Caring for America's Veterans:

Attracting and Retaining a Quality VHA Nursing Workforce

National Commission on VA Nursing, 2002-2004

Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
National Commission on VA Nursing (108N)
Washington DC 20420

March 18, 2004

The Honorable Anthony J. Principi
Secretary of Veterans Affairs
Washington, DC 20420

Dear Mr. Secretary:

The National Commission on VA Nursing is pleased to submit its final report. Providing quality health care to America's veterans is essential to keeping the nation's commitment to those who have given so much to maintain our freedom. America's healthcare system remains in a state of constant flux and turmoil due to increasing demand from an aging more chronically ill populous. The shortage of nursing personnel to meet the demand for health care is an underlying symptom of the health care system in crisis. Fixing the nursing shortage alone will not resolve the fundamental health care delivery system issues that exist.

The National Commission on VA Nursing report calls for the redesign of the practice environment within VHA facilities as the first step to addressing the system issues. We believe that addressing the issue facing nursing and contributing to the American nursing shortage will positively effect VHA and enable the delivery of safe, quality health care despite the cyclical shortages that may occur in the future.

The key driver to improving VHA's ability to retain and recruit a qualified nursing workforce is leadership and commitment to engaging nurses and other health professionals in the transformation of care delivery. Nurses and other health professionals must receive education to assure their ability to deliver patient centered, safe, satisfying, and evidenced based, quality care. Nurses must be engaged in the governance and system design processes of healthcare organizations. Research and innovation must be applied to create systems of care that attract and retain nurses because they are rewarding and satisfying to patients and care providers. It is essential if we are to keep our promise to America's veterans that VHA lead efforts to create such systems.

I interviewed facility directors, nurse executives, chiefs of staff, registered nurses, advance practice nurses, managers, researchers, licensed practical nurses and nursing assistants. The same common thread was evident in their response; *it is our desire to strengthen VA so we can provide excellent care*. I will always treasure the opportunity I was given to lead a group of talented and committed commissioners and complete our charge. I will always remember the faces and voices of VA nursing and leadership personnel and their plea to the Commission. Hopefully our recommendations meet their requests.

The Commission's legislative and organizational recommendations are a blueprint for the reinvention of nursing. We believe that the VA model may serve as a foundation for the creation of a care delivery system that meets the needs of those who we serve and those providing care.

Sincerely,

Linda Burnes Bolton

Linda Burnes Bolton, DrPH, RN, FAAN
Chairperson,
National Commission on VA Nursing

Acknowledgements

The Department of Veterans Affairs acknowledges the National Commission on VA Nursing members and advisors for donating their valuable time to this significant undertaking. Special thanks to Dr. Linda Burnes Bolton who accepted the chairmanship half way into our work. Her leadership to this project was invaluable in assisting members to formulate recommendations and articulate nursing issues on a national and VHA level.

Thanks also to Dr. Marilyn Pattillo who chaired the Commission from March 2002-June 2003.

Commission Members

Ann Collins Adair, MSN, MPH, M.Ed-*Veterans Representative*
*Linda Burnes Bolton, Dr. PH, RN, FAAN-Chairperson
Ann Converso, RN-*Employee Representative*
J. David Cox, RN-*Employee Representative*
David W. Gorman-*Veterans Representative*
Phyllis Shanley Hansell, Ed.D, RN, FAAN-*Nursing School Affiliate*
John Dandridge, Jr., MHA-*Secretary Appointee*
Eileen Kingston, MPA, BSN, RN, C N A-*Secretary Appointee*
Mary Raymer, MA, RN, CNAA-*Professional Association*
Julie Sochalski, PhD, RN, FAAN-*Secretary Appointee*
Joanne Spetz, PhD-*Economist*
Mary Wakefield, PhD, RN, FAAN-*Secretary Appointee*
Cathy Rick, FACHE, RN, CNAA-*VA Chief Nursing Officer, Ex-Officio Member*

Commission Advisors

Michael Good, M.D.- *Former Chief of Staff, Gainesville, FL VAMC*
Lucretia M. McClenney, MSN, RN, CNA- *Special Assistant to the Assistant Secretary for Policy and Planning and Preparedness*
Enrique Mendez, Jr., M.D.-*Retired Major General, U.S. Army Medical Corp*
Marla Salmon, ScD, RN, FAAN- *Dean, Nell Hodgson Woodruff School of Nursing, Emory University*

VA Central Office Commission Staff

Oyweda W. Moorer, MSN, RN, C N A-BC-*Director*
Stephanie Williams, MPH-*Program Analyst*
Jessica Hunter-*Program Support Assistant*
Robert W. Swanson-*Management Support*
Kathy Heaphy-*General Counsel*
Angela Prudhomme-*VHA Center for Health Ethics*
Andre Washington-*Office of Nursing Services*
Suzanne McNicholas-*Washington, DC VAMC*
Julius McClary-*VHA Business Office*
Dr. Randy Taylor-*VHA Baldrige Program*
Dr. Michael Hodgson-*Occupational Health*
Laurie Tranter-*Public Affairs*
Donna L. Schroeder- *Human Resources*
Jeff Hallmark- *Washington, DC VAMC*

Report Writer

Rebecca B. Rice, Ed.D, RN, MPH

Reviewers

A draft of this report was reviewed for clarity and soundness by a select group considered experts in their respective fields. The Commission requested feedback and opinions regarding the report in genera. Participation in this endeavor was voluntary and required reading and responding to the report. The Commission appreciates the feedback received and wishes to thank the following leaders for lending their expert opinions to this work:

Denise Geolot, PhD, RN, FAAN
Director, Division of Nursing, Department of Health and Human Services

Janet Heinrich, DrPH, RN, FAAN
Director, Health Care-Public Health Issues for the U.S. General Accounting Office

Sandra Janzen, MS, RN, CNAA-BC
Associate Chief of Staff for Nursing Programs at the Tampa, FL VA Medical Center

Tim Porter O'Grady, EdD, PhD, FAAN
International Consultant and Mediation Specialist focused on Human Relations and Organizational Dynamics

Edward O'Neil, PhD, MPA, FAAN
Professor of Family and Community Medicine and Dental Public Health at the University of California, San Francisco; Director of the Center for the Health Professions

Table of Contents

EXECUTIVE SUMMARY

Providing high quality nursing care to the nation's veterans is integral to the mission of the Department of Veterans Affairs (VA). The current and emerging gap between the supply of and demand for nurses may adversely affect the VA's ability to meet the healthcare needs of those who have served our nation. The men and women of the uniformed services who have defended our nation's freedoms in global conflicts deserve the best treatment our nation can provide. Nurses, comprising the largest proportion of health care providers, are central to the Department of Veterans Affairs' duty to provide safe, quality patient care. While the Commission acknowledges that there are shortages of other healthcare personnel, nurses are a source of care and support for patients at the most vulnerable points in their lives. Nearly every person's health care experience involves a registered nurse. From birth to death, and in all various health/illness situations in between, nurses offer support, knowledgeable care, and comfort to their patients (JCAHO, 2002).

If we as a nation cannot provide the necessary resources for nursing care of veterans, we will fail them and their dependents. We must recruit the best nurses, and we must retain a cadre of experienced, competent nurses. Over 55,000 Veterans Health Administration (VHA) employees are nursing staff. To provide safe, quality care to veterans, VHA will need to maintain and expand its nursing personnel as the number of veterans increase. Like other healthcare employers, VHA must actively address those factors known to affect retention of nursing staff: leadership, professional development, work environment, respect and recognition, and fair compensation. To create a nursing workforce for the future, VHA must develop and test technology and actively embrace research leading to the creation of new nursing roles that complement innovations in health care. Action is required now to address underlying issues of nursing shortage and retention while simultaneously implementing strategies that assure the availability of a qualified nursing workforce to deliver care and promote the health of America's veterans in the future.

In 2002, the National Commission on VA Nursing was established through Public Law 107-135 and charged to consider and recommend legislative and organizational policy changes that would enhance the recruitment and retention of nurses and other nursing personnel and assess the future of the nursing profession within the Department of Veterans Affairs. A 12-member Commission was appointed and given a 2-year timeline to complete its charge. The Commission's focus was on identifying strategies and tactics to assure the readiness and capacity of VA to meet the current and future health care needs of America's veterans. As the nation's largest employer of nursing personnel, VHA can serve as a model for the nation in creating, implementing, and monitoring a work environment that retains and attracts nurses and other health care personnel and assures the availability of a qualified nursing workforce.

The Commission developed the desired future state for VHA nursing and recommendations to achieve that vision. The statement reads:

> *VA Nursing is a dynamic diverse group of honored, respected and compassionate professionals. VA is the leader in the creation of an organizational culture where*

excellence in Nursing is valued as essential for quality healthcare to those who have served America.

To achieve that state, the Commission recommends organizational **(O)** and legislative **(L)** policy changes in leadership, professional development, work environment, respect and recognition, fair compensation, technology, and research/innovation. The recommendations follow.

Leadership

1. The facility nurse executive should have line authority, responsibility, and accountability for nursing practice and personnel. **(O)**
2. The facility nurse executive should be a member of the executive body at VISN and facility levels. **(O)**
3. The facility nurse executive should be accountable for (a) the effective performance of nurse managers, (b) leadership development of all nursing staff, (c) development and implementation of clinical leadership roles at the point of care, and (d) compliance with standardized Nurse Professional Standards Board (NPSB) protocols. **(O)**
4. VHA should clearly define Nurse Qualification Standards to facilitate consistent interpretation across VA. **(O)**

Professional development

1. VHA should structure career development opportunities to assure that every nurse in VHA can actualize his or her goals within one or more career paths with the opportunity for professional growth and advancement. **(O)**
2. VHA should establish national policy guidelines for schools of nursing comparable to the medical school model in policy memorandum Number 2 and actively promote nursing school affiliations. **(O)**
3. VHA should assure that the VA's Health Professionals Educational Assistance Program is funded equitably with other federal programs such as military scholarships. **(L) (O)**

Work environment

1. VHA should develop, test, and adopt nationwide staffing standards that assure adequate nursing resources and support services to achieve excellence in patient care and desired outcomes. **(O)**
2. VHA should review and adopt appropriate recommendations outlined in the Institute of Medicine report, *Keeping Patients Safe: Transforming the Work Environment of Nurses,* to determine specific strategies for implementation across VHA. **(O)**

Respect and Recognition

1. VHA should expand recognition of achievement and performance in nursing service. **(O)**
2. VHA should create a sense of value and culture of mutual respect for nursing through all levels of VHA to include physicians and other colleagues, management, and stakeholders. **(O)**

Fair Compensation

1. VHA should amend Title 38 to establish procedures for assuring that RN locality pay policies are competitive with local RN employer markets. **(O)**
2. VHA should change hiring and compensation policies to promote recruitment and retention of licensed practical nurses and nursing assistants. **(L) (O)**
3. VHA should strengthen human resources systems and departments to develop an active hiring and recruiting process for nursing staff that is consistent, to the extent possible, across facilities and VISNs. **(O)**

Technology

1. VHA should give priority to the continued rollout of the VA Nursing Outcomes Database (VANOD) as the data repository for nursing performance standards and the evaluation of effective patient care delivery models. **(O)**
2. VHA should engage experts to evaluate and redesign nursing work processes to enhance patient care quality, improve efficiency and decrease nurse turnover through the use of technology. **(O)**
3. The Agency for Healthcare Research and Quality (AHRQ) and the VHA should partner in applying findings from information systems and technology research projects into patient care delivery. **(O)**

Research/Innovation

1. VHA should establish a Center for Excellence in Quality Nursing Care to create and implement a research agenda consistent with the VA mission. **(O)**

To implement these recommendations, VA and Congress must allocate adequate resources. If the recommendations are carried out, the Commission believes that VHA will attract and retain a qualified nursing work force. Responsibility and accountability for implementing the recommendations lie with VHA nurses—from the Chief Nursing Officer to the direct care giver. VHA nursing leaders must be responsible and accountable at each facility for nursing practice, resource allocation, education, and research. Staff nurses at all levels in nursing must be engaged in decision-making on policies affecting clinical care, resource allocation, and working conditions at the facility and VISN levels. Staff nurses, managers, medical staff, labor organizations and veterans' representatives must work together to assure a collaborative practice environment beneficial to veterans and nursing. Finally, partnerships and collaboration among local VHA facilities and the broader nursing education and service community must be developed to support the professional advancement of nursing personnel and recruit new and diverse individuals into the nursing workforce and VHA.

The Commission believes that implementation of these recommendations will position VHA for the future of health care delivery and nursing. As delineated in *VHA Vision 2020,* VHA already leads in benchmarking quality indicators, safety initiatives, and models of integrated care delivery. VHA nurses are integral to care delivery in all VHA settings, and VHA should continue to design, develop, test, and implement futuristic nursing roles and evidence-based models of care to serve our nation's veterans.

CHAPTER 1

INTRODUCTION

The Veterans Health Administration (VHA) is a critical component of the nation's healthcare delivery system, providing health care services, educating health professionals, and developing and testing innovations. VHA nursing employs an integrated clinical nursing model, consisting of administrative and clinical practice, education and research. One of four professional nurses in the country receives some of his/her clinical education within VHA (VA, 2001f). Moreover, VHA is a leading innovator of integrated patient information and safety systems, developing information technology that can be accessed by patients and providers.

Recruiting and retaining nursing personnel are priority issues for every healthcare system in America. VHA is no exception. With the aging of the population, including veterans, and the U.S. involvement in military activity around the world, VHA will experience increasing numbers of enrolled veterans. Consequently, as the demand for nursing care increases, the nation will grapple with a shortage of nurses that is likely to worsen as baby boomer nurses retire. VHA must attract and retain nurses who can help assure that VHA continues to deliver the highest quality care to veterans. Further, VHA must envision, develop, and test new roles for nurses and nursing as biotechnologies and innovations change the way healthcare is delivered.

In response to the nursing shortage, in 2001 VHA instituted a Nursing Workforce Group to "critically review salient aspects of the national shortages for VA and formulate strategies to ensure VHA's ability to attract and maintain a qualified nursing staff**"** (Department of Veterans Affairs [VA], 2001a, p.3). The report of this workgroup, *A Call to Action: VA Response to the Nursing Shortage (Call to Action),* recommended that VHA establish a National Commission on VA Nursing to "[r]eview legislative and organizational policy changes to enhance the recruitment and retention of nurses and assess the future of the nursing profession in VA" (VA, 2001a, p. 12).

In 2002 the National Commission on VA Nursing was established through Public Law 107-135. In SEC. 142, the duties of the Commission are specified as follows:

(a) Assessment. –The Commission shall—
  (1) consider legislative and organizational policy changes to enhance the recruitment and retention of nurses and other nursing personnel by the Department of Veterans Affairs; and
  (2) assess the future of the nursing profession within the Department.

