ensure the efficient and appropriate management of nurse staffing resources. Concur.		Recommendation Metrics					
GOAL	STRATEGY	MEASURE	TARGET	STATUS	ACTUAL	BENCH-MARK	PRIOR FY
Ensure efficient use of nursing resources at the facility level through the implementation, monitoring and use of a standardized National staffing policy, and standardized methodologies and databases.	VHA currently has a draft directive in concurrence that requires the medical centers to develop and implement formal plans linking staffing levels and staff mix with patient outcomes and other performance measures. This directive covers all services, including the Office of Nursing Services and once fully implemented, will address the elements of this recommendation. The directive is expected to be published in July 2004.	Measures are expected to be developed by the end of FY 2009.			The Office of Nursing Services is in the process of identifying members of its internal workgroup that will be responsible for overseeing the roll-out of the requirements of this directive for nursing. They expect to have the charter for this workgroup prepared by August 2004 and to have it begin its work in Q1 FY 2005.		

Action Plan for draft OIG report, “Evaluation of Nurse Staffing in Veterans Health Administration Facilities”, Project No. 2003-00079-HI-0007.

Recommendation 2: The Acting Under Secretary for Health, in conjunction with VISN and facility managers, needs to take actions to: a) Design a process to systematically measure the impact of nurse staffing issues on patient care outcomes. Concur.		Recommendation Metrics					
GOAL	STRATEGY	MEASURE	TARGET	STATUS	ACTUAL	BENCH-MARK	PRIOR FY
Ensure an on-going process is in place at all facilities to review the relationship between nurse staffing issues and patient outcomes.	<p>Actions are already in place to address this recommendation as follows:</p> <p>1. In 2002, the Under Secretary for Health approved funding for the VA Nursing Outcomes Database (VANOD) project. Its purpose is to collect data related to nurse-sensitive indicators of quality within VHA facilities that would be integrated into a national database. The project includes a pilot project at 12 acute care VA facilities that began in March 2003 and is scheduled to end September 30, 2004. Its purpose is to establish reliable data collection methods for obtaining quality indicators that impact patient outcomes.</p> <p>2. Once the pilot is completed, the plan is to expand indicator</p>	<p>1 & 2. To date the following seven indicators have been developed as nursing sensitive quality indicators: nursing hours per patient day; skill mix; patient falls; pressure ulcer prevalence; patient satisfaction; RN satisfaction; nursing staff muscular-skeletal patient handling injuries. Other indicators will be added as the project expands to other care settings. Monitors will be developed and implemented after findings of the pilot are reviewed.</p>			<p>1. The VANOD working group has weekly to monthly meetings, and minutes and reports of this workgroup are available at the Intranet site: http://vaww.collage.research.med.va.gov/collage/VANOD</p> <p>The pilot project will be completed in September 2004 and final results of the pilot will be reviewed in the first quarter of FY 2005. Data collection is currently underway at the 12 pilot sites.</p> <p>2. Data collection is on going at the 12 pilot sites. Preliminary findings note there are wide variations throughout VA in how nursing staffing hours are collected. The pilot project is addressing this variation by clearly defining the databases from which information for the indicators will be extracted.</p>		

Action Plan for draft OIG report, "Evaluation of Nurse Staffing in Veterans Health Administration Facilities", Project No. 2003-00079-HI-0007.

Recommendation 2: The Acting Under Secretary for Health, in conjunction with VISN and facility managers, needs to take actions to: a) Design a process to systematically measure the impact of nurse staffing issues on patient care outcomes. Concur.		Recommendation Metrics					
GOAL	STRATEGY	MEASURE	TARGET	STATUS	ACTUAL	BENCH-MARK	PRIOR FY
2a) cont.	<p>development to geriatrics and extended care, mental health and ambulatory care over the next 3 to 5 years. In addition, the goal is to have a system rollout of the data collection processes and indicators to all acute care sites by the end of FY 2009. Additional clinical and administrative indicators will be developed as indicated. The long-term aim is to make VANOD data utilization a part of routine nursing practice and to standardize the process for data collection and extraction. The VHACO Office of Nursing Service will conduct on-going monitoring and review of the data collection and indicator findings.</p> <p>The progress of this group is routinely discussed in quarterly National Nursing Executive Council (NNEC) Conference calls, monthly at each of the 12 pilot sites and in monthly conference calls for the various project workgroups. In addition, the project was discussed at the national VA Nursing Leaders Conference held April 15 to 16, 2004 that targeted nurse executive, associate directors, and other nursing leaders.</p>				In the 3 rd and 4th quarters of FY 2004, preliminary discussion will be held between the VHACO Office of Nursing Service (ONS), the Field and appropriate headquarters offices, such as geriatrics and extended care, mental health, primary care service, and to identify and define additional indicators.		

