In the Matter of

DEPARTMENT OF VETERANS AFFAIRS
CHARLIE NORWOOD VA MEDICAL CENTER
AUGUSTA, GEORGIA

and

LOCAL 217, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

Case No. 12 FSIP 3

ARBITRATOR'S OPINION AND DECISION

The Department of Veterans Affairs, Charlie Norwood VA Medical Center, Augusta, Georgia (Employer) filed a request for assistance with the Federal Service Impasses Panel (Panel) under the Federal Employees Flexible and Compressed Work Schedules Act of 1982 (Act), 5 U.S.C. § 6120, *et seq.*, to resolve an impasse with Local 217, American Federation of Government Employees, AFL-CIO (Union) arising from the Employer's determination to terminate the 5-4/9 and 4/10 compressed work schedules (CWS) in the Rehabilitation Service Line (RSL).

Following investigation of the request for assistance, the Panel determined that the dispute should be resolved through mediation-arbitration with the undersigned. The parties were informed that if a settlement were not reached during mediation, I would issue a binding decision to resolve the dispute. Consistent with the Panel's procedural determination, on February 16, 2012, I conducted a mediation-arbitration proceeding with representatives of the parties at the Employer's facility in Augusta, Georgia. Because there was no mediated voluntary settlement I am required to issue a final decision resolving the parties' dispute in accordance with 5 U.S.C. § 6131 and 5 C.F.R. §2472.11 of the Panel's regulations. In reaching this decision, I have carefully considered the entire record, including witness testimony and the parties' closing arguments.

BACKGROUND

The Employer's mission in RSL is to treat patients in acute inpatient hospital settings, as outpatients, and provide in-home care.[1/] RSL provides orthopedic and neurological therapy to veterans who are referred to RSL by their primary care physicians. The VA's goal for RSL, for inpatient care, is to see the patient the day of the referral; for outpatient and home care, the goal is to see the patient as soon as possible to enable veterans to become independent and allow for faster recovery. The Union represents a bargaining unit consisting of approximately 1,900 professional and nonprofessional employees, 30 of whom work in RSL. The parties are covered by a master collective-bargaining agreement in effect until March 2014 that contains in Article 21, "Hours of Work and Overtime," a provision for alternative work schedules including CWS. At the local level, the parties have negotiated agreements on various subjects, but none concern compressed schedules within RSL though these are authorized by the Master Agreement.

In RSL, four employees currently work compressed schedules; they hold positions as either physical therapist or occupational therapist. Two work a 4/10 CWS and two work a 5-4/9 CWS. Within RSL there are 14 licensed therapists (occupational and physical) spread among four RSL offices: the uptown and downtown physical therapy units, and uptown and downtown occupational therapy units. The CWS employees are spread among these units.

In all four locations RSL provides 5-day-a-week therapeutic services to outpatients referred by medical providers for evaluation and follow up appointments, acute patients and hospital in-patients sent for evaluation upon admission, for treatment while hospitalized, and before being released to go home. Inpatients have to be seen on the day of referral and on successive days up to their release, sometimes twice a day. The four therapists on CWS, along with their colleagues, evaluate and treat all these types of patients.

Because patients at the Augusta VA hospital come from a large geographic area they may travel a considerable distance to get to the hospital. Consequently, when outpatients come in to see a medical provider for a problem and are referred to physical therapy (PT) or occupational therapy (OT), there is a strong incentive to try to get them seen for their initial

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1/ This dispute does not involve therapists providing home care who the Employer states are eligible to work CWS.

appointment on that same day. If the return trip is a long one it imposes an additional burden on patients and incurs an additional cost because the VA medical system pays veterans for transportation costs.

Also relevant to this case is the VA medical system's process for data collection and productivity monitoring. The Decision Support System (DSS) is a billing program into which there is daily entry of information about patient care hours and specific treatment delivered. VA management uses DSS data to determine and monitor productivity within the system by determining the ratio of the number of patient care hours provided compared to the number of patient care hours available. Productivity is judged against national standards. Both individual and cumulative productivity data are calculated and are an element of employee and management performance evaluation. In RSL occupational and physical therapists enter the data into DSS and can calculate their daily productivity. One direct result of the reliance on productivity data is that, per Employer witnesses, new hires are not approved unless it is demonstrated that existing employees are working as productively as they should be according to the standards.

CWS schedules in RSL were instituted some years ago as a RSL management initiative, apparently without higher-level review. At the start of 2010, 12 of the 14 OT and PT therapists in RSL were on CWS. Through a process of attrition (resignations and retirements), voluntary changes to an 8-hour day (at the Employer's request) and CWS not being offered to new hires, the number on CWS has shrunk from 12 to four.[2/] At one time, RDOs were either Monday or Friday. The regular day off (RDO) for all those currently on CWS is Friday. Other employees work 8-hour tours of duty with staggering start times that typically begin at 7, 7:30, 8, 8:30, and 9 a.m.