(b) Recommendations. –The Commission shall recommend legislative and organizational policy changes to enhance the recruitment and retention of nurses and other nursing personnel in the Department.

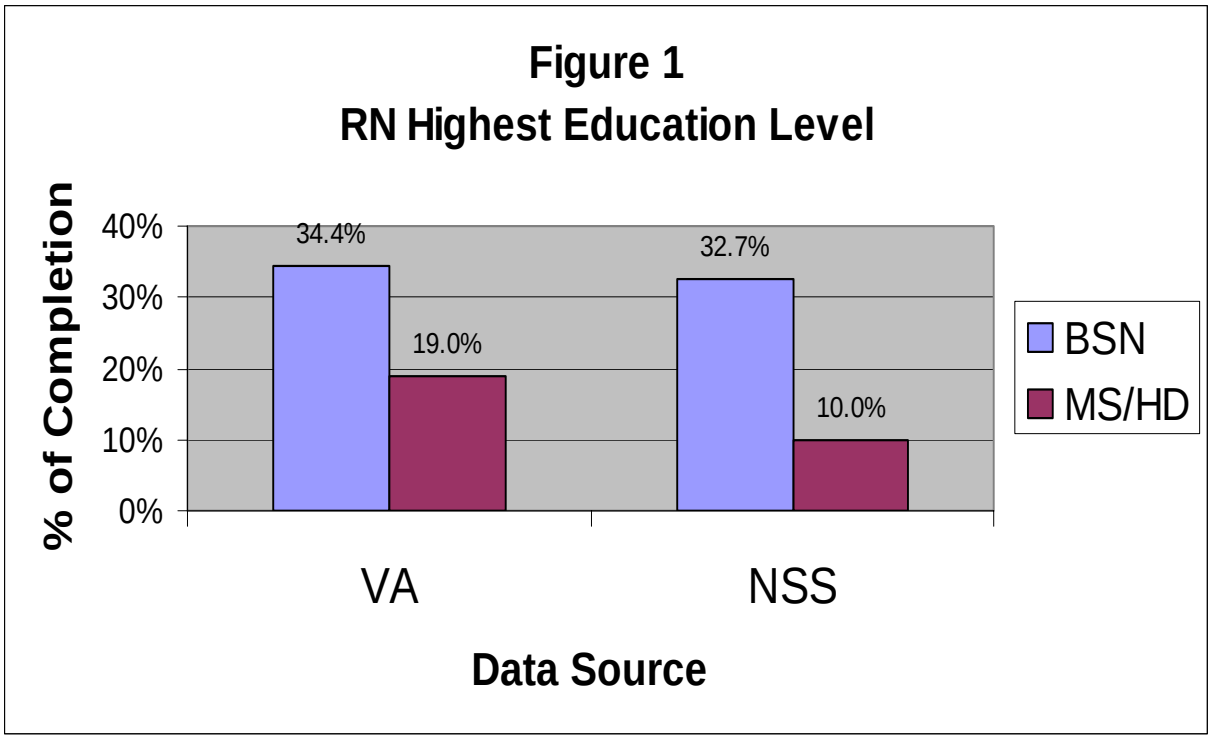
This report describes the work of the Commission and its recommendations.

Nursing in VHA

VHA provides a broad spectrum of health care services across a continuum of settings. In 2003, VHA had over 7.2 million veterans enrolled for health services, and more than 4.8 million veterans received care (VA, 2003b). VHA maintains 162 hospitals, 137 nursing homes, 681 community clinics, 11 mobile clinics, and 43 domiciliaries. VHA reported over 13.1 million bed days of care and more than 49,000,000 outpatient visits in FY 2003 (VA, 2003j).

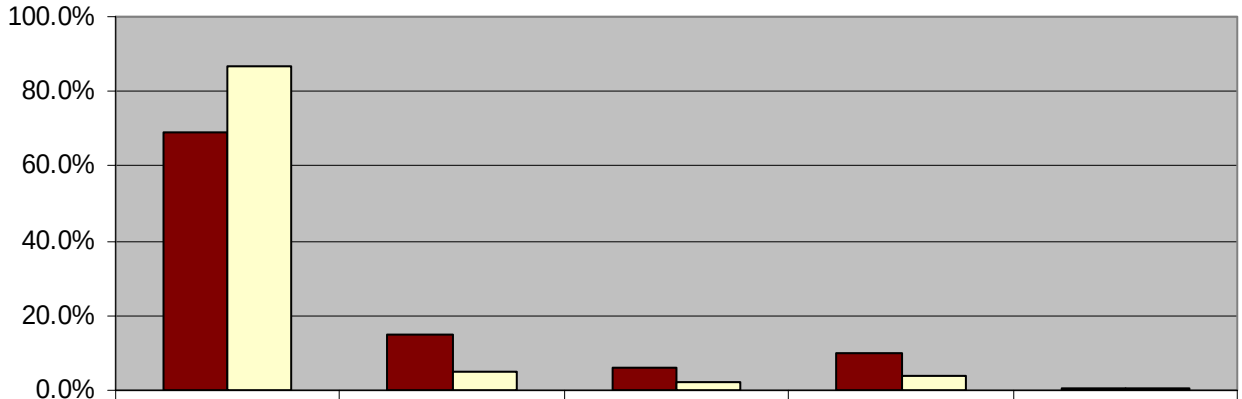
More than 180,000 VHA employees provide healthcare services in all 50 states, the District of Columbia, and U.S. territories. Nurses comprise the largest group of health care providers. Of the total number of employees, 32 percent (58,000) are nursing staff. As of September 2003, 21 percent (38,000) were Registered Nurses (RNs), 6 percent (10,000) were Licensed Practical Nurses (LPNs), and 5 percent (9,000) were Nursing Assistants (NAs) (VA, 2003k).

VHA RNs differ from the national nursing workforce in several important ways. The VHA RN workforce is more highly educated than the national RN workforce (see Figure 1). Of the more than 38,000 RNs, 34 percent hold bachelor's degrees in nursing, and 19 percent are master's or doctorally prepared (VA, 2003k). These figures exceed national averages, according to the 2000 National Sample Survey of Registered Nurses (NSS), which found that 32.7 percent of RNs report holding a bachelor's degree in nursing with 10 percent holding a master's or doctorate (Spratley, Johnson, Sochalski, Fritz, & Spencer, 2000).



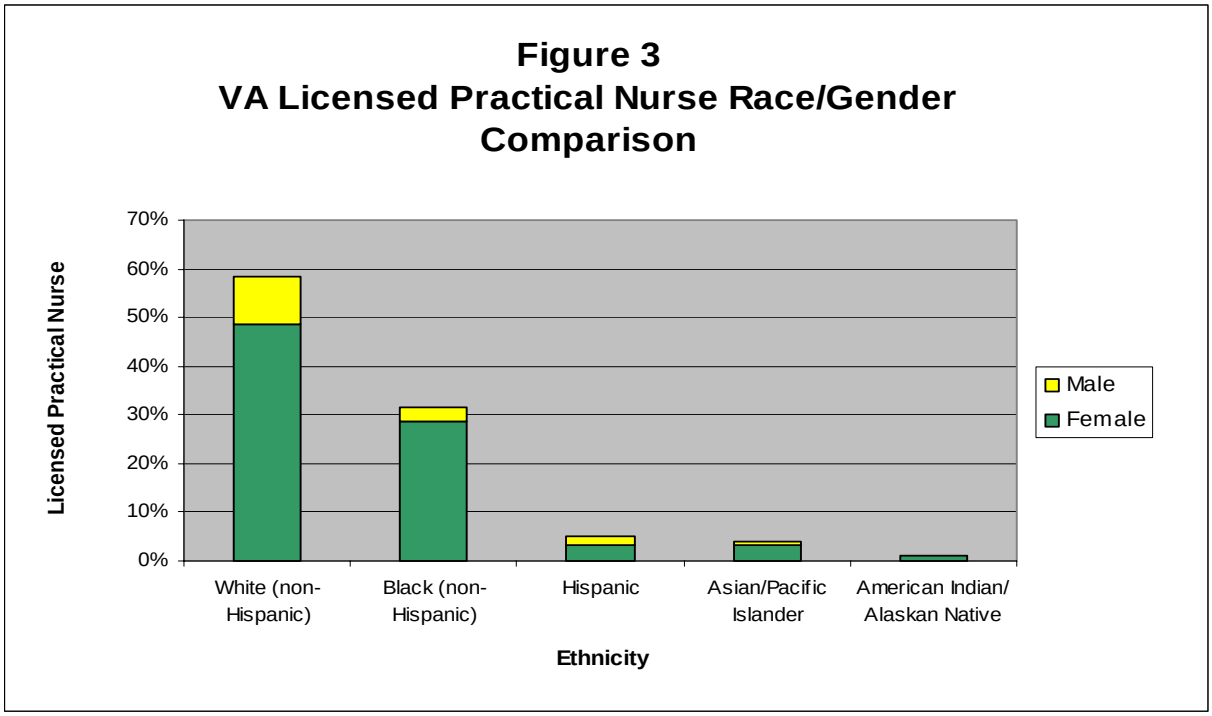
Diversity in race/ethnicity and gender in nursing strengthens its ability to care for current and future populations of veterans. The VHA RN workforce is more ethnically and gender diverse than the national RN workforce (Figure 2). Males comprise 14.3 percent of the VHA RN workforce, compared with 5.4 percent nationally. 69% of VHA RN staff is White compared to national RN workforce of 86.6%. VHA RN workforce exceeds national averages for all minority groups. Almost 15 percent of VHA RNs are African-American (U.S., 4.9 percent); 6.2 percent are Hispanic (U.S., 2 percent); 10.1 percent are Asian-Americans (U.S., 3.7 percent); and 0.7 percent are American Indian/Alaskan Native (U.S., 0.5 percent) (VA, 2003k; Spratley, et al., 2000).

Figure 2
Ethnic/Racial Comparison of VA RNs and National Sample Survey (NSS) RNs

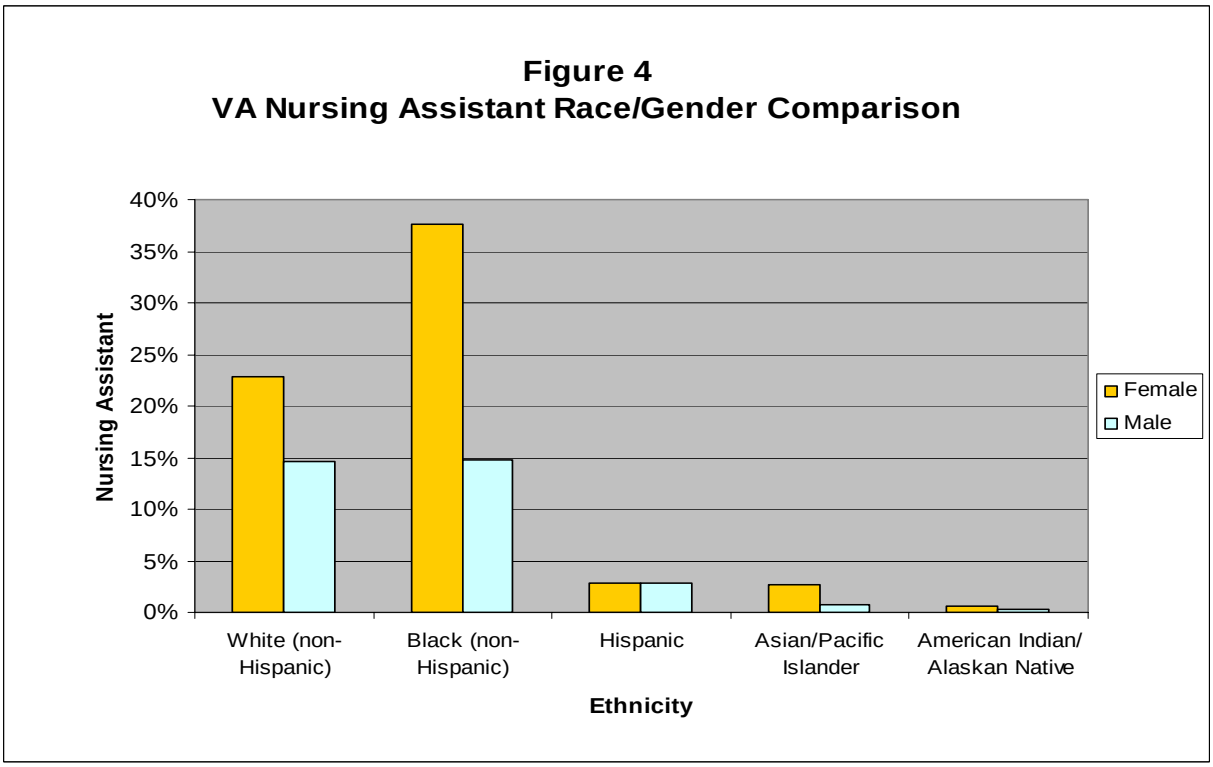


	White	African American	Hispanic	Asian/Pacific Islander	American Indian/Alaskan
VA	69.0%	15.0%	6.2%	10.1%	0.7%
NSS	86.6%	4.9%	2.0%	3.7%	0.5%

The racial/ethnic and gender composition of VHA LPNs and NAs is more diverse than the RN workforce (Figure 3). Fifty-seven percent of VHA LPNs are white, and 31 percent are African-American. Six percent of the LPN workforce are Hispanics with Asian Americans each comprising 4 percent respectively. One percent of VHA LPNs are American Indian/Alaskan natives. Over 15 percent of VHA LPNs are men.



Among NAs, over half (52 percent) are African-Americans, and 37 percent are white. Almost 6 percent are Hispanic, and 4 percent are Asian Americans. Less than 1 percent of NAs are American Indian/Alsakan native. Thirty-two percent of NAs are men. (Figure 4)



VHA RNs are aging, like the general population of RNs, although on average, VHA RNs are older. As of September 2003, the average VA RN was 48.9 years old (national average, 41.8, in 2000). Seventeen percent of VA nurses were under the age of 40 (U.S., 31.7 percent). In 2002, the average age of a VHA RN new-hire was 41.6 years old (VA, 2003k). Like the private sector, VHA must consider strategies that will be successful in retaining the older nurse.

Data on other VHA nursing personnel reveal that LPNs and NAs are on average similar in age to RNs. The average age of full-time LPNs is 45.6, and for NAs is 45.9 (VA, 2002). National demographic data on LPNs and NAs are not available.