Action Plan for draft OIG report, "Evaluation of Nurse Staffing in Veterans Health Administration Facilities", Project No. 2003-00079-HI-0007.

Recommendation 3: The Acting Under Secretary for Health, in conjunction with the Acting Assistant Secretary for Human Resources and Administration, needs to take actions to: a) Develop and implement a process to ensure that direct patient care assignments offer opportunities similar to non-patient care assignments. The Acting Under Secretary for Health, in conjunction with VHA facility managers, needs to take actions to: b. i) Implement a process to ensure aggressive succession and contingency planning, and b. ii) Evaluate the effectiveness of recruitment and retention practices. Concur.	Recommendation Metrics
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GOAL	STRATEGY	MEASURE	TARGET	STATUS	ACTUAL	BENCH-MARK	PRIOR FY
3a) Ensure that direct patient care assignments offer opportunities similar to non-patient care assignments.	The Office of Nursing Services has established a work group to make recommendations related to this issue by the end of FY 2005.	Development of measures to begin once the final report of the workgroup is analyzed and completed, projected to be by the end of 2005.		Pending	Pending		
3b. i) Ensure an aggressive succession and contingency planning process is implemented for nursing services.	Succession and contingency plans have been developed, are in place, and have been monitored for the past four years. The plans cover aggressive recruitment, leadership development, employee morale and satisfaction issues, as well as numerous legislative and policy initiatives. Each VISN, using workforce assessment tools, develops annual strategic workforce plans. These plans are a major component of each VISN Director's performance contract. The VHA Succession Planning website provides documentation of these activities: http://vaww.va.gov/succession/ .	A variety of measures on our succession and contingency plans are in place and have been monitored for the past four years. A copy of the VHA Succession plan for FY 2003-2007 is being sent to you under separate cover for review.	See the succession planning website	See the succession planning website	On-going		
3b. ii) Ensure effective nursing recruitment and retention practices are in place.	VHA monitors the use of recruitment, relocation and bonus awards, as well as funds expended under the employee incentive scholarship and debt reduction programs.						

Action Plan for draft OIG report, "Evaluation of Nurse Staffing in Veterans Health Administration Facilities", Project No. 2003-00079-HI-0007.

Recommendation 3: The Acting Under Secretary for Health, in conjunction with the Acting Assistant Secretary for Human Resources and Administration, needs to take actions to: a) Develop and implement a process to ensure that direct patient care assignments offer opportunities similar to non-patient care assignments. The Acting Under Secretary for Health, in conjunction with VHA facility	Recommendation Metrics
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managers, needs to take actions to:
b. i) Implement a process to ensure aggressive succession and contingency planning. b. ii) Evaluate the effectiveness of recruitment and retention practices. Concur.

GOAL	STRATEGY	MEASURE	TARGET	STATUS	ACTUAL	BENCH-MARK	PRIOR FY
3bii) cont.	<p>The numbers of waiver pay reductions for the re-employment of annuitants and of education for advancement purposes are also monitored. Some of the procedures related to employment, including obtaining direct hire authority are cumbersome. The Office of Personnel Management mandates such procedures and VA is legally obligated to comply with them. Currently, VHA's Health Care Staff Development and Retention office is developing a nurse-specific recruitment campaign through a national advertising contract. The plan's objectives focus on identifying the market conditions that impact on nursing shortages, defining key issues related to nurse recruitment in VA, describing the critical elements of a coordinated nurse recruitment campaign, and identifying implementation strategies for the recruitment campaign. All focus groups and related analyses are completed and the contractor has made a preliminary presentation to VA officials. A final report is due in the fourth quarter of FY 2004.</p>	<p>Measures of the effectiveness of the VHA nurse specific recruitment campaign will be developed once the final report is issued. The final report is due the end of FY 2004. Development of measures is expected by the end of the first quarter, FY 2005.</p>			<p>VA monitors and annually provides reports to Congress on recruitment, retention, and relocation bonuses, the incentive scholarship and debt reduction programs, as well as other authorities concerning experienced nurses. As a condition of their delegation, the Office of Personnel Management (OPM) requires VA Central Office approval of waivers of reductions in pay for reemployed annuitants. In addition, VA must maintain and make available to OPM a record of each request and approval for a 2-year period.</p> <p>Action pending final report</p> <p>Action pending final report</p>		

Action Plan for draft OIG report, "Evaluation of Nurse Staffing in Veterans Health Administration Facilities", Project No. 2003-00079-HI-0007.