The Employer first informed the Union of its desire to terminate CWS in March 2010. In April 2011, the Union was

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2/ Throughout this time when CWS participation was shrinking neither the Union nor any individual employee pursued a grievance over CWS under the Master Agreement though in May 2010 the Union President raised an objection to the failure to offer CWS, citing a violation of the Act and the Master Agreement, and threatening formal action. Apparently none was ever taken. There does not appear to have ever been an effort to negotiate a local AWS agreement covering RSL employees.

presented with documentation of productivity data for all of fiscal year 2010 and a claim of adverse agency impact. The Union did not agree with terminating CWS. After negotiation efforts encouraged by the Panel and a mediation effort at the Federal Mediation and Conciliation Service, the Employer perfected its filing with the Panel in January 2012.

ISSUE AT IMPASSE

The sole issue before me is whether the finding on which the Employer has based its determination to terminate the 4/10 and 5-4/9 compressed schedules in RSL is supported by evidence that the schedules are causing an adverse agency impact.[3/]

1. The Employer's Case

The Employer makes two basic assertions: that compressed work schedules in RSL produce lower, substandard levels of work unit productivity; and that because of the nature of the 5-day-a-week services provided by RSL, the RDOs of CWS employees have a significant, negative impact on the level of patient care and produce additional direct costs.

The testimony reveals that productivity became a focus after RSL gained new leadership in 2008. There were persistent complaints about the inability of RSL to provide timely services to patients. Requests for new hires were rejected by higher ups

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3/ Under 5 U.S.C. § 6131(b), "adverse agency impact" is defined as:

> (1) a reduction of the productivity of the agency;
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> (2) a diminished level of the services furnished to the public by the agency; or
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> (3) an increase in the cost of agency operations (other than a reasonable administrative cost relating to the process of establishing a flexible or compressed work schedule).

The burden of demonstrating that a CWS is causing an adverse agency impact falls on the employer under the Act. See 128 CONG. REC. H3999 (daily ed. July 12, 1982) (statement of Rep. Ferraro); and 128 CONG. REC. S7641 (daily ed. June 30, 1982) (statement of Sen. Stevens).

because of low productivity. Looking for answers, the new Director discovered that nearly all RSL therapists were working on CWS. During two periods in 2009 and 2010 significant backlogs built up in the PT units with up to 16-week waits for outpatient appointments. To reduce the backlogs employees were temporarily shifted from other units and contractors were hired. CWS was suspected as contributing to this problem and to low productivity in general, and from this point forward new hires to replace resigning and retiring staff were offered only 8-hour schedules, and some employees on CWS were asked to switch to 8 hours and did so. After productivity data for FY 2010 was available, it showed that when the number of 8-hour employees increased, both in the OT and PT units, productivity increased significantly thereafter. On this basis the Employer concluded that CWS had a negative effect on productivity. At the mediation-arbitration the Employer presented productivity data for the individual therapists for 2011 showing an increase in productivity for one employee who changed from CWS to an 8-hour schedule. No cumulative productivity figures for 2011 were yet available.

The Employer's contention is that productivity of CWS schedules is lower because of when and how patients are seen in RSL. Few patient care hours take place in the time periods worked by CWS therapists that are outside the non-CWS workday because, typically, veterans do not like to come in for later therapy appointments. Very few veterans are seen during those times because most are either retired or disabled. Also, inpatient and acute patients are seen during normal workday hours as are active duty military patients. The 2010 data show less than 1 percent of the patients served by RSL scheduled at 4:30 or after. Records from the first quarter of 2012 show a similar pattern of small numbers of later appointments. For most outpatient appointments (and all follow-up appointments) scheduling is done by the therapists.

The Employer rejects the idea that hiring more therapists would alleviate the problems being raised. The size of the RSL staff is not the issue; rather, it is how staff is being utilized. The data show that when staffing is spread across all 5 days of the week, productivity is maintained with no need for additional positions.

The RDOs of CWS employees affect the level of services provided to patients and incur added costs. On RDOs, those patients of the absent CWS employee who have to be treated that day (e.g. inpatients) must be seen by other staff.

Additionally, unscheduled patients (*e.g.* admissions) have to be handled by fewer therapists. The situation is exacerbated if there is another therapist off on sick leave.[4/] The resulting situation is that patients are "juggled" which, as described by witnesses, means more patients are treated simultaneously with less personal attention available, effecting what can be done and for how long. Safety is a bigger issue. Evaluations for newly admitted patients are particularly difficult to absorb since they take a longer time. In order to complete patient care on RDOs it is sometimes necessary to have scheduled staff work beyond normal work hours for which they receive compensatory time. If a patient appointment has to be rescheduled, the patient is inconvenienced and the VA incurs added transportation costs. Changing the RDOs to include other days besides Friday would not eliminate the problems of coverage given that the same services are provided 5-days a week. Fridays are the busiest days.