Because VHA is a major component of the U.S. health care delivery system, changes in the way health care is delivered within VHA have the potential to influence the delivery of health care within other government-sponsored programs and the private sector. Changes in nursing care delivery and practice may have the same effect, and VHA can serve as an excellent laboratory to test models of nursing care and recruitment/retention strategies that can be evaluated for their effectiveness and exported to other facilities throughout the U.S. healthcare delivery system.

The Effect of the Nursing Shortage on VHA

Like private health care, the demand for VHA health care is projected to rise. VA projects that from FY 2002 through FY 2012, the average patient *enrollment* (i.e., veterans eligible for health care) will increase by 39% from 6.4 million to 8.9 million veterans. The projected numbers of veterans *seeking* VHA health care over this 10-year period are expected to increase by 31%, at an average annual increase of 2.7 percent (VHA, 2001b).

Recent trends for nurses in VHA are promising. From FY 1995 through FY 2001, the number of staff RNs declined 8.5 percent (from 40,585 to 37,151). However, at the end of FY 2003, the number increased to 38,426. This increase is welcome news, especially given the projected retirements of the baby boomers slated to begin in 2008.

Retention of nurses is critical to the VHA mission, and VHA turnover rates are slightly less than the national average. According to the American Hospital Association (AHA), the national RN vacancy rate reported in the fall of 2001 was 13 percent (American Hospital Association [AHA], 2002). At the same time, VHA experienced a vacancy rate of 8.2 percent. Although VHA RN vacancy rates remained below the national rate, they actually rose 3.3 percent between 1998 and 2001. In the FY 2003 year, VHA vacancy rate had declined to 7.1 percent (VHA Annual Report on Staffing, 2001, 2002, 2003).

The Commission's Work

The Commission began its work in May 2002 and met eight times in various locations throughout the nation. It reviewed published studies and literature and heard presentation from various stakeholder groups. Commission members interviewed VHA facility leaders at ten facilities, and reviewed employee satisfaction survey results. The Commission received comments via fax, oral, and written testimony from the public and VHA nurses. A web site was established for posting public information and receiving comments (http://www.va.gov/ncvan/).

In April 2003, the Commission held public hearings in New Orleans, Philadelphia, Chicago, and Long Beach.

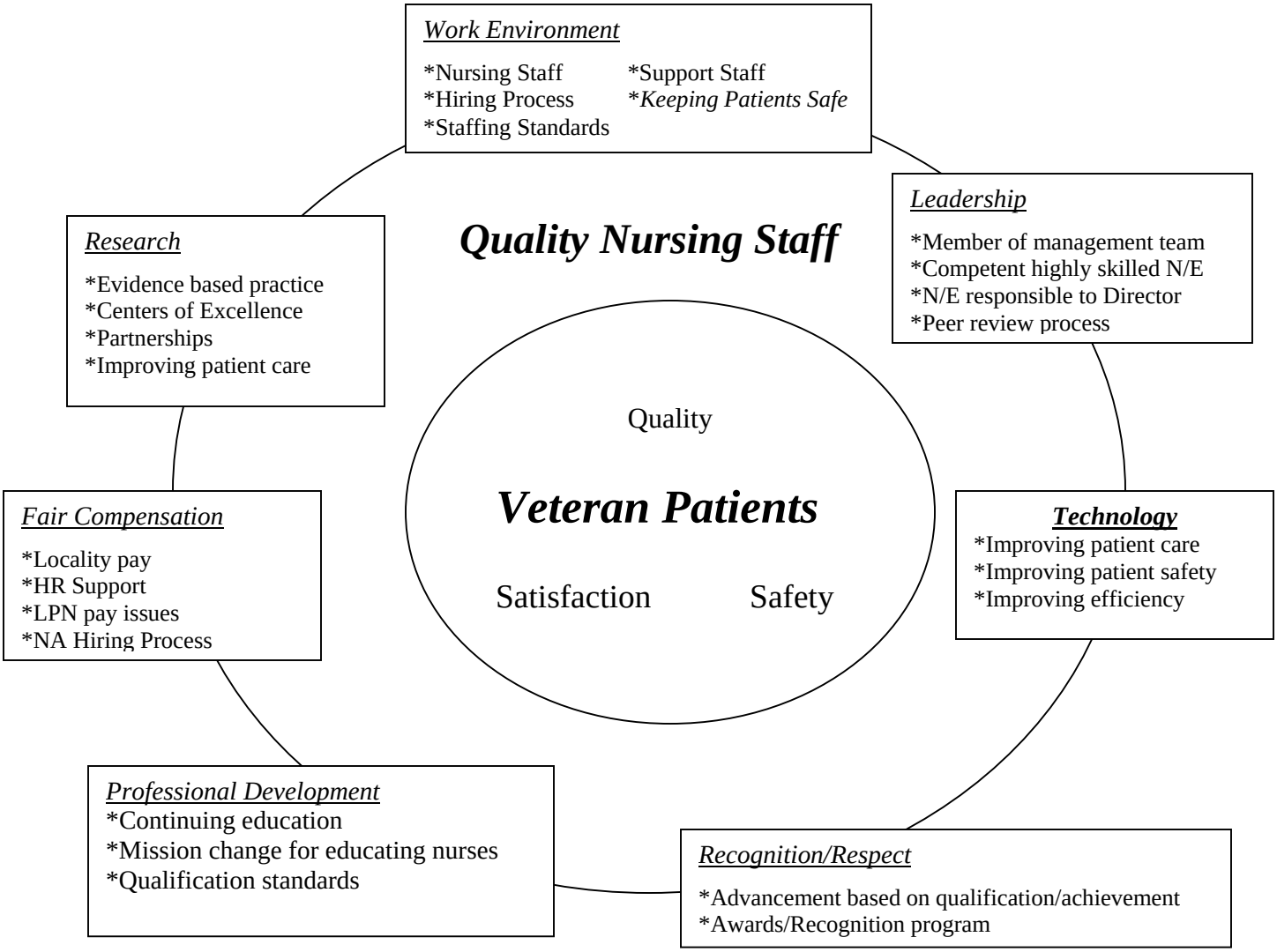
To guide its work, the Commission described a desired future state of VA nursing. In developing the statement, members agreed that it should be futuristic and innovative, with a focus on valuing of staff and reflecting the VA's mission. The statement reads:

> *VA Nursing is a dynamic diverse group of honored, respected and compassionate professionals. VA is the leader in the creation of an organizational culture where excellence in Nursing is valued as essential for quality healthcare to those who have served America.*

The Commission's recommendations are structured around its two assessment duties as specified in Public Law 107-135. In considering legislative and organizational policy changes to enhance recruitment and retention of nurses and other nursing personnel by the Department of Veterans Affairs, the Commission focused on the following areas: leadership, professional development, work environment, fair compensation, respect and recognition, technology, and research/innovation. Each area has a direct influence on nurses and nursing care as all VHA healthcare professionals work to achieve safe, quality patient care (Figure 5, Model for Recruitment/Retention). The Commission also discussed how VHA can position itself to proactively address the requirements for nursing within the context of rapidly advancing health care research. The Commission puts forth these recommendations, believing that implementation of these, along with the recommendations in the *Call to Action* report, will create a thriving nursing department that will provide excellence in nursing care to veterans and serve as a model for nursing service in the private sector.

The remaining sections of this report specify the Commission's assessment processes and findings (Chapter 2) and its recommendations and implementation strategies (Chapter 3).

Figure 5
Model for Recruitment/Retention



National Commission on VA Nursing, 2004

CHAPTER 2

ASSESSMENT

In carrying out its charge, the Commission gathered information from a variety of sources. These included reviewing the current status of nursing within VHA through analyzing nursing's infrastructure and recent and current VHA nursing initiatives; reviewing recent research studies and expert literature on nursing; conducting hearings and forums; receiving input from web-based postings and faxes; hearing presentations from stakeholder groups; and conducting key informant interviews of facility leadership. The results of these findings are contained in this chapter of the report.

ASSESSMENT SOURCES

VHA Nursing Staff

The Commission collected data and obtained input from various levels of VHA nursing staff using several methods. A web site was developed to disseminate and gather information. A total of 135 web-based messages were posted. The Commission also received over 970 faxes.

In April 2003, the Commission conducted hearings in four cities—Long Beach, New Orleans, Chicago, and Philadelphia—with over 325 VHA nursing staff in attendance. The Commission heard oral testimony from 190 individuals and received 826 written statements. Transcripts of oral testimony are available on the Commission web site (http://www1.va.gov/ncvan/) (See Appendix A for demographics of hearing participants).

The Commission also reviewed the results of two recent VHA surveys—one on staffing and the other on employee satisfaction. The staffing survey provided information on turnover, vacancy, and replacement rates and budgeted positions and position losses.

VHA Nursing Leadership

In March 2003, 100 VHA nurse leaders participated in a forum held to elicit feedback to the Commission (a summary of the findings from the leadership forum can be found in Appendix B). The participants responded to a set of questions on the recruitment and retention of nurses, VA's role in providing excellence in nursing care across all facilities, areas needing change and areas of strength within VHA nursing, and the future of nursing in the VA.

VHA Facility Leadership

Over a 2-week period in March 2003**,** two non-VHA Commission members held key informant interviews with leaders from 10 facilities, including directors, chiefs of staff, and chief nurse executives. In these interviews, participants were asked to identify their concerns about nursing in their facilities and recommendations they would like the Commission to consider (Summary of findings, appendix C).

VHA Reports

The Commission reviewed numerous VA reports, including the Office of Nursing Service Strategic Plan, the VHA Strategic Plan, the 2001 Succession Plan, VHA Vision 2020, Annual Reports on Locality Pay Adjustment, Requests for Waivers of Pay Reductions, Annual Report on Use of Authorities to Enhance Retention of Experienced Nurses, and the Annual Report on Staffing for Nurses and Nurse Anesthetists; and Mandatory Overtime Report.

The Commission also reviewed the *Call to Action* report of the Nursing Workforce Planning Group. Chartered in 2000, and under the leadership of the Chief Nursing Officer, the Nursing Workforce Planning Group provided advice on issues that affected VHA's future supply and utilization of RNs. The group's membership consisted of representatives from multiple parts of the organization, including clinical and administrative experts. Its report was issued in 2001 and contained recommendations in the areas of utilization, retention, recruitment, and outreach (Department of Veterans Affairs [VA], 2001a). The VHA National Nurse Executive Council (NNEC) is responsible for implementing the *Call to Action's* recommendations. Where possible in this report, both the *Call to Action* recommendations are cited as well as the NNEC follow-up.

Nursing Literature and Other External Expert Sources

The Commission reviewed the literature on recruitment and retention of nurses and the future of nursing and healthcare. This review included a detailed analysis of sources containing best practices for recruiting and retaining nurses. Of these, the Institute of Medicine's report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001), the Malcolm Baldrige Quality Award program (National Institute of Standards and Quality, 2003), and *Magnet Hospitals Revisited: Attraction and Retention of Professional Nurses* (McClure & Hinshaw, 2002) formed the basis for identifying the categories for organizing Commission recommendations on leadership, professional development, work environment, and respect and recognition. In making its recommendations, the Commission also consulted extensively the following sources:

- *Nurse Recruitment and Retention Survey* (American Organization of Nurse Executives, 2000);
- *In Our Hands: How Hospital Leaders Can Build a Thriving Workforce* (American Hospital Association's Commission on Workforce for Hospitals and Health Systems, 2002); and
- *Health Professions Education: A Bridge to Quality* (National Institute of Medicine Committee on the Health Professions Education Summit, 2003*).*

In addition, the Commission has made recommendations in three other categories: fair compensation, research/innovation, and technology. Fair compensation was chosen as a priority area because of input received by VHA nursing staff. Research/innovation and technology were chosen because of the Commission's charge to assess the future of the nursing profession.

REVIEW OF FINDINGS

The remainder of this chapter describes the Commission's findings from which recommendations are made. First, the organization of VHA nursing is described. Following are sections on each of the recommendation categories—leadership, professional development, work environment, fair compensation, respect and recognition, research/innovation, and technology. Each section consists of relevant findings, such as review of the literature; findings from VHA reports and initiatives; input from faxed and web-based comments, written and oral testimony; and summaries of the nursing leadership forum and key informant interviews.

VHA Nursing

VHA nursing personnel provide services to veterans across a wide array of settings, including acute, long-term, psychiatric, home, and primary care settings. In addition to providing direct nursing care, VHA nurses serve as leaders in program development and implementation; participate on nursing, medical center, Veterans Integrated Service Network (VISN), and Central Office committees; and play vital roles in national efforts to meet patient care performance measures. VHA nursing's mission is *to provide patient-centered, state-of-the-art nursing care to the veteran population utilizing collaborative, innovative research-based models of care that consider the biopsychosocial, emotional, spiritual and community support needs of veterans and their families* (VA, 2003f).

VHA nursing personnel are supported centrally through the Office of Nursing Service (ONS) headed by the Chief Nursing Officer. Since the early 1990s, ONS has served in a consultative role to facility nursing staff. Facility nurse executives participate in decision making at the national level through the National Nurse Executive Council (NNEC). Membership on the NNEC consists of one nurse executive from each VISN and Central Office nursing program directors. The Chief Nursing Officer chairs the NNEC. The main purpose of the NNEC is to establish, review, revise and administer the national nursing strategic plan. Deployment of the strategic plan is accomplished through work groups chaired by nurse executives on the NNEC in collaboration with other levels of staff from the field. NNEC members also share information and obtain feedback from other nurse executives in the VISN as well as nursing staff at facilities.

Through the leadership of the Chief Nursing Officer, VHA nursing is guided by its strategic plan, consisting of the following components: leadership development, interdisciplinary patient care delivery models, collaboration with external forces, development of nursing practice quality/performance indicators, nursing workforce, and technology/system development. The current strategic plan consists of the following goals in each of these areas:

- *Leadership development.* Operationalize the High Performance Development Model for all levels of nursing personnel.
- *Interdisciplinary patient care delivery models.* Collaborate to enhance interdisciplinary healthcare delivery models in VHA's dynamic/changing healthcare system.
- *External forces: Collaboration.* Develop and strengthen partnerships between nursing and "external" organizations.
- *Development of nursing practice quality/performance indicators.* Identify and measure key indicators to support evidence-based nursing practice.

- *Nursing workforce.* Recruit and retain a qualified nursing workforce.
- *Technology/system development.* Develop and enhance systems and technology to support nursing's role in healthcare delivery models.

VHA in the Future: *VHA Vision 2020*

In April 2003, VHA published its vision for the future. Included are the themes—refocusing on core veterans and implementing CARES (Capital Asset Realignment for Enhanced Services)—that build on recent organizational and delivery changes.