<p>Recommendation 3: The Acting Under Secretary for Health, in conjunction with the Acting Assistant Secretary for Human Resources and Administration, needs to take actions to: a) Develop and implement a process to ensure that direct patient care assignments offer opportunities similar to non-patient care assignments. The Acting Under Secretary for Health, in conjunction with VHA facility managers, needs to take actions to:</p>	<p>Recommendation Metrics</p>
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b i) Implement a process to ensure aggressive succession and contingency planning. b. ii) Evaluate the effectiveness of recruitment and retention practices. Concur.							
GOAL	STRATEGY	MEASURE	TARGET	STATUS	ACTUAL	BENCH-MARK	PRIOR FY
3b.ii) cont.	To assist with recruitment and retention, \$10 million annually is appropriated for the Employee Incentive Scholarship and Employee Debt Reduction programs. VHA has also committed \$10 million annually for a period of five years for the National Nurse Education Initiative. This program is scheduled to end next year, is an award scholarship program designed for VHA registered nurses interested in furthering their education. Finally, VHA has authorized \$16.9 million annually under the VA Nursing Education Employment Program, a program that will provide salary replacement or money to temporarily replace nurses attending school.						

Action Plan for draft OIG report, “Evaluation of Nurse Staffing in Veterans Health Administration Facilities”, Project No. 2003-00079-HI-0007.

<p>Recommendation 4: a. The Acting Under Secretary for Health, in conjunction with VHA facility managers, needs to take actions to: i) Monitor overtime use in accordance with PL 107-135. VHA will need to rely on data collected at the facility level until enhancements to the pay system are accomplished, ii.) Conduct a study to assess the impact of overtime, floating, and tour of duty changes on nurse job satisfaction, recruitment, and retention. In the course of study, determine whether safe limits on the use of these measures should be set and</p>	<p>Recommendation Metrics</p>
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monitored, iii) Involve staff nurses in staffing decisions, and b. The Acting Under Secretary for Health, in conjunction with the Acting Assistant Secretary for Human Resources and Administration, needs to pursue opportunities to compensate LPNs according to local market standards. Concur.							
GOAL	STRATEGY	MEASURE	TARGET	STATUS	ACTUAL	BENCH-MARK	PRIOR FY
4i. Ensure monitoring of overtime use takes place at the facility level.	VHA will conduct its own study of this issue and develop strategies to address the identified issues appropriately. We wish to note that VA provided Congress a report on mandatory overtime in July 2000. The report indicated that on average full-time registered nurses performed 37.7 hours of overtime per year (18.32 hours if compensatory time off is subtracted). In addition, VHA queried the VA National Center for Patient Safety information systems for adverse events and close calls directly affected by nursing staff overtime (i.e. nursing staff overtime was considered to be a root/contributing cause of the adverse event or close call). Of over 2,000 root cause analyses of adverse events or close calls contained in the database for the period covering November 1999 through June 2002, less than one	Deferred until VHA completes its study on overtime use.			July 2005		

Action Plan for draft OIG report, “Evaluation of Nurse Staffing in Veterans Health Administration Facilities”, Project No. 2003-00079-HI-0007.

<p>Recommendation 4: a. The Acting Under Secretary for Health, in conjunction with VHA facility managers, needs to take actions to: i) Monitor overtime use in accordance with PL 107-135. VHA will need to rely on data collected at the facility level until enhancements to the pay system are accomplished, ii.) Conduct a study to assess the impact of overtime, floating, and tour of duty changes on nurse job satisfaction, recruitment, and retention. In the course of study, determine whether safe limits on the use of these measures should be set and monitored, iii) Involve staff nurses in staffing decisions, and b. The Acting Under Secretary for Health, in conjunction with the Acting Assistant Secretary for Human Resources and</p>	<p>Recommendation Metrics</p>
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Administration, needs to pursue opportunities to compensate LPNs according to local market standards. Concur.							
GOAL	STRATEGY	MEASURE	TARGET	STATUS	ACTUAL	BENCH-MARK	PRIOR FY
4 i. (cont)	percent indicated nursing staff overtime was involved in the adverse event or close call. In no case was nursing staff overtime identified as the primary cause of an adverse event. In addition, VHA has asked the Office of Budget and Finance to modify the Personnel And Accounting Integrated Data (PAID), On Line Data Entry (OLDE), and the Enhanced Time and Attendance (ETA) system to permit tracking of mandatory overtime. These changes have been delayed and are being considered as part of VA's migration to the Defense Finance and Accounting Service. Once in place, we will be able to assess the ability of these modification to monitor the use of both mandated and voluntary overtime against information in the VA Nursing Outcomes database.						