The Employer is not opposed to compressed work schedules across the board. There are rotating 6-month assignments within RSL for home-based treatment where CWS would work well since all appointments are scheduled in advance. The Employer has negotiated AWS agreements for other groups of employees at the Augusta facility.

2. <u>The Union's Case</u>

The Union contends that RLS can accommodate compressed work schedules while meeting mission needs.

The data from FY 2010 which the Employer relies upon is not reliable because many other factors affect productivity and are not accurately reflected by DSS in how the Employer computes productivity. When patients cancel an appointment or do not show up for one, DSS captures that information as "a missed opportunity for an appointment," which makes it appear that the therapist was not available for the appointment. There is also a great deal of leave usage in RSL contributing to low productivity and this is not accounted for.

4/ In its April 2011 letter to the Union, the Employer cited the number of episodes during 2010 when three or more OTs, or two or more PTs were off simultaneously (63 and 83 respectively) reducing patient care. No data of this type respecting 2011 was provided.

The coverage issues the Employer discusses are really staffing issues. The Union maintains that RSL is "chronically short-staffed" and that the Employer wants to make its short-staffing problem a problem with CWS. The improvements in productivity that occurred when contractors were added show the effect of increased staff not work schedules. Employees work together effectively to handle patient care despite the challenges when employees are absent for a variety of reasons.

The Union disagrees with the Employer's claim that veterans typically do not want to have therapy appointments later in the day. Patients who work find it more convenient to have later appointments. In the absence of seeing patients later in the day, those on CWS use the time productively to keep up with the paperwork generated from patient appointments.

Eliminating CWS will adversely affect employee morale; compressed schedules are a significant benefit for the four employees who have worked these schedules for a long time and have structured their private lives around them. There are ways to address any legitimate interests of the Employer short of terminating the compressed schedules. The Union is amenable to RDOs being expanded to days other than Friday. There are other avenues for handling any individual productivity issues.

CONCLUSION

Under § 6131(c)(2)(B) of the Act, the Panel is required to take final action in favor of the agency head's determination to terminate a CWS if the finding on which the determination is based is supported by evidence that the schedule is causing an "adverse agency impact." As its legislative history makes clear, Panel determinations under the Act are concerned solely with whether an employer has met its statutory burden on the basis of "the totality of the evidence presented."[5/]

5/ See the Senate report, which states:

> The agency will bear the burden in showing that such a schedule is likely to have an adverse impact. This burden is not to be construed to require the application of an overly rigorous evidentiary standard since the issues will often involve imprecise matters of productivity and the level of service to the public. It is expected the Panel will hear both sides of the issue and make its determination on the totality of the

The Employer here has the burden to prove that current compressed work schedules in RSL cause an adverse agency impact. The parties have debated whether CWS offers benefits to patients (opportunities for later appointments) but the outcome of this case does not depend on the Union proving any benefit from the CWS. The Act favors the use of CWS unless it causes specified adverse effects.

The record here is mixed. The numbers and charts offered by the Employer do not prove all that the Employer asserts. Nonetheless, for the reasons provided below I find that the Employer has met its statutory burden of establishing adverse agency impact based on diminished services to the public (patient care) and a negative effect on productivity.

From my perspective, the crux of the case is the evidence concerning the types of patients served and the nature of patient services provided by RSL. The question is whether the four compressed work schedules align with the demands of these patients and services in a way that avoids an adverse impact. My conclusion is that they do not. On 5 days a week there is a demand on RSL to not only provide scheduled physical and occupational therapy but also to evaluate and provide therapy to patients who come in without advance scheduling and need to be seen, and to hospital inpatients who have to be evaluated and then treated daily until their release. The RDOs reduce coverage on 1 or 2 days every pay period (depending on whether the CWS schedule is a 5-4/9 or 4/10) and the unscheduled and acute patients make it impossible to avoid the negative effects of this reduced coverage. An OT/PT practice that was entirely outpatient would present a very different scenario.

The Union has not effectively answered this point. Its suggestion to move the RDOs to days other than Fridays does not cure the problem even though Fridays are worse than most days. The Union did not challenge or counter the testimony of the four employee witnesses who described the impact of RDOs: patients being juggled; extra work for other staff members; and compensatory time for any overtime hours needed to complete patient care. Witnesses described that a lack of coverage on a RDO can and does lead to patients being treated for less time, and getting less individual attention. Instead of handling two patients at a time, a therapist might be juggling three or four. Rescheduling is not a ready solution. In my view, the combined

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evidence presented. S. REP. NO. 97-365, 97th Cong., 2d Sess. at 15-16 (1982).

effect is that employees picking up the slack on RDOs are forced to work less effectively. Statements by a Union witness that employees cover for each other and for her as the only current CWS employee in her unit "without problems," do not adequately address the issue. Co-workers with good relationships and loyalty to the mission will do that. But this does not mean that patient care is not diminished or other employees' performance not affected.