VHA health care is increasingly more patient-centered and is nationally recognized as a benchmark for health care management and delivery. In its report, *Leadership by Example,* the Institute of Medicine (IOM) praised VHA's use of performance measures to improve quality in clinical disciplines as well as ambulatory, hospital, and long-term care, stating that VHA's integrated health care system is one of the best in the nation (Institute of Medicine [IOM], 2003). To improve its ability to deliver health care to more veterans, *Vision 2020* states that VHA will increase its health care workforce by 800 physicians and 2,500 nurses by the end of 2004.

In keeping with its aim for patient-centeredness, VHA plans to expand a care coordination program that provides home care to patients. This program enables practitioners to manage patients in the home, 24 hours a day, 365 days a year. The program involves interactive sessions via the Internet, telephone lines, and tele-health units that assist providers in determining patient status and effectiveness of treatment plans. VHA is exploring computerization and new technologies that can be used by patients to monitor their blood pressure, blood glucose levels, weights, and other health status indicators and transmit these data via the Internet to VHA care providers. By keeping veterans in their homes and requiring their participation in monitoring their health status, VHA anticipates that the care coordination program will reduce hospitalizations, emergency room visits and prescription drug requirements (VA, 2003l).

VHA also has plans for long-term care that include an integrated care management system. This system will incorporate patients' clinical care needs and include more care in the home and community-based settings. The system will call for increased research and educational initiatives to determine how to optimally improve and structure delivery of services and outcomes for VHA's elderly veteran patients.

VHA's performance in quality indicators surpasses many government targets for health care quality. VHA is the benchmark for all 18 clinical performance indicators that include use of beta-blockers after a heart attack, breast and cervical cancer screening, cholesterol screening, immunizations, tobacco use screening and counseling, and guidelines for diabetes care. VHA will continue to use clinical practice guidelines to help ensure high-quality health care linked to improved health outcomes (VA, 2003l).

VHA is also providing a Web-based portal for patients to manage their health and health records. The program, "My Health*e*Vet," will create a web-based environment that allows patients to access their medical records, find the answers to health questions, and alert providers to

problems. In the future, patients will be able to reorder medications and schedule appointments online (VA, 2003l).

As VHA develops these innovations in health care delivery, VHA nursing is creating new and expanded nursing roles. For example, in the care coordination program, nurses will increase their abilities to coordinate care not only across settings but also through the remote delivery of care, including telephone, video, and the Internet. Future roles for nurses may be developed around this program to include tele-health nurse practitioner and Internet ask-a-nurse. Nurses are already well positioned to work with patients who are empowered to monitor their own health status, and in the future, nurses can play pivotal roles in teaching chronically ill patients and care givers additional ways to maintain and improve health and quality of life. VHA nurses will explore additional roles in disease state management, population health, and care coordination using the Internet as the communication medium.

Leadership

Findings from the literature. Strong and effective nursing leadership is critical for excellence in nursing practice. The recent IOM report, *Keeping Patients Safe: Transforming the Work Environment of Nurses* (*Keeping Patients Safe)* (2004), describes the relationship between work environment and the delivery of safe patient care. The IOM cites four serious threats to patient safety. Among those is a failure to follow management practices necessary for safety. These practices include balancing the tension between production efficiency and safety, creating and sustaining trust throughout the organization, actively managing the processes of change, involving workers in decision-making pertaining to the design of work and its flow, and using knowledge management practices to establish the organization as a "learning organization." Related to these practices, the IOM found that loss of trust in hospital administration is widespread among nursing staff and that clinical nursing leadership has been reduced at multiple levels, diminishing the voice of nurses in patient care decisions.

On the other hand, in magnet hospitals, the nursing leadership is characterized as participative, with the executive and unit level leaders being seen as visible and influential (McClure & Hinshaw, 2002). These hospitals structure nursing through a single department with a strong, visible, and visionary chief nurse executive and dynamic nursing managers for the units (McClure & Hinshaw, 2002).

Further, in magnet hospitals, strong, effective nurse leadership is evident throughout the organization. Especially pivotal in retaining nurses is the role of the nurse manager. The nurse manager typically directs the patient care environment, including budgeting and procuring supplies and equipment. The nurse manager is responsible for personnel management, including scheduling, counseling, and evaluation of staff. With the roles of chief nurse executives expanding, nurse managers have more responsibility for instilling and maintaining the organizational culture and values. The quality and support of managers are recognized as central to retaining nurses in magnet hospitals (McClure & Hinshaw, 2002).

Finally, magnet hospitals are characterized by their commitment to the development of managers. Nurse executives in magnet facilities have indicated the need for developing quality

middle managers. Therefore, these facilities tend to offer programs for assessment and training of managers. Staff nurses in these facilities view management training as a form of recognition and are eager to participate in these educational offerings (McClure & Hinshaw, 2002).

Nursing leadership must be responsible for changing nursing's roles as advances in health care research influence how health care is delivered. In its report, *Keeping Patients Safe: Transforming the Work Environment of Nurses*, the IOM calls for *transformational* leadership as an essential precursor to addressing nurses' work environment. Transformational leaders engage their followers toward pursuing jointly held goals and are perceived to be "inspiring" by their followers. In achieving transformational leadership, leaders create two-way communication and exchange of ideas and change the values and goals of followers by addressing their needs while moving the organization toward higher goals (2004).

In the *Call to Action* report, several recommendations related to nursing leadership were made. These included developing a cadre of well-qualified nurse leaders; enabling nurse executives to develop excellence in managing within the context of a nursing shortage; supporting the development of nursing self-governance models; and establishing a nurse executive special pay program (VA, 2001a).

The Commission supports the *Call to Action* recommendations on leadership. Additionally, the Commission makes recommendations that address responsibility, accountability, and authority; performance of managers; leadership development of all nursing staff; development of clinical leadership; compliance with standardized protocols for the Nurse Professional Standards Board; and interpretation of the Nurse Qualification Standards. Findings supporting each of these are described below.

Enhancing Nursing Leadership Responsibility, Accountability, and Authority and Participation at the Executive Levels in the Organization

Current VHA practice: VHA service line delivery system. In 1995 VHA reorganized its health care delivery system into integrated delivery networks (IDNs) to provide services across the continuum of care. Twenty-two IDNs were created, termed "Veterans Integrated Service Networks" (VISNs). This new structure was based on the concept of coordinating and integrating VHA's healthcare delivery assets and decentralized decision-making. The VISNs also sought to increase ambulatory care access points that emphasized primary care.

In order to best support the new decentralized structure**,** VHA Central Office was reorganized to accommodate the implementation of service (product) lines. The intent was to replace "stovepipe" structure organized around discrete professions and disciplines with a structure that would be organized around substantive clinical functions and product lines. Examples of such activities or product lines are primary care, acute inpatient care, rehabilitation, and long term care. The reorganized VHA Central Office would provide support for specific groups of patients or functions rather than advocacy for specific medical or technical disciplines. The only line responsibility to the VISN from the new Central Office would be the Office of the Under Secretary for Health and the Deputy Under Secretary for Health.

Reorganization in the VISN's and facilities was based on the assumption that with service lines, clinical care and structure would be better aligned. As a result, individuals from different disciplines were assigned to permanent service-delivery specific teams. Service line managers were selected from a variety of disciplines (VA, 2001c). In some facilities, the lines of authority and reporting for nursing changed, so that nurses ultimately reported to a service line manager who was not a nurse. In others, nurses became service line managers. Because of wide variation in structure and function of service lines among facilities, each facility had its own organizational structure/position for overall responsibility for nursing care.

At the present time, service lines continue to be widely used within VHA, but the structures vary considerably. In some facilities, there is a chief nurse executive who maintains direct accountability for nursing care, including fiscal decisions, while in others the chief nurse executive has less direct accountability for nursing care and fiscal decisions.

Findings from testimony, interviews, forums, web-based and faxed input. Testimony at the four regional hearings reflected perceptions about nurse leadership skills and competencies. Among those were statements of nursing administrators' failure to consult with nursing employees and other instances of poor communication among direct-care givers and administrators. There were also statements reflecting perceptions of nursing administrators' failure to advocate for nurses and diminished nursing presence at multidisciplinary meetings. Other statements reflected perceived lack of support from nurse managers. In the key informant interviews, several informants noted that service lines had been problematic, and at least one site had returned line authority for the facility nurse executive due to problems with morale that arose from service lines.

In faxed and web-based communications, a small percentage (8 and 5 percent respectively) related to leadership issues overall. Among these were concerns expressing perceived lack of nursing department accountability and diminished nursing representation in the hospital leadership structure.

Participants in the March 2003 VA Nursing Leadership Forum indicated that they would like to see the organizational structure changed in VHA in the following ways: (1) permit the facility nurse executive to manage his/her budget; (2) streamline the reporting lines so that the facility nurse executive reports at the Director level; and (3) eliminate service line structures that remove the nursing staff from nursing service.

Improving Nursing Leadership Functions

These functions include leadership development and accountability within the facilities and compliance with the Nurse Professional Standards Board protocols.

Developing leaders in the organization

Findings from VHA studies. Within VHA, a succession plan is in place to assure replacement at executive levels (VA, 2001d). This plan includes all types of RNs, and it projects losses, gains, and the need to replace nurses to 2007 (VA, 2001f).

Findings from testimony, forums, web-based and faxed input. At the March 2003 Nursing Leadership Forum, nurse leaders overwhelmingly supported more leadership development initiatives within the VA. Suggestions included restoring the Nurse Executive training program and providing adequate professional development resources for managers and executives.

Complying with and Standardizing the Nurse Professional Standards Boards (NPSB)

Current VHA practice. The NPSB consists of RNs appointed by management to consider employees for advancement, promotion, appointment, and retention beyond the probationary period. An RN serves as Chairperson of the NPSB. Any number of RNs may serve as board members; however, when a specific NPSB is convened, it is composed of three or five RNs depending on the duties and grade level of the employee being considered (the grade of members must be equal to or higher than the grade of the employee being considered). The NPSB is responsible for adhering to the established criteria in the Nurse Qualification Standards. The nurse executive and the NPSB chair are responsible for assuring that the criteria are applied in a consistent and uniform manner (VA Handbook 5005 Part II, Chapter 3, Section C, April 15, 2002).

When the NPSB makes a recommendation to management regarding advancement of an employee, management may approve or disapprove the recommendation. If the employee is not advanced to a higher level or promoted, the employee is entitled to formally request an independent higher-level review (called promotion reconsideration). The NPSB is also involved in special advancements that are advancements of 1 to 5 steps within the pay range based on exceptional performance or other accomplishments (research, involvement in professional associations, etc.).

The facility nurse executive has a pivotal role in assuring that Boards follow standardized processes and are equitable in their decisions. Within the facility nurse executive role is the responsibility to ensure appropriate composition and functioning of the Board. The facility nurse executive must also be knowledgeable about Title 38 and VHA regulations regarding the Board. In order to develop expertise in this area, VHA Nursing has conducted a number of workshops on the peer review process for facility nurse executives, NPSB board chairpersons, and Human Relations specialists. References and presentation materials are also available on the ONS web page (http://www1.va.gov/nursing/)

Findings from testimony, forums, web-based and faxed input. The most frequently cited concern across the four regional hearings related to the current peer review system, the NPSB and the Nurse Qualifications Standards (addressed in the next section). The NPSB is seen as providing a valuable opportunity for professional peer review and a means of assuring integrity of professional nursing practice. However, concerns were expressed about the NPSB, including lack of fairness, inconsistency in decision-making processes, and inappropriate composition of

boards (consisting of all administrative staff rather than a combination of administration and peers). There were also concerns relating to poor communication in articulating standards to new staff as well as board members receiving limited orientation to their roles. Some individuals commented that the Boards needed more oversight.

Interpreting the Nurse Qualification Standards

Current VHA initiatives. Registered nurses, LPNs, and nurse anesthetists are exempted from the competitive civil service hiring process. The Secretary of Veterans Affairs establishes qualification standards for these occupations. VHA Nurse Qualification Standards are used to appoint, grade, advance, and, in the case of RNs and nurse anesthetists, retain or separate probationary employees. Although VHA Nurse Qualification Standards differ for each category, they establish basic and specific requirements for placement of employees at each level or grade. There are provisions for deviations or waivers of grade requirements.

The basic qualification requirements for being a VHA RN have remained essentially the same for a number of years. However, in 1999, the Nurse Qualification Standards were revised to increase the education requirements at certain grade levels and establish within each grade performance requirements called "Dimensions of Practice." These nine dimensions (practice, quality of care, performance, education/career development, collegiality, ethics, collaboration, research, and resource utilization) are based on the American Nurses Association Standards of Care and Standards of Professional Practice (VA, 1999). Under these standards employees were to have had a baccalaureate degree in nursing (BSN) for advancement to Nurse II and a Master's degree in nursing or a related field with a BSN for advancement to Nurse III. Waivers of education were not permitted upon appointment, but the higher education requirements will not be applied to current employees until September 30, 2005. In addition, $50 million were set aside to assist employees in meeting these requirements. The higher educational requirements reflect organizational expectations such that RNs are generally expected to operate with more independence and to have a broader knowledge of nursing practice.

Revised Nurse Qualification Standards went into effect on January 12, 2002. These permitted the substitution of a bachelor's degree in a related field for the BSN requirement. The new Standards provide that RNs may advance to Nurse II if they possess an Associate Degree or Diploma and a bachelor's degree in a related field. Certain non-citizen nurses are also required to possess a certificate from the Commission on Graduates of Foreign Nursing Schools (VA, 2003i).

The Nurse Qualification Standards for nurse anesthetists were significantly modified with the implementation of locality pay at the beginning of the 1990's and were only changed to add certification by the Council on Certification of Nurse Anesthetists as a condition of employment in the middle 1990's. The Nurse Anesthetist Qualification Standard is under review for possible modification.

Qualification standards for LPNs are established by VHA, and relate to corresponding responsibility levels of General Schedule employees. VHA recognized that the grade range for LPNs was inadequate and in 2001 appointed a field-based work group to revise the standards. The new LPN standards were implemented in April 2003 (VA, 2003i). The new standard

provides for appointment and advancement of certain LPNs to the GS-7 grade level, that certain entry level employees may be appointed at GS-4, and that employees at all grade levels, including entry levels, may be assigned duties if their competence to perform clinical procedures has been validated and certified.

Findings from testimony, forums, web-based and faxed input. During the public hearing and comment period, the Nurse Qualification Standards also received much attention. Of those individuals presenting oral testimony at the four regional hearings, 75 percent addressed the qualification standards. Furthermore, of the 973 faxes received as of May 27, 2003, 64 percent addressed the Nurse Qualification Standards as a primary concern. The Commission also received 135 responses on the web site, and 25 percent of these addressed the qualification standards as a primary concern. Concerns addressed poor communication in articulating the standards, limited opportunities for advancement with current standards, and perceived inequities in administration and interpretation of the standards.