Action Plan for draft OIG report, "Evaluation of Nurse Staffing in Veterans Health Administration Facilities", Project No. 2003-00079-HI-00007.

Recommendation 4: a. The Acting Under Secretary for Health, in conjunction with VHA facility managers, needs to take actions to: i) Monitor overtime use in accordance with PL 107-135. VHA will need to rely on data collected at the facility level until enhancements to the pay system are accomplished, ii.) Conduct a study to assess the impact of overtime, floating, and tour of duty changes on nurse job satisfaction, recruitment, and retention. In the course of study, determine whether safe limits on the use of these measures should be set and monitored, iii) Involve staff nurses in staffing decisions, and b. The Acting Under Secretary for Health, in conjunction with the Acting Assistant Secretary for Human Resources and Administration, needs to pursue opportunities to compensate LPNs according to local market standards. Concur.

Recommendation Metrics

GOAL	STRATEGY	MEASURE	TARGET	STATUS	ACTUAL	BENCH-MARK	PRIOR FY
ii. Ensure overtime, floating and tours of duty are monitored at the facility level in order to evaluate their impact on nurse retention, job satisfaction, and recruitment	Literature and the nursing industry lack information regarding the correlation of these issues. VHA will conduct its own study of the issue in the coming year to assess the issues and address the findings of that study. There is currently no electronic interface with the time and attendance system that allows VHA to monitor floating and tour of duty changes at the facility level. It is unclear if the Department is going to continue with the use of the Electronic Time and Attendance system as it phases VA into the Department of Defense's Financial Accounting System (DFAS). Once the Department clarifies this issue with the Department of Defense, we will be able to consider its utility in addressing whatever findings result from VHA's study of the correlation between floating, tours of duty and nurse retention and recruitment.	Deferred until VHA completes its study on overtime use.			July 2005		

Action Plan for draft OIG report, “Evaluation of Nurse Staffing in Veterans Health Administration Facilities”, Project No. 2003-00079-HI-0007.

Recommendation 4: a. The Acting Under Secretary for Health, in conjunction with VHA facility managers, needs to take actions to: i) Monitor overtime use in accordance with PL 107-135. VHA will need to rely on data collected at the facility level until enhancements to the pay system are accomplished, ii.) Conduct a study to assess the impact of overtime, floating, and tour of duty changes on nurse job satisfaction, recruitment, and retention. In the course of study, determine whether safe limits on the use of these measures should be set and monitored, iii) Involve staff nurses in staffing decisions, and b. The Acting Under Secretary for Health, in conjunction with the Acting Assistant Secretary for Human Resources and Administration, needs to pursue opportunities to compensate LPNs according to local market standards. Concur.

Recommendation Metrics

GOAL	STRATEGY	MEASURE	TARGET	STATUS	ACTUAL	BENCH-MARK	PRIOR FY
iii. Ensure staff nurses are involved in decision-making.	VHA has a draft directive in final concurrence that was developed in response to Section 124 of Public Law 107-135. This directive, when approved, provides that employees at the point of care are responsible for providing input into staffing decisions.	Monitors of compliance with this directive will be established once the directive is published.			The directive is expected to be published in July 2004. Monitor development to begin in first quarter of FY 2005, and piloting of monitors to begin in second quarter of FY 2005.		
b. Compensate licensed practical nurses (LPNs) according to local market standards.	The Office of Human Resources and Administration is reviewing whether there is sufficient justification to propose legislation that would remove the legal limitations on special salary rate ranges for LPNs and other health care providers.				This issue is under review by the Office of Human Resources and Administration. VHA will provide appropriate follow-up upon receiving the decision of the Department on this issue.		