I have taken into account that with the variation in work load, no-shows, cancellations, and sick leave, not every RDO presents the same challenge for meeting patient care demands. But I have to conclude that regularly, predictably, and directly because of compressed work schedules, there are a significant number of occasions when patients get less treatment, and other employees have to work more than they should; otherwise, avoidable costs are incurred.

The parties' debate over whether more patients can be seen later in the day is a bit of a red herring. As stated at the outset, CWS does not have to be justified as improving patient care. If the evidence showed inferior productivity for the employees currently on CWS, then the usability of late afternoon work hours would be more important. But I have reviewed the 2011 data provided by the Employer for the mediation-arbitration and it reveals that all four employees remaining on CWS not only meet but exceed productivity goals. They are as or more productive than many 8-hour employees. This was true in 2010, as well.

Reviewing this, as well as other data on individual productivity, the Arbitrator is not persuaded that the 2010 data proves that fewer CWS schedules in and of itself caused the improvements in productivity that occurred in 2010 when the number of 8-hour tours increased. The individual data for 2010 and 2011 shows that at least some CWS employees who left RSL or switched their schedules were among the least productive, so that new hires may have increased productivity simply by replacing them, regardless of the schedule worked. That the four employees today remaining on CWS were productive throughout this same time period undermines any fixed link between CWS and poor productivity. We have no cumulative productivity data for 2011 but this current group's individual data shows positive productivity continuing. The fact is that the improvements in productivity during 2010 do not prove that productivity is diminished by *any* amount of CWS by *any* employees, no matter how productive they are on the days they work. The burden under the

Act is to prove *actual* adverse impact from the CWS in place, not probabilities.[6/]

Even with the inconclusiveness of the Employer's productivity data I find that the record establishes a diminution of productivity in one important respect. This is the impact of RDOs on employees who have to cover the work by taking on extra patients, modifying treatment and sometimes, extending their work hours. The RDOs force choices on these employees about how to perform their work and use their time that would not otherwise have to be made and in ways that, in my view, reduce their efficiency and effectiveness.

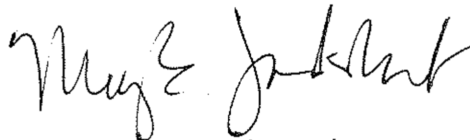
It is my conclusion, based on a totality of the evidence, that the current CWS schedules do not work in RLS because, as presented in this record, they cause demonstrated negative impacts on service and productivity that arise from the nature of the patient care that RSL must deliver. To conclude otherwise would require finding that there is some acceptable level of reduced medical services to patients justified by maintaining an alternative work schedule. I do not believe that this is what the Act envisions. Alternative work schedules are indeed a valuable benefit that employees have a right to utilize when it does not cause the adverse agency impacts Congress has identified.

6/ The Union's points about the data do not contribute to this conclusion. The Union appears to have ignored the detailed explanations about how productivity numbers are computed. Verifying that leave is factored out in calculating productivity is easily done by looking at the data (as I did). It is obvious that no-shows and cancelled appointments impact everyone's productivity numbers, not only those on CWS, so do not prejudice anyone's score. Staffing levels are not linked to productivity because productivity is calculated by comparing actual patient care hours with the potential patient care hours *of the current level of staff.* To quote one of the Employer's pieces of technical guidance that the Union received, "One might think that by adding more people to a department the efficiency of that department would improve because more patients could be treated. This is not the case. The only way to increase efficiency is to optimally utilize the existing labor resources . . .," in other words, increase the patient hours *per employee*. (Quotation from a document headed, "Decision Support System Data for Clinics.") There is no evidence in the record of a current staff shortage.

Having concluded that the Employer has established that current CWS schedules in RSL are causing an adverse agency impact, I will order that the schedules be terminated. As referenced above, in footnote 1, this case does not concern employees who provide in-home care; they remain eligible to work compressed schedules.

DECISION

Pursuant to the authority vested in me by the Federal Service Impasses Panel under the Federal Employees Flexible and Compressed Work Schedules Act, 5 U.S.C. § 6131(c), and § 2472.11(b) of its regulations, I hereby order the termination of the 5-4/9 and 4/10 compressed work schedules in the Rehabilitative Service Line.



Mary E. Jacksteit
Arbitrator

March 12, 2012
Takoma Park, Maryland