Professional Development

Findings from the literature. Professional development is the process of setting and pursuing educational and experiential programs and experiences to enhance one's ability to perform the various roles that nurses assume in practice. Professional development is critical to providing excellent nursing care for veterans as well as creating futuristic nursing roles in support of new patient care technologies. VHA supports professional development of nurses through a variety of initiatives and given the magnitude and complexity of VHA, nursing has the opportunity to expand, enhance, and showcase its commitment to professional development. The Commission heard and read reports of current VHA professional development initiatives and received input on issues related to professional development.

While in the end professional development is dependent upon the individual nurse, the organization creates a culture that values the development of each of its employees and furthermore, commits resources to assure that professional development occurs. In an early study, administrative support for professional development of nursing staff was identified as one of the key characteristics of the recognized magnet hospitals. Nurses perceived that the organizational focus on education was a commitment not only to improving the quality of nursing care but also to valuing the nurses themselves. Most magnet hospitals invested in tuition reimbursement benefits for their nurses, and the employers were perceived as supporting, promoting, and encouraging education (McClure, Poulin, Sovie, & Wandelt, 1983).

More recent studies of those facilities certified as magnet hospitals by the American Nurses Credentialing Center Magnet Nursing Service Recognition Program (ANCC) indicate that education and professional development continue to be financially supported and valued. The return on investment is mutual. Magnet hospital studies confirm that nurses are attracted and retained in hospitals that foster and reward professional development (McClure & Hinshaw, 2002). In return, nurses who participate in professional development form the cadre of experienced, competent nurses who provide nursing care that is associated with improved patient outcomes (Aiken, Clarke, Cheung, Sloane, & Silber, 2003).

The IOM report, *Health Professions Education: A Bridge to Quality,* called for a major overhaul in the education of health professionals. The 2001 IOM Report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, in support of patient care, quality, and safety, recommends that an interdisciplinary summit be held to develop recommendations to reform health profession education. The report found that "clinical education has not kept pace with or been responsive enough to the shifting patient demographics and desires, changing health system expectations, evolving practice requirements and staffing arrangements, new information, a focus on improving quality or new technologies" (IOM, 2001). The interdisciplinary groups made recommendations that included oversight, the training environment, research, public reporting and leadership. The report suggested that the education of health professions be based on a competency-based model that would emphasize the attainment of the following competencies: provide patient-centered care; work in interdisciplinary teams; employ evidence-based practice, apply quality improvement, and utilize informatics (IOM, 2003).

The Baldrige organizational performance improvement criteria also address professional development. Hospitals that focus on continual improvement of their processes recognize that there are organizational needs for continuing clinical education and gaining skills for knowledge sharing. Among those factors that ensure overall staff satisfaction, motivation, and high performance are staff development and career opportunities (2003).

In preparing nurses for the future, the American Association of Colleges of Nursing (AACN) is currently spearheading a discussion among nursing educators, nursing service providers, and other stakeholders in nursing care about future roles for nurses. The AACN document, *Working Paper on the Role of the Clinical Nurse Leader,* states that for nurses to meet the health care needs of society, the profession must produce graduates who are prepared for clinical leadership in all health care settings, who can implement outcomes-based practice and quality improvement strategies, who are career professionals remaining in and contributing to the profession, and who create and manage systems of care that are responsive to the health care needs of the society. Clinical nurse leaders will be leaders at the point of care delivery across all settings. These individuals will assume accountability for client care outcomes through the assimilation and application of research-based information. They will serve as providers and managers of care at the point of care to individuals, groups, and/or populations. Additionally, clinical nurse leaders will coordinate, delegate, and supervise the care provided by the health care team, including nurses, technicians, and other professionals (American Association of Colleges of Nursing [AACN], 2003).

The clinical nurse leader is one concept being advanced to strengthen the nurse's role at the point of care delivery. Kimball and O'Neil describe nurses as "professional partners." Three examples in the "professional partner" paradigm already exist but have potential for future expansion and refinement within VHA. First, nurses serve as care coordinators of the frail elderly in the community where services are based on a multidisciplinary model. The model includes nursing, medicine, and dentistry and involves such settings as hospice and acute-care. Nurses also coordinate non-health services such as meals and transportation. A second example, already being implemented in VHA, is the nurse as case manager for patients being treated in home through biometric monitoring where nurses provide personal support between clinician

visits, either in person or through tele-health modalities. A third example is the nurse as member of a critical-care monitoring program through an off-site electronic intensive care unit system. In this model, a critical care nurse works with a physician intensivist to monitor and provide immediate response and clinical support to the on-site critical care nursing staff in outlying units. Patients are monitored through television monitors, electronic medical records and other decision support tools (Kimball & O'Neil, 2002).

Promoting Individual Career Development

Findings from testimony, forums, web-based and faxed input. From the employee information obtained through faxes, hearings, and web postings, education reimbursement, continuing education, and skills training for RNs, LPNs, and NAs were recurring themes. Staff indicated that tuition reimbursement processes were too complex and that often staff were required to pay out large unexpected sums. Furthermore, there were complaints that VHA reimbursement rates for semester hours were too low in some areas of the country and that VHA should reimburse at rates that reflect regional education costs. Additional input indicated that consideration should be given to the provision of compensation for full time study as well as salary advancement in recognition for advanced clinical training.

Nursing staff also stated that they were not supported with funding or replacements if they chose to attend continuing education sessions. When there are programs in place to support the education of nurses, nursing staff especially in rural areas complained that there was little access and support to attend educational programs. Nursing staff were frequently told that there were no funds to permit them to attend continuing education. Funds notwithstanding, staff also stated they were not able to attend continuing education programs because their units were short-staffed.

At the nursing leadership forum held in March 2003, VHA nursing leaders envisioned the future nursing workforce at VHA as being more educated with more emphasis on career enhancement. These leaders indicated that VHA must support education in order for VHA to attract, develop, and retain nursing leaders. To accomplish this, the leaders indicated that VHA should continue its academic affiliations, provide educational reimbursements, and promote educational requirements for RNs.

Current VHA initiatives. As one of its four statutory missions, VA conducts an ongoing education and training program for health professions students and residents to enhance the quality of care provided to veteran patients within the VHA healthcare system. In accordance with this mission, "To educate for VA and for the Nation", education and training efforts are accomplished through coordinated programs and activities in partnership with affiliated U.S. academic institutions (VA, 2003c).

VHA sponsors a variety of educational programs that promote professional development of nursing personnel. The programs include the Health Professionals Educational Assistance Program (HPEAP), within which are the Employee Incentive Scholarship Program (EISP) and the Education Debt Reduction Program (EDRP). Another program for nursing education, the National Nursing Education Initiative (NNEI), is a component of the EISP. The EISP, NNEI,

and EDRP are centralized programs administered by the Health Care Staff Development and Retention Office (HCSDRO). Each of these programs is described briefly in the next few paragraphs.

The EISP authorizes VHA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel are difficult. EISP awards cover tuition and related expenses such as registration, fees, and books. The academic curricula covered under this initiative include education and training programs in fields leading to appointments or retention in title 38 or hybrid title 38 positions listed in 38 U. S. C. Section 7401. The specific health care professions include medicine, dentistry, podiatry, pharmacy, licensed practical/vocational nursing, expanded-function dental auxiliary, registered nursing, nurse anesthesia, physician assistance, optometry, physical therapy, occupational therapy, and respiratory therapy. Public Law 108-170 added doctors of chiropractic to title 38 and covered a number of occupations under the hybrid title 38 authority.

The maximum amount of a scholarship that may be awarded to an employee enrolled in a full-time curriculum in FY 2003 was $32,043 for the equivalent of 3 years of full-time coursework. Through this program the VHA can obtain new nursing personnel as individuals complete entry level nursing education as licensed vocational/practical nurses (LVN/LPN) and RNs. Through FY 2003, 50 employees were enrolled in LVN/LPN programs with 8 graduates, and 260 were enrolled in associate degree in nursing programs with 34 graduates in 2003. Since its inception, VHA has awarded $43.9 million in scholarship awards through the EISP (VA, 2003j).

The NNEI component of EISP specifically supports educational opportunities for VHA's RNs to expand their formal education by funding baccalaureate in nursing and advanced degrees. NNEI funding was initially apportioned from the EISP funds in the amount of $10 million per year for five years commencing in 2000. As of September 2003, NNEI scholarships had been awarded to 3,211 VA RNs with 495 of the participants graduating in 2003 (VA, 2003j).

Consistent with the primary goal of increasing the number of baccalaureate prepared nurses, approximately 58 percent of the NNEI awards are for RNs enrolled in BSN programs. Additionally, staff nurses received 83.8 percent of the awards (VA, 2003j).

The NNEI also supports advanced nursing practice. As of September 2003, the NNEI had 1,209 master's level, 61 doctoral level, and 82 post-graduate level participants. NNEI participants must agree to remain with VHA for up to three years after completing their academic coursework. The fact that NNEI participants typically work full-time while pursuing their academic studies enhances the retention value of the program. Through FY 2003, approximately $37.5 million were obligated for NNEI scholarships for coursework that averaged 2.2 years per participant. The average total award per participant was $11,691 (VA, 2003j).

The Education Debt Reduction Program (EDRP) authorizes VA to provide education debt reduction payments to employees with qualifying loans who are recently appointed to positions providing direct-patient care services or services incident to direct-patient care services for which recruitment and retention of qualified personnel are difficult. An employee is considered to be recently appointed to a position if that individual has held the position for less than six months.

Registered nurses represented 46.6 percent (1,337) of the 2,872 EDRP awards that were authorized in FY 2003. Additionally, RNs accounted for nearly $19.2 million, or 35.8 percent of the $53.6 million that was authorized for the FY 2002 awardees. The average total award for RNs amounted to $14,333. The EDRP has been a powerful recruitment incentive for RNs (VA, 2003j).

Recognizing the need for more aggressive nurse development programs and as a follow up to the *Call to Action* recommendation to fund upward mobility positions for each facility, VHA approved in September 2003 two initiatives aimed at professional development. First, funding dedicated to the National Nursing Education Initiative (NNEI) and Education Debt Reduction Program (EDRP) for nurses was continued at $10 million per annum. The second initiative consists of funding upward mobility positions for LPN and RN education. This is a critical component as it provides new nurses for the workforce and is a primary source of career development for current VA employees. This program will be implemented in FY04 and will provide salary replacement dollars, replacement employees, and funds to cover the cost of tuition, books and certain fees to allow employees (75 positions) enrolled in Licensed Practical (or Vocational) Nurse (LPN/LVN), Associate Degree in Nursing and Bachelor's Degree in Nursing programs (200 positions) to pursue their studies on a full-time basis.

Establishing a National Policy Guidance for Schools of Nursing and Actively Promoting Nursing School Affiliations

Current VHA Initiatives—the CARES Commission and the VA Learning Opportunities Residency program (VALOR. The Capital Asset Realignment for Enhanced Services (CARES) Commission is charged with reviewing VA capital assets to recommend the realignment and reallocation of VHA health services over the next 20 years. In February 2004, the Commission found that, given the trends in supply and demand for nurses, the VA should position nursing more prominently in its educational initiatives.

The CARES Commission recommends that VA establish national policy guidance for schools of nursing comparable to the medical school model in Policy Memorandum #2 (Appendix L) Established in 1946, this memorandum created a formal relationship between VA facilities and schools of medicine and teaching centers in order to enhance quality care. The partnership between academic medicine and VHA continues to the present time. It is a key attraction in the recruitment and retention of academic physicians for research, education, and clinical care in VA facilities. In fact, in FY 2002, 16,000 medical students received training at VA facilities. This figure represents more than 67 percent of all medical students (VHA, 2003c).

VHA offers the VA Learning Opportunities Residency (VALOR), which is a program for nursing students who have completed their junior year in baccalaureate degree programs. This program has been operational since 1990 and provides paid, precepted work experience for nursing students with the goal of retaining those students as VA employees following their graduation. The funds are always utilized with facility requests for additional positions

exceeding the funding limitations. The majority of medical centers (116 of 162) have at least one VALOR student.

Work Environment

Implementing Staffing Plans

Findings from the literature. Adequate staffing is essential for quality patient care and patient safety. Recent large-scale and national studies have demonstrated the relationship between nurse satisfaction, patient outcomes and RN staffing levels. A number of factors are involved with adequate staffing. These include the education and experience of the nurse, the skill mix of the nursing personnel, the acuity levels and turnover of patients, nurse-physician collaboration, a supportive supervisor, and a sense of trust and rapport among team members (McClure & Hinshaw (2002).

The AHA's Commission on Workforce for Hospitals and Health Systems (AHA's Workforce Commission) identified that changes in workload, which include a faster pace and increased fragmentation, may result in harried dissatisfied caregivers with less time at the bedside. The Workforce Commission recommended assessing and monitoring the number and mix of staff so that safe and timely care can be administered (AHA, 2002).

The IOM report, *Keeping Patients Safe,* includes a comprehensive review of work environment issues, including research on staffing and patient outcomes and concerns regarding current staffing methodologies. The report delineates principles for developing and testing staffing plans that have the following characteristics: incorporate admissions and discharges and less-than-24 hour patients into estimates of daily patient volume; involve direct-care nursing staffing in selecting, modifying, and evaluating staffing methods; and provide for "on-time' staffing to accommodate unpredicted variations in patient volume and/or acuity. The IOM report also recommends that hospitals employ staffing practices that identify needed nurse staffing for each patient per shift and that hospitals should perform ongoing evaluation of the effectiveness of their nurse staffing practices (2004).

In addition, the *Call to Action* report recommended that VHA eliminate shift rotations and dependence on overtime and hire ancillary support staff to relieve nurses from performing non-nursing tasks. Non nursing tasks identified as seen most frequently were housekeeping, messenger and other clerical duties and utilization of nursing staff to substitute for absent allied health and ancillary positions. This report also recommended that nurse executives be authorized to evaluate staffing variances and when necessary, to make staffing adjustments or limit the number of patients to be managed (VA, 2001a).

Findings from testimony, forums, web-based and faxed input. The most frequently recurring theme in testimony related to Work Environment was *staffing*—nursing staff and ancillary support staffing shortages. Associated with inadequate staffing were its consequences—increased workload and burnout. Testimony was also directed at the absence of a staffing methodology for workload and outdated patient acuity measures. Some nursing staff testified

that there was a perception that budgets were being met by keeping staff to a minimum. There were concerns that inadequate nurse staffing was associated with difficulties in providing adequate care to veterans.

Current VHA initiatives. In 1991, a panel of nationally distinguished staffing experts, in collaboration with VHA staff, made recommendations to completely overhaul VHA's method for staffing. Prior to this time, VHA used a patient classification system for determining staff requirements. The panel recommended that VHA move beyond projecting staffing requirements through the patient classification system to a system that would support decision-making with overall resource management. This system became known as the Expert Panel-Based Methodology for Nurse Staffing and Resource Management (Staffing Methodology).