**Acting Assistant Secretary for Human Resources and Administration
Comments**

**Department of
Veterans Affairs**

Memorandum

Date: July 20, 2004

From: Acting Assistant Secretary for Human Resources and Administration (006)

Subj.: Evaluation of Nurse Staffing in Veterans Health Administration Facilities

To: Office of the Inspector General

1. The Office of Human Resources and Administration (HR&A) has reviewed the Healthcare Inspection Report on the Evaluation of Nurse Staffing in Veterans Health Administration Facilities and offers the following comments. Regarding Recommendation 3: Recruitment and Retention: Alternative Career Options and Promotion Opportunities:

- o RNs are attracted to non-direct patient care positions such as utilization management, information technology, and quality management because these types of positions offer
 - more stable work schedules
 - more promotion opportunities
 - increased responsibilities and challenges
- o There is a widely held perception that in the Federal system in order to be promoted and earn a higher salary, employees must leave the practice of their technical field and enter supervisory, management, or other positions that do not involve the direct application of their technical knowledge and skills. This perception is to a great degree true as the federal system awards higher grades and salaries to positions that require the knowledge and skills of the technical field AND additional knowledge and skills such as supervisory or managerial, IT, quality management, education, or other oversight abilities. The possession and application of two distinct sets of knowledge and skills is consistently rewarded at higher levels than the practitioner applying the skills of the occupation.
- o The establishment of a direct-patient care senior clinician at a grade level above the full performance level has been raised in other healthcare occupations and administrative occupations. Since there is significant interest and background

material available for the nursing profession, this profession can serve as a useful pilot in determining the feasibility and process for establishing a direct-patient care senior clinician.

- o It is recommended that the Under Secretary for Health assume the lead for this action in partnership with the Assistant Secretary for Human Resources & Administration.

2. Regarding Pay Flexibilities for recruitment and retention, the Department of Veterans Affairs has considerable discretionary authority to provide additional compensation to enhance the recruitment and retention of Licensed Practical Nurses (LPNs).

- o Under 38 U.S.C. 7455, VA has the authority to establish or adjust special salary rates for positions performing direct patient care services or services incident to direct patient care based on a finding that recruitment or retention efforts are, or would likely become, significantly handicapped without higher rates. Rates may be set at levels necessary to be competitive within the local labor market area. Under current law, the minimum rate of a special rate range may exceed the maximum rate of the corresponding grade by as much as 30 percent. The authority to establish special rates for LPNs has been delegated to facility directors.
- o Additionally, the Office of Human Resources Management and Labor Relations is currently gathering data so as to evaluate whether a legislative proposal to increase the statutory maximum of special salary rates is warranted.
- o The following is a summary of additional compensation flexibilities as they pertain to LPNs. Specific procedures for utilizing these authorities can be found in VA Handbook 5007.

Advances in Pay for New Employees. Facility directors may advance a new hire up to two paychecks so that the new employee can meet living and other expenses. The advance payment may be made when without the payment; the prospective employee may not accept the position because of immediate financial obligations associated with the acceptance.

Reference: VA Handbook 5007, Part VI, Chapter 5

Dual Compensation Waivers for Re-employed Annuitants. Civilian annuitants who are re-employed normally have their salary offset by the amount of their annuity. The Office of Personnel Management may approve exceptions to this reduction when necessary to meet emergency hiring needs or when there is exceptional difficulty recruiting a qualified candidate for a particular position. The VA has been delegated the authority to waive dual compensation restrictions for LPNs and other medical occupations. Requests for waivers must be submitted to the Office of Human Resources Management and Labor Relations.

Reference: VA Handbook 5007, Part VIII, Chapter 5, paragraph 5.

Higher Rates of Additional (Premium) Pay. Facility directors may authorize higher rates of premium pay (tour differential, Sunday pay, Saturday pay, holiday pay, overtime and on-call) for LPNs that have been authorized premium pay on the same basis as nurses when necessary to address recruitment or retention problems being caused by higher non-Federal rates of premium pay in the community. For instance, VA may have difficulty staffing positions because VA's tour differential rate is 10 percent and other establishments in the community pay 15 percent for similar tours. This gives facilities a mechanism to ensure all areas of pay are competitive to meet staffing needs.

Reference: VA Handbook 5007, Part V, Chapter 4

Highest Previous Rate. Upon reemployment, transfer, reassignment, promotion, demotion, or change in type of appointment, appointing officials have discretionary authority to set the rate of basic pay of an employee by taking into account (1) the actual rate of basic pay for the highest grade and step previously held by an individual while employed in a GS position; or (2) the highest actual rate of basic pay received by an individual while employed in a position in any branch of the Federal Government, a Government corporation, the U.S. Postal Service, the Postal Rate Commission, or the DC government (with certain exceptions).