The Staffing Methodology was implemented in some VHA facilities between 1993 and 1994. Factors that influenced implementation included whether the facilities had resources to support data gathering, staff to support an expert panel, and sufficient oversight and monitoring for implementation. Some facilities were unable to implement the Staffing Methodology because its implementation was considered labor and resource intensive. Currently, the Staffing Methodology is inconsistently utilized across VHA. Therefore, there is no system wide methodology for determining staffing needs.

Reviewing Recommendations in the IOM Report, Keeping Patients Safe: Transforming the Work Environment for Nurses

The IOM report discusses the evidence base for medical error potential within nurses' work environment. Specifically the report documents practices leading to unsafe workforce deployment, work and workspace design, and "punitive" (2003, p. 7) cultures that hinder the reporting and prevention of errors. The report further recommends the need for "bundles of mutually reinforcing patient safety defenses in nurses' work environments" (p. 7) that can be created through transformational leadership and evidence-based management, maximizing workforce capability, designing work and workspaces to prevent and mitigate errors, and creating and sustaining a culture of safety. The Commission's recommendation directs VHA to evaluate the IOM report recommendations and act on those that will improve patient safety and quality of care.

Respect and Recognition

Recognizing Achievement and Performance

Findings from the literature. Respect and recognition of nurses and nursing are values integral to the mission and vision of VHA. Respect and being valued are top characteristics that nurses look for in their work settings (American Organization of Nurse Executives, 2000). The importance of respect and recognition was cited in the IOM's report on safety and error reduction, which requires an organizational commitment to vigilance for potential errors.

Rewards recognize and reinforce valued performance. Thus, the use of rewards is integral to creating a culture of value, respect, and safety for quality patient care (IOM, 2004). The AHA

Workforce Commission stated that hospitals must develop a range of rewards for workers that reflect their high value to the organization. This includes working with employees to develop a comprehensive rewards strategy that broadly reflects the high value of hospital workers to their communities and the hospital. Further, hospitals should include an employee recognition component in the hospital's comprehensive rewards strategy (2002).

In the VHA *Call to Action* report several recommendations were issued relating to Respect and Recognition. Among them were to establish a dedicated, equitable and consistent awards budget for nurses at the medical center level and to create strategies to encourage and reward nurses for staying in direct patient care positions.

Findings from testimony, forums, web-based and faxed input. In the four regional hearings, Commission members heard testimony related to respect and recognition, including the following perceptions: nurses feel unappreciated, and bedside nursing is not valued; awards programs have been put on hold; retention and recruitment bonuses are not used for RNs; there are no expectations that managers sustain programs to award and recognize employees; and there is a lack of recognition of minority nurses. The March 2003 Nursing Leadership Forum participants stated that improving the image of nursing within VHA would be one means to attract, develop, and retain nursing leaders.

Current VHA initiatives. Since 1984, VHA has recognized excellence in nursing through the Secretary's Award for Excellence in Nursing. Other awards include the Secretary's Award for Advancement of Nursing Programs--Facility Director, the Secretary's Commendation Award for Outstanding Performance in Nursing Research, and the Secretary's Award for Advancement of Nursing Programs--Nurse Executive.

The Excellence in Nursing Award annually honors one RN in each of the following categories--staff nurse and nurse in expanded role. Each of the honorees must additionally be actively engaged in the care of patients at a VA facility.

The Advancement of Nursing Programs Award annually honors one facility director and one nurse executive. A VA Medical Center Nurse Executive is selected, who has achieved distinction in promoting VA's nursing program. The honoree is selected for his/her ability to influence the work environment and relationships among health care professionals involved in ensuring quality patient care and to create a professional nursing climate that promotes career development and enhanced/rewarding roles in patient care, management, and research.

The newest national award is the Office of Nursing Service Innovations Awards Program, established in April 2003. In an effort to recognize nursing leadership in quality improvement, the Office of Nursing Service solicited submissions for best practices centered on the themes of care coordination and patient self-management. Team submissions were required to describe quality improvements initiated and led by nursing staff that address the concepts and aims described in the 2001 IOM report, *Crossing the Quality Chasm: A New Health System for the 21st Century.* Submissions were ranked based on the significant role of nursing leadership in these initiatives, emphasizing either care coordination or patient self-management.

In addition, VHA nurses periodically earn recognition, awards and grants from other VA and non-VA entities. Nurses are recognized, either in national VHA nursing forums or in national VA/VHA leadership forums.

Creating a Culture of Respect

Findings from the literature. The AHA's Workforce Commission reported that many hospital workers do not feel valued and discourage others from entering health care. To resolve this, the Commission recommended that hospital and health system leaders, including governing boards, executives, managers, and physicians—create a culture in which all workers feel valued. This includes increasing the ability of employees to be heard by decision makers at all levels in the organization and helping employees develop the skills necessary to understand and participate in discussions of organizational issues.

The IOM report, *Keeping Patients Safe,* characterizes the organizational culture that promotes safety as one in which everyone in the organization is a valued contributor. People in the organization recognize and state the need for collaboration among departments and functions. They receive support from management for collaborative work. Further, the relationship between management and employees is respectful and supportive (2004, 297).

In addition to respectful, supportive relationships among management and employees, collaborative and collegial nurse-physician relationships are noted to be associated with retaining nurses in the workplace (Aiken, Smith & Lake, 1994; Buchan, 1999; Kramer, 1990a; Kramer & Hafner, 1989; Kramer et al., 1989; Kramer, 1990b; Kramer & Schmalenberg, 1993; Havens & Aiken, 1999; McClure & Hinshaw, 2002; McClure, Poulin, Sovie, & Wandelt; 1983; Scott, Sochalski & Aiken, 1999). Good nurse-physician relationships are also integral to giving quality care (Peters & Waterman, 1982; Kramer & Schmalenberg, 1988; Kramer, 1990a).

Current VHA initiatives. Stress and Aggression in the Workplace – A VA Collaboration Action Research Project has demonstrated that workplace climate and design (especially "involvement and influence" of the worker) has the strongest influence on employee satisfaction – stronger than perceived quality or pay.

The Nurse – Physician Collaboration Breakthrough Series is currently being implemented through the Field Office of the VA National Center for Patient Safety in White River Junction, Vermont. It accommodates 50 self-selected teams (5-7 members each) from throughout the country. Among its goals are to foster greater awareness/knowledge of the scope of the problem of nurse retention (succession planning) and nurse-physician interactions as they relate to quality patient care; build specific skills and abilities to improve quality patient care through improving a range of workforce issues; and identify/develop and awareness and solutions to real local problems related to nurse/physician interactions.

Fair Compensation

Findings from the literature. On average, national RN salaries are significant influencing factors but not the primary motivators for remaining in nursing. Among nurses who have considered

leaving patient care, the highest ranked reason (56%) was for a less stressful/physically demanding job. More money was ranked third (18%). And when queried about the most enjoyable aspects of being a nurse, the majority (62%) replied helping patients and their families. Salary ranked last at 5 percent. When asked about changes that would do the most to improve their jobs, nurses ranked highest increased staffing (43%). Higher wages and better fringe benefits were ranked third at 27 percent (Peter D. Hart Associates, 2001).

Economic theory suggests that when a job category is in high demand with an inadequate supply, employers will increase wages to attract these workers. In the RN shortage of the late 80s, wages increased more among RNs (20.7%) than across all professional employees (16.0%). With the balance restored and an apparent over-supply of nurses in the mid-90s, wages stagnated, and fewer persons enrolled in nursing programs across the country (Congressional Research Service [CRS], 2001). That decline in enrollments persisted until recently.

With the current shortage, nurses' wages have risen. To determine if wages alone can eliminate the projected long-term gap between supply and demand, Spetz & Given found that increasing wages by themselves would not solve the nursing shortage. Using a forecasting model, the researchers determined that, in order for wages alone to balance supply with demand, inflation-adjusted wages would have to increase up to 3.8 percent every year—until 2016, resulting in nearly a 70 percent cumulative increase, an increase not likely sustainable by the health care industry (2003).

Achieving Fair Compensation for RNs

Findings from testimony, forums, web-based and faxed input. Numerous concerns were expressed about locality pay. There were perceptions that determining locality pay is a highly subjective process, varies across facilities, and is based on an antiquated pay scale that has not been adjusted to reflect current practice expectations. VHA is perceived as unable to remain competitive, at least in part because of budget limitations. Additionally, there was the expressed sentiment that "laws" prohibit VA from being a pay leader.

A review of the March 2003 annual report on The Use of Authorities to Enhance the Retention of Experienced Nurses, revealed that only 32% of VA facilities made a locality pay adjustment in January 2003. 68% of facilities gave the 3.1% cost of living adjustment.

Of the faxes received and web postings, 12 and 34 percent respectively were devoted to compensation issues, including concerns about locality pay, weekend premiums for nursing assistants (NAs), LPN pay, inflexible benefits, discrepancies between General Scale and nursing pay schedules, and compensation issues for LPNs who become RNs.

In key informant interviews, participants indicated concerns about compensation. With regard to salary, the administrators noted they had difficulty in meeting prevailing RN wages due to wage inflation.

In March 2003, the participants in the Nursing Leadership Forum were asked to identify characteristics they would like to see improved in the VA. Among the highly ranked items were pay issues, improved locality pay processes, human resource rules and regulations to enable

direct hiring of NAs, delays in hiring, premium pay for NAs, and ability to give steps/grades to clinical staff more easily.

Current VHA initiatives: the Locality Pay System. In 1946, President Truman signed Public Law 79-293 establishing a Department of Medicine and Surgery (now Veterans Health Administration), and a personnel system separate from the competitive civil service. A flexible system was needed so the Veterans Administration (now Department of Veterans Affairs) could recruit and retain demobilizing VA physicians, dentists, and RNs, most of whom had been detailed to the military. A nationwide 8-grade and pay structure for RNs was established, with grades and pay rates related to the General Schedule, the nationwide grade and pay schedule used for most Federal employees.

In 1973, VA received legislative authority for premium pay (overtime, night, holiday, Sunday, and on-call pay), and this reduced, but did not eliminate the need to approve salary rates. Maintaining a nationwide pay schedule along with an administrative apparatus for approving special salary rates meant VA was unable to quickly respond to changes in local labor markets, a factor that often contributed to recruitment and retention problems.

In the late 1980s, nursing shortages made it extremely difficult for VA to effectively respond to quickly changing local market conditions. The nationwide pay schedule was not working as demonstrated by the fact that most VA RNs were receiving centrally approved special salary rates. In 1991 VA implemented a 4-grade Locality Pay System for RNs and nurse anesthetists that based VA salaries on the salaries of comparable non-VA nurses in the local labor market. VA established two levels within each grade, and salaries were to be determined through job matching and salary surveys. A fifth grade was added in 1993, and it remains today. Nurse I is the entry grade, and within that grade there are three levels. Nurse I is the only grade with levels.

The Locality Pay System was an improvement over the nationwide pay system; however, as competition for nursing staff increased, VA's competitors became less willing to provide VA with salary survey information. Registered nurse salaries also were being tied to recruitment and retention statistics and budgets so that RNs at several VA facilities received no salary increases for several years. In 2000, Congress enacted legislation requiring VA to annually apply at a minimum the amount of the General Schedule pay increase to RNs. This legislation also permitted VA to use third-party surveys to set RN salaries. In addition, facility directors were authorized to extend the rate range of Nurse 1 to a step rate within 6 percent of the maximum rate for Nurse II.

The Locality Pay System does not cover LPNs and NAs. Their grades and salaries correspond to those on the General Schedule.

Promoting Recruitment and Retention of LPNs and NAs Through Hiring and Compensation Policies

Findings from testimony, forums, web-based and faxed input. In key informant interviews, participants noted difficulty in meeting prevailing LPN wages because LPN wages are not adjusted using the same methodology as for RNs.

Current VHA practice: Special salary rates in 38 U.S.C. 7455. Under 38 U.S.C. 7455, the maximum rate of any approved special salary rate range may not exceed two times the amount by which the maximum rate for the grade exceeds the minimum rate for the grade. This works out to be Step 28 of the expanded General Schedule. When special rates are authorized for a position, a 10-step range from the expanded schedule is chosen for each grade. The 10^{th} step for each range may not exceed the 28^{th} step of the General Schedule. The only positions currently excluded from this limitation are pharmacists, physical therapists and nurse anesthetists. Adding LPNs to this list would facilitate more flexibility in adjusting LPN compensation.

Current VHA practice: Compensation for LPNs. The salaries of VHA LPNs converted to RN positions are based on the employee's "highest previous salary rate." Depending on the relative positions of the LPN and RN salary schedules, some employees actually receive minimal pay increases upon conversion to RN positions. Some LPNs who convert actually receive less compensation upon boarding to RN positions. The salaries of individuals appointed as RNs from outside VA also do not reflect prior LPN experience.

Current VHA practice: Appointment, advancement and pay of NAs. VHA nursing assistants are appointed under competitive civil service procedures and the provisions of title 5, United States Code. Individuals wishing to work for VHA must submit employment applications to the Office of Personnel Management or VHA Delegated Examining Unit (certifying office). The certifying office evaluates the application against Office of Personnel Management qualification standards and advises the applicants of their rating. The facility describes the duties and responsibilities of the position that are then graded in accordance with Office of Personnel Management classification standards.

When facilities have vacancies, they request a list of eligible candidates at the approved grade level from the certifying office. Once the list is provided, facilities contact the individuals for interviews and possible selection. Even if the process goes well, it takes individuals months to actually get appointed to VHA positions. In many instances, facilities have to resort to temporarily appointing individuals under title 38 until their appointments can be approved under civil service procedures.

Generally, employees below the "journeyman" grade (GS-5) can be promoted without competition. However, all vacant positions must be advertised to internal candidates through local competitive merit promotion procedures. This often delays filling these positions for weeks. The process is required as a specification of collective bargaining agreements.

Prior to December 6, 2003**,** NAs did not receive basic and premium Saturday pay under title 5, United States Code. These are benefits received by RNs and LPNs.

Strengthening Human Resource Systems and Departments

Findings from VHA reports. Human resource (HR) deficiencies were noted in the *Call to Action* report. Recommendations included initiating a national program that demystifies and facilitates the use of existing pay authorities. The report recommended that HR enhance recruitment and retention practices.

In 2001, a Nurse Hiring Timeline Work Group (Group) was established to address issues in the pre-employment process for RNs. The task of the Group was to explore ways that facilities could reduce the time from interview to Entry-on-Duty for new hires and to prepare a succinct brochure to outline the nurse application process for prospective applicants.

The Group surveyed the facilities about their hiring timeline practices. Of 162 facilities, 56 (35% response rate) indicated that 28 (50%) had nurse recruiters. The following table summarizes the results of this survey. These results indicate that in those facilities with nurse recruiters, the hiring timeline for nurses was 22.59 days compared with 27.79 days in facilities without nurse recruiters. However, the Group cautioned that no conclusions could be drawn from the differences in time-to-hire for facilities with nurse recruiter positions because of individual differences in hiring processes within facilities.

	Range – Time to Interview	Average Time to Interview	Range – Time to Select	Average Time to Select	Range – Time to EOD	Average Time to EOD
No Recruiter	2 days-2 months	10.77 days	1 day – 5 weeks	7.4 days	1 week – 9 weeks	27.79 days
Recruiter	1 day – 6 weeks	13.2 days	1 day – 9 weeks	10 days	2 weeks-9 weeks	22.59 days

The Group identified 14 delay/barriers that impede the nurse hiring process. These included environmental constraints, such as the nursing shortage; VHA Central Office policies, such as budget and non-competitive salaries; and facility concerns, such as drug screening turnaround times, reference checks, and boarding (bringing the new employee on board) delays. At the same time, the Group also noted that individual facilities had developed strategies to overcome some of these barriers. Information on how broadly the best practices were disseminated is not available.

Findings from testimony, forums, web-based and faxed input. In the March 2003 nursing leadership forum, there were multiple comments by participants about VHA HR processes. When asked about what needs to be improved, the participants indicated removing HR restrictions for terminations, more administrative support to nursing, and decreasing delays in hiring.

Current VHA initiatives. The VHA National Nurse Executive Council (NNEC) has been tasked with implementing the recommendations in the *Call to Action* report. By September 2003, the NNEC had reported progress in implementing the *Call to Action* recommendations as follow:

- Established benchmarks for usual time to hire (2-3 weeks).
- Developed and distributed a *Guide to VA Pay and Hiring Authorities* brochure.
- Implemented an all-employee entrance survey to address factors that influenced personnel to become employed at VHA.
- Developed a recruitment and retention manual containing recruitment and retention initiatives that have well developed templates and strategies for implementation as well as creative ideas of other strategies that can be developed more fully.

Technology

Expanding the VA Nursing Outcomes Database
Evaluating and Redesigning Nursing Work Processes
Using Technology to Improve Nursing Care

Findings from the literature. The practice of nursing in the future should make the most efficient and productive use of technology as it helps to transform how nursing care is administered. Technology is defined as the application of scientific or other organized knowledge--including any tool, technique, product, process, method, organization or system--to practical tasks. In health care, technology includes drugs; diagnostics, indicators and reagents; devices, equipment and supplies; medical and surgical procedures; support systems; and organizational and managerial and managerial systems used in prevention screening, diagnosis, treatment and rehabilitation (National Information Center on Health Services Research & Health Care Technology [NICHSR], 2004).

Four key areas of healthcare delivery can benefit from technology. These are decision support, streamlined and integrated documentation support, embedded metrics, and workflow management. Decision support can be provided by technology to help the nurse with protocols for medication administration, admission, patient rounding, and discharge and transfer functions. Streamlined and integrated documentation support can transform documentation so that there is only one entry into a patient documentation system. Embedded metrics can measure the intensity of care, the care provided, the impact of care on outcomes, and the comparison of care provided by best practices. Workflow management tools can help orchestrate the numerous, often simultaneous, processes of caring for patients by putting tasks in individual work lists, monitoring to ensure tasks are completed, and notifying when tasks fail. Use of these technologies has the potential to transform nursing practice into a high-tech, high-touch, high-productive evidence-based discipline (Kennedy, 2003).

The *Call to Action* report recommended that VHA make maximum use of technology to optimize nursing practice and create safe working environments. This would require clinical end-user participation in development, trials, and evaluation prior to implementation. It would also involve provision of state-of-the-art software, a system of evaluating the effects of technology before implementation, provision of equipment to support physical care (such as lifting devices), adequate training on technology, and a system for ongoing evaluation of the effectiveness of the technology by the end-users.

Findings from testimony, forums, web-based and faxed input. There were isolated comments offered in testimony related to the use of technology. These were aimed at technology inefficiencies, or the perception that technology caused more work for nurses instead of less. Nursing staff cited that VHA has a dual system for nursing documentation. The Computerized Patient Record System (CPRS) does not include certain forms for documenting nursing care; therefore, nursing staff document some of their care in the computer and other parts of care on paper. Information systems problems were perceived to increase the task burden on nursing

staff, rather than decreasing it, because of the significant amount of time used in managing data input.
In key informant interviews, participants expressed concerns over the use of technology. Technology was generally seen as a satisfier for nursing staff, especially the technologies used in ICU monitoring, patient lifts and patient record systems. Several respondents cited the Bar-Coded Medication Administration (BCMA) as problematic. BCMA problems relate to how BCMA was planned (without nursing input) and how it was rolled out in patient care units (training, timing, staffing). Nurses also complained about the difficulty in using BCMA in ICUs. Nurses were supportive of the outcomes achieved once BCMA was integrated into the unit.

In March 2003, the participants in the Nursing Leadership Forum were asked to describe how VA nursing would look in the future. Participants envisioned nurses using electronic handbooks for standards, policies, and documentation tools.

Current VHA initiatives. There are two major information technology initiatives for nursing. The first is the Nursing Integrated Information System (NIIS). This presents existing patient care data in a user-friendly way. One of the requests nurses have made for improving information technology for nurses was to have an interface for all components of the patient information computer systems – Bar Code Medication Administration (BCMA), Computerized Patient Record System (CPRS), and Veterans Health Information Systems and Technology Architecture (VISTA). This project is currently a line item in the FY 04 budget.

The second project is under development. It will be an attempt to create a Nursing Administration Information System (NAIS). NAIS will integrate administrative databases, such as workload indicators, patient acuity, and financial reports, to improve and inform decision-making for nurse managers.

Research and Innovation

Establishing a Center for Excellence in Quality Nursing Care

*Findings from the literature***.** Predictions about the supply and demand for nurses indicate that the supply/demand gap will widen through 2020. Nursing care stakeholders must consider ways to deliver safe, quality nursing care within the constraints of a diminishing nursing workforce. VHA can employ its resources to experiment with the design and delivery of evidence-based clinical care models using a diverse skill mix of nursing personnel.

Integral to the implementation of an evidence-based staffing system are adequate data on nursing outcomes. VHA nursing leadership, through the National Nursing Executive Council, has launched a 16-month national pilot project to create a nursing outcomes database. This project, VA Nursing Outcome Data (VANOD), has three objectives: (1) to establish feasible, consistent, and reliable data collection methods for obtaining nursing-sensitive quality indicators and staffing at the patient care level; (2) to build the pilot VA nursing database; and (3) to develop prototype reporting processes and formats that will help sites benchmark and compare patient quality outcome indicators at the local, network, and national levels (Miller, 2003).

In addition to its three stated purposes, VANOD will assist in meeting Joint Commission on Accreditation of Healthcare Organizations (JCAHO) staffing effectiveness requirements. JCAHO's expectations are that hospitals measure their effectiveness through linking staffing effectiveness to clinical outcomes. Presently, four indicators must be tracked, several of which will be components of the VANOD database. This project has the potential to improve patient care processes, support nurse management decisions, and ultimately improve care to veterans (VA, 2003f).

The Under Secretary for Health will review a draft directive that requires facilities to develop and implement formal plans for linking levels and staff mix with patient outcomes and other performance measures. At the time of this report, the Directive has not yet been approved.

The *Call to Action* report recommended that evidence-based clinical practice models be developed to maximize the skills and knowledge of all levels of nursing staff.

Findings from testimony, forums, web-based and faxed input. In March 2003, the nursing leadership forum participants envisioned a future VA nursing which would include the development of new care models and models to work with increasing hospital acuity levels. These models would have the following characteristics: more support staff, proper utilization of the RN role, care coordination, role diversity, increased use of telemedicine and enhanced technology.

The next chapter presents the Commission's recommendations on leadership, professional development, work environment, respect and recognition, fair compensation, technology, and research and innovation.

CHAPTER 3

RECOMMENDATIONS

Introduction

In 2002, the National Commission on VA Nursing began its work of assessing legislative and organizational policy changes that would enhance the recruitment and retention of nurses and other nursing personnel by the Department of Veterans Affairs and assessing the future of the nursing profession within the Department. Chapter 2 of this report describes the Commission's assessment findings. This chapter outlines each of the Commission's recommendations in the areas of leadership, professional development, work environment, respect and recognition, fair compensation, technology, and research and innovation. Appendices D-J contains specifics for each implementation strategy, including accountability, recommended timeline with deliverables, and metrics.

The Commission also supports the recommendations cited by the Nursing Workforce Planning Group in the *Call to Action* report. The Commission believes that implementing both sets of recommendations will position VHA as the employer of choice for nurses and nursing personnel and assure nursing's presence and active role in the future. Each of the recommendations is described in further detail in appendices D- J. These appendices contain the recommendations' implementation strategies, accountability, timeline and deliverables, and metrics.

LEADERSHIP

Recommendation:

The facility nurse executive should have line authority, responsibility, and accountability for nursing practice and personnel. [Facilities wishing to be excluded from this recommendation should submit a waiver to the Secretary of Veterans Affairs office through the Office of Nursing Service.]

Recommendation:

The facility nurse executive should be a member of the executive body at VISN and facility levels.

The Commission found that the nursing administrative structure varied among the VISNs and facilities, primarily as a result of the institution of service lines. Some facilities have strong nurse executive presence and adequate communication from the executive level to the direct care providers. Others do not. In some facilities, nurse executives do not have line authority over nursing and to the facility director—they work within a staff arrangement. Testimony and key informant interviews reflect concern about the effectiveness of facility nurse executives' ability to be accountable and have the authority for nursing service.

In all matters related to nursing, the facility nurse executive must have the line authority and responsibility to speak for and direct nursing standards and practice and nursing personnel. In facilities where the facility nurse executive is not part of the leadership team, he/she must become an integral member with direct responsibility to the facility Director. The facility nurse

executive should be a member of the executive body at the VISN level as well. By including the facility nurse executive in administrative leadership entities at all levels within VHA, the challenges and concerns of nursing will be heard from the facility to the Central Office.

Furthermore, the facility nurse executive must have budgetary accountability for management of resources for nursing. The facility nurse executive should also possess hiring authority for nursing personnel.

In order to accomplish these changes, the Under Secretary for Health, along with the VISN and facility directors, will need to create a directive authorizing these changes and ensure that the changes are carried out within facilities.

The Commission recommends that facility nurse executives enhance and be held accountable for their communication with all areas of nursing service. This should be accomplished through developing, implementing, and evaluating communications plans

Recommendation:

> **The facility nurse executive should be accountable for (a) the effective performance of nurse managers, (b) leadership development of all nursing staff, (c) development and implementation of clinical leadership roles at the point of care, and (d) compliance with standardized Nurse Professional Standards Board (NPSB) protocols.**

The Commission recommends that the *Call to Action* report recommendation, 1.8, "Develop a cadre of well-qualified nurse leaders by ensuring that a representative number of nurses are included in all levels of VA leadership training" be fully funded and implemented (VA, 2001a). Other recommendations from additional reports on leadership development, such as *Succession Planning* (VA, 2001d) and *Workforce Planning* (VA, 2001f), should be carried out.

Leadership development at all levels of nursing must be implemented both through formal leadership development programs and informal leadership activities. Facility nurse executives should hold nurse managers and other facility nurse leaders accountable for performance standards that relate to leadership development. Facility nurse executives should include the number, extent, and effectiveness of leadership development activities in their annual reports.

Despite the presence of specific guidelines and policies for the Nurse Professional Standards Board (NPSB), there is evidence of inconsistent adherence to these, as presented in testimony from staff nurses. For example, the membership of the Board is not rotated consistently in all facilities, and the criteria for processing Board actions and carrying out the business of the Board vary across the VHA system. The Commission found that there were no written procedures for various aspects of the peer review process.

In order to eliminate the perceptions that NPSB membership is not representative of the nurses undergoing Board consideration, the Commission recommends that the Chief Nursing Officer be responsible for developing and implementing policies that assure equitable, standard NPSB

membership across facilities. To the extent possible, NPSB membership should reflect the total roles, grades, and diversity of the nursing staff.

Recommendation:

VHA should clearly define Nurse Qualification Standards to facilitate consistent interpretation across VA.

The Commission found widespread dissatisfaction among RNs with the education component of the Nurse Qualification Standards. Additionally, some RNs perceived that the administration of the Nurse Qualification Standards was subjectively and inconsistently applied.

The Chief Nursing Officer and facility nurse executives should create and implement policies aimed at removing these inconsistencies in interpreting the Nurse Qualification Standards. In facilitating adherence to the policies, the facility nurse executives should ensure that supervisors and employees alike understand the Standards, the proficiency rating system, and the processes by which the Standards are reviewed.

PROFESSIONAL DEVELOPMENT

Recommendation:

VHA should structure career development opportunities to assure that every nurse in VHA can actualize his or her goals within one or more career paths with the opportunity for professional growth and advancement.

The Commission found that there is widespread support for nursing education for VHA nursing personnel; however, it appears as though there is no coordinated plan for individual career development.

To implement this recommendation, the Under Secretary for Health should allocate a funding stream in the strategic plan priority for VHA that includes sufficient resources to implement this recommendation. Once funds are appropriated, the Chief Nursing Officer will assure that policies and procedures are developed and the plan is implemented that would provide for professional development of each individual nurse within VHA. This career plan should include the assignment of mentors to assist the nurse and sufficient release time so that the nurse can pursue a career path.

In structuring career development opportunities, VHA should consider the wide range and variety of nursing roles that will frame nursing practice in the future. These will include, but not be limited to, clinical nurse leaders at the point of care delivery, care coordinators in disease state and population health management, tele-health nurse coordinators and practitioners, Internet ask-a-nurse coordinators, cyberspace patient educators, nurse informaticists, and acute-care nurse practitioners/hospitalists. As nurses expand their roles, VHA should consider expanding the roles and competencies of LPNs and NAs and develop training programs accordingly. These roles should complement the expanded roles of nurses and serve, when appropriate, in support of other members of the health care team.

Recommendation:

VHA should establish national policy guidelines for schools of nursing comparable to the medical school model in policy memorandum Number 2 and actively promote nursing school affiliations. (Appendices K and L)

Establishing a comparable policy guidance for nursing will serve to expand formal relationships with schools of nursing and increase the numbers of undergraduate and graduate nursing students and nurses receiving their education at VHA facilities. Through a system built on the medical school model, VHA facilities will serve as laboratories for nursing research and education.