Reference: VA Handbook 5007, Part II, Chapter 4

Incentive Awards Programs. Recognition and awards programs motivate employees to make contributions that support and enhance organizational goals and objectives. The types of awards available include special contribution awards (e.g., time-off awards and on-the-spot awards), suggestion awards, gainsharing awards, honor awards, and non-monetary awards. Detailed information regarding these awards can be found in the handbook referenced below.

Reference: VA Handbook 5017

Individual Appointment Above the Minimum Rate of the Grade (for GS health care appointees). Facility directors have the authority to set pay for new appointments or reappointments of individuals to General Schedule health care occupations, including LPNs, based on the candidates existing pay, higher or unique qualifications or special needs of the VA. This authority is intended to enhance VA's ability to meet its recruitment needs.

Reference: VA Handbook 5007, Part II, Chapter 3, paragraph 3.

Premium Pay on the Same Basis as Nurses. Facility directors may approve premium pay on the same basis as nurses for any "hybrid" occupation (e.g., licensed practical/vocational nurse) when such action is necessary to obtain or retain their services. Such approval requires the existence of a recruitment or retention problem. This provides affected employees with an uncapped overtime rate and allows them to receive tour differential for their entire tour as long as 4 hours are worked between 6 p.m. and 6 a.m.

Reference: VA Handbook 5007, Part V, Chapter 3

Recruitment Bonus. A recruitment bonus of up to 25 percent of the rate of basic pay may be authorized for a candidate. It must be determined that, without the bonus, it would not be possible to fill the position with a high quality candidate. This incentive is attractive to potential candidates because the bonus is paid in a lump sum. It is beneficial to the VA because the candidate must agree to complete a service obligation with VA in order to receive the bonus.

Reference: VA Handbook 5007, Part VI, Chapter 2

Relocation Bonus. A relocation bonus of up to 25 percent of the rate of basic pay may be authorized for an employee who must physically relocate and change duty stations to accept a position in a different commuting area. It must be determined that, without the bonus, it would not be possible to fill the position with a high quality candidate. Similar to the recruitment bonus, this bonus requires a service obligation and is paid in a lump sum.

Reference: VA Handbook 5007, Part VI, Chapter 2

Retention Allowance. A retention allowance of up to 25 percent (for individuals) or up to 10 percent (for a group or category of employees) of the rate of basic pay may be authorized if it is determined to be essential because of unusually high or unique qualifications or a special VA need and, absent the bonus, the employee would be likely to leave Federal service. This allowance is paid as an hourly rate.

Reference: VA Handbook 5007, Part VI, Chapter 3

Student Loan Repayment Program. This program allows facilities to repay Federally insured student loans as a recruitment or retention incentive for candidates or current employees. Facilities may make payments to the loan holder up to a maximum of \$10,000 for an employee in a calendar year and a total of not more than \$60,000 for any one employee. An employee receiving this benefit must sign a service agreement to remain in the service of the paying facility for a period of at least 3 years. Loans eligible for payment are those made, insured, or guaranteed under parts B, D, or E of title IV of the Higher Education Act of 1965 or a health education assistance loan made or insured under part A of title VII or part E of title VIII of the Public Health Service Act.

Reference: VA Handbook 5007, Part VI, Chapter 8

3. If you have any questions regarding this information, please contact Michael L. Watson, Office of Human Resources Management and Labor Relations at (202) 273-4920.

(Original Signed by:)
Tom Hogan obo

William H. Campbell

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Evaluation of Nurse Staffing in Veterans Health Administration Facilities

Report Number: _____

Issue	Citation	Estimated Better Use of Funds
1	Reduce supplemental nursing resources by 10 percent	\$17,820,000
1	Reduce absenteeism rate by 1 percentage point	\$17,820,000
3	Reduce RN turnover at the 5 facilities that exceeded the VHA average (9.4 percent)	\$2,708,300
Subtotal		\$38,348,300

Issue	Citation	Estimated Waste of Funds
1	Percent of annual DSS maintenance costs attributed to nursing resources management	\$4,100,000
Subtotal		\$4,100,000
Total		\$42,448,300

OIG Contact and Staff Acknowledgments

OIG Contact	Julie Watrous, Project Manager Director, Los Angeles Office of Healthcare Inspections (310) 268-3005
Acknowledgements	John Tryboski, Team Leader Terra Ansari Carol Arthur Daisy Arugay Elizabeth Bullock Marisa Casado Marnette Dhooghe Gilbert Melendez Victoria Pilate

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