Further, nursing faculty and VHA nursing staff will serve in collaborative partnerships to develop new education models that will thrust VHA at the forefront of leading a national agenda for transforming nursing education. VHA should consider proactively testing with nursing education new and emerging nursing roles, such as clinical nurse leaders at the point of care, nurse informaticists in evaluating new nursing care technologies, nurse experts on bio-preparedness and other global challenges, and nurse (pharmaco- and bio-) geneticists in researching the effects of genetically enhanced medical therapeutics on patients and patient care.

In providing leadership to effect needed change in health care, the federal government has a unique position as regulator, purchaser, health care provider; and sponsor of research, education, and training (IOM, 2003). VHA is nationally recognized for supporting medical education programs and applied research programs enhancing patient care, quality, and developing new health care technology.

In order to execute this recommendation, the Under Secretary for Health and the Chief Nursing Officer, along with the VA Office of Academic Affiliations and academic partners, should develop the collaborative model that will achieve this recommendation's goal. Once the model is developed, the Chief Nursing Officer should assure that the program guide and implementation policies and procedures are developed. Within two years, the model should be tested in at least 20 facilities.

Recommendation:

VHA should assure that the VA's Health Professionals Educational Assistance Program is funded equitably with other federal programs such as military scholarships.

The Commission found that while VHA maintains a vigorous investment in medical education, it lacks comparable investment in nursing education except for its employees. VHA scholarships for undergraduate non-VHA employee students are not comparable with other federal programs, such as the uniformed services.

The Commission recommends that VHA consider funding an education program comparable to other federal programs such as medical scholarships. The program would enhance VHA's ability to recruit nurses. This program would require legislative action and thus, the Under Secretary for Health and the Chief Nursing Officer would be responsible for advocating for appropriation of funds to support the program.

WORK ENVIRONMENT

Recommendation:

VHA should develop, test, and adopt nationwide staffing standards that assure adequate nursing resources and support services to achieve excellence in patient care and desired outcomes.

The Commission found that concerns about staffing were one of the most frequently recurring themes heard in testimony. Staff expressed perceptions of burnout from increased workloads and inadequate resources.

In developing its recommendation, the Commission recognizes that safe, quality patient care is dependent upon the presence of sufficient numbers of experienced and educated nurses who have adequate support and resources. The Commission is not recommending that VHA establish minimum nurse-to-patient ratios. However, the Commission is recommending that VHA create staffing standards based on the development and testing of a workload system that considers multiple factors and patient outcomes. Among these factors are the education and experience of the nurse, availability of support services and staff, the physical lay-out of the work area, time away from the patient unit for committees and continuing education, and the involvement of the nurse in the education and training of nurses and other health professionals, to name a few. In addition, the system should be sufficiently flexible to adjust for changes in patient condition, discharges and admissions, and other factors that may vary shift to shift. VHA maintains electronic technology and databases that could support the development of patient acuity and staffing standard systems. The Commission has also recommended that VHA continue to support the development and implementation of VANOD, which provides the evidence base for patient outcomes that can be linked to staffing and workload. VANOD will assist in measuring the effectiveness of the staffing standards. VHA must provide sufficient nursing staff such that nursing care is consistent with standards of nursing practice, patient safety, and patient care needs.

The Commission also recommends setting into action a plan to eliminate the performance of non-nursing tasks by nursing personnel. These tasks include, but are not limited to, delivering and obtaining supplies, making patient appointments and searching for missing reports, passing and removing dining trays, making trips to the laboratory and pharmacy, searching for wheelchairs and stretcher, and filling pitchers of water. Facility nurse executives, along with directors of other departments, must be responsible for developing and implementing plans aimed at assigning tasks to the appropriate departments.

Recommendation:

VHA should review and adopt appropriate recommendations outlined in the Institute of Medicine report, *Keeping Patients Safe: Transforming the Work Environment of Nurses,* to determine specific strategies for implementation across VHA.

The Chief Nursing Officer should convene a work group consisting of facility nurse leaders and direct care providers to critically analyze the IOM report recommendations and determine which ones to implement in VHA facilities. The group should establish by consensus operating procedures that will assure an objective review of each of the IOM recommendations. Recommendations of the work group should inform and influence changes in nurses' work environment at VHA facilities that will ultimately reduce errors and the potential for errors.

RESPECT AND RECOGNITION

Recommendation:

VHA should expand recognition of achievement and performance in nursing service.

The Commission found that VHA national awards and recognition of nursing are well established. Testimony from staff nurses, however, revealed that at the facility level, some nurses perceive that they are not treated with respect. A compendium of awards and other initiatives related to honoring nurses and nursing may be useful in helping facilities to learn exemplary practices within VHA. In addition, the Commission recommends that the VHA develop a standardized recognition process at the facility level.

Recommendation:

VHA should create a sense of value and culture of mutual respect for nursing through all levels of VHA to include physicians and other colleagues, management, and stakeholders.

The Commission recommends that VHA examine and replicate at least two VA projects designed to create a sense of value and decrease stress in the workplace. The Nurse – Physician Collaboration Breakthrough Series is currently being implemented through the Field Office of the VA National Center for Patient Safety in White River Junction, Vermont. VHA should consider expanding this program and collecting outcomes data on perceptions of reduced stress and improved collaboration among nurses and physicians.

Similarly, the Stress and Aggression in the Workplace – A VA Collaboration Action Research Project has been shown to improve employee satisfaction and reduce employee turnover. The program is being implemented in VISN 23, in 11 pilot sites, (with 15 non-participating sites are being studied for comparison). Outcome data indicate that the top 10 aggressive behaviors have been significantly reduced in the pilot sites (8 of 10) but not in the comparison sites (2 of 10). Similar reductions have occurred with other types of aggression. The program involves a multi-disciplinary approach built from grassroots action teams that problem-solve around identified aggressive situations. The project is designed to reduce stress and turnover in employees. The Commission recommends that this project be expanded to other VISNs.

The Commission also recommends that the facility nurse executives promote employee involvement in public relations efforts with local media to showcase the work of VHA nursing in the community.

Finally, the Commission recommends that each facility adopt a code of conduct aimed at promoting positive relationships among patients, employees, and other stakeholders. To adopt a code of conduct, all involved should be held to zero tolerance policy for verbal and physical abuse.

FAIR COMPENSATION

Recommendation:

VHA should amend Title 38 to establish procedures for assuring that RN locality pay policies are competitive with local RN employer markets.

The Commission found that the locality pay system is an essential tool to minimize attrition and promote recruitment of nurses into VHA. However, in testimony, nursing staff observed that third-party surveys conducted by each site appeared to be manipulated to obtain desired results, leading to lower salary, rather than competitive, levels. Noncompetitive pay scales are demoralizing to staff, especially if the process that determines the pay scale is perceived as being subjective or inadequate.

The Commission recommends that the locality pay system be overhauled to provide for central oversight in conducting locality pay surveys and to assure that facilities are provided with funding to accommodate the full cost of compensation to their employees. This should include commissioning a central contracted agency to conduct the locality pay survey. Facility directors should be directed to pay according to the report from the agency contracted to conduct the survey. Priority must be given to assuring that these processes are objective and fully funded.

Recommendation:

VHA should change hiring and compensation policies to promote recruitment and retention of licensed practical nurses and nursing assistants.

The Commission found that current policies guiding compensation for LPNs inhibit VHA's ability to be competitive with local labor markets. Adding LPNs to the list of occupations not covered by limitations on salary rates would assist VHA in maintaining a competitive position. The Commission urges VHA to implement direct hiring authority for nursing assistants to facilitate timely filling of vacancies. Nursing assistants are an integral part of the nursing care delivery team with roles that are evolving with more complexities to support the changing needs of patient care delivery.

Recommendation:

VHA should strengthen human resources systems and departments to develop an active hiring and recruiting process for nursing staff that is consistent, to the extent possible, across facilities and VISNs.

The VHA Hiring Timeline Work Group concluded in 2001 that each facility has a different array of reasons for hiring delays. There are opportunities at every step of the hiring process to

decrease the time it takes for an applicant to enter on duty. Many of the delays could be avoided if decisions were delegated to the lowest level possible at each facility.

Furthermore, VHA has significant authority to develop pay policies that retain nurses. The compensation and benefits plan should be used to make the VHA the employer of choice; however, VHA has little control over benefits plans that are administered by the Office of Personnel Management. VA must designate funds and resources to ensure that the Central Office and all facilities have strong HR departments.

Special pay rates for nursing staff may be implemented, but only in response to a problem. Compensation should be actively changed to prevent problems – namely, attrition and unfilled vacancies. VHA needs highly skilled HR professionals and adequately staffed departments so they can lend effective and efficient support to nursing on hiring and appointment issues, adverse and disciplinary actions, labor/management concerns, NPSB, locality pay issues, and awards and recognitions programs.

TECHNOLOGY

Recommendation:

VHA should give priority to the continued rollout of the VA Nursing Outcomes Database (VANOD) as the data repository for nursing performance standards and the evaluation of effective patient care delivery models.

VANOD has the potential to create a wealth of information that can be used for developing decision-support software for nursing. The Commission recommends that grant funds be used to develop plans within each facility that would assist in developing and testing models for patient care delivery.

Recommendation:

VHA should engage experts to evaluate and redesign nursing work processes to enhance patient care quality, improve efficiency and decrease nurse turnover through the use of technology.

VHA has been an innovator in the use of technology for healthcare purposes. However, the Commission heard from testimony and interviews that nursing's input in information technology has been limited. The Commission recommends that VHA integrate nursing input into the design of work processes that enhance patient care delivery and improve efficiency.

Recommendation:

The Agency for Healthcare Research and Quality (AHRQ) and VHA should partner in applying findings from information systems and technology research projects into patient care delivery.

The Commission recommends that VHA partner with AHRQ to focus research initiatives on patient safety.

RESEARCH/INNOVATION

Recommendation:

VHA should establish a Center for Excellence in Quality Nursing Care to create and implement a research agenda consistent with the VA mission.

The Commission recommends that VHA nursing establish a center, The Center for Excellence in Quality Nursing Care, focused on expanding the evidence base for quality nursing care and improving patient care within VHA. The Center should provide the infrastructure for developing nurse research scientists, who can guide the design and implementation of a research agenda that is crafted to solve current research problems. The Center should also serve as the incubator for the future of nursing in VHA. This should include the design and testing of new nursing roles, models of care, decision support tools, and data systems.

VHA is an innovator in the use of technology, and VHA nursing already has begun to create and implement the VA Nursing Outcomes Database. A research agenda could be implemented that includes effective staffing models, the application of patient care technologies, evidence-based practice, clinical practice models, and specific practice models/technologies that support an aging nursing workforce. The Center could also serve as the infrastructure for the creation and testing of new roles for nurses. As health care changes with new innovations in pharmacology, genetics, robotics and other therapeutics, the Center could explore the interface of these innovations with nursing and patient care and determine what nursing roles should be expanded or created within the changing healthcare environment. The Center could thus become an incubator for emerging nursing roles.

In establishing the Center, VHA nursing would maintain a centralized approach to developing and issuing grant programs congruent with the VA mission. In addition, the Center would possess the necessary expertise in developing nurse researchers and providing technical assistance within VHA facilities.

The Commission puts forth these recommendations as complementary to the recommendations issued in the *Call to Action* report and work already underway to implement VA nursing's strategic plan. To fully implement the recommendations will require nursing leadership with support from the Secretary and Under Secretary for Health. Further, the Commission recommends that staff nurses participate in decision-making in all aspects that involve patient care.

CHAPTER 4

CONCLUSION

The National Commission on VA Nursing was established in 2002 through Public Law 107-135 and charged to consider and recommend legislative and organizational policy changes that would enhance the recruitment and retention of nurses and other nursing personnel and assess the future of the nursing profession within the Department of Veterans Affairs. A 12-member Commission was appointed and given a 2-year timeline to complete its charge.

The Commission focused on identifying strategies and tactics to assure the readiness and capacity of VA to meet the current and future nursing needs of American's veterans. As the nation's largest employer of nursing personnel, VHA can serve as a model for the nation in creating, implementing, and monitoring an environment that retains and attracts nurses and other health care personnel.

In putting forth its recommendations, the Commission reviewed the findings from multiple sources and sought to develop visionary changes to the VHA that, if implemented, will serve to assure that nurses will be available in adequate numbers with the requisite skills for caring for the nation's veterans through the foreseeable future. Further, the Commission believes that if VHA were to implement these recommendations, it will serve as a model for nursing throughout the nation.

In determining its recommendations, the Commission received input from many diverse sources. It reviewed the *Call to Action* report of the Nursing Workforce Group (VA, 2001a), a recommendation from which the Commission was formed. It heard status reports on VHA nursing initiatives and received reports from stakeholder groups. Four regional hearings were held to allow for in-person testimony by nurses regarding their perceptions about their work environment and their ability to deliver care. The Commission also received faxed and web-based comments during a public comment period. Non-VHA staff Commission members conducted informant interviews of facility leaders. In March 2003, VHA nursing leaders participated in a Nursing Leadership Forum**,** contributing their input to the Commission.

Through deliberate processes of review, analysis, and synthesis, the Commission developed its recommendations in the areas of leadership, professional development, work environment, respect and recognition, fair compensation, technology, and research/innovation. The Commission also recommends that VHA continue to implement the recommendations from the *Call to Action,* and the goals and initiatives set forth in VA Nursing's Strategic Plan (2003f).

The Commission believes that implementation of these recommendations will position VHA for the future of health care delivery and nursing. As delineated in *VHA Vision 2020,* VHA already leads in benchmarking quality indicators, safety initiatives, and models of integrated care delivery. VHA nurses are integral to care delivery in all VHA settings, and VHA should continue to design, develop, test, and implement futuristic nursing roles and evidence-based models of care to serve our nation's veterans.

The Commission commends VHA for acknowledging the contributions of nursing to the health and welfare of the nation's veterans. Achieving the work set forth in the Commission's recommendations and continuing the ongoing work in Nursing's Strategic Plan and the *Call to Action* report require resources and participation of nurses at all levels of the organization. The Commission notes the rich tradition of cooperation among the Department of Veterans Affairs, the American Federation of Government Employees, the National Federation of Federal Employees, the Service Employees International Union, the National Association of Government Employees, and the United American Nurses in advising the Secretary and VA leadership on matters associated with labor-management relations VA wide and on VA initiatives which affect employees. To accomplish Commission recommendations, cooperation between labor and management is critical, and the Commission encourages continued efforts of all stakeholders to support VA nursing.

Implementing these recommendations will require human and fiscal resources. These recommendations will be not accomplished without the active involvement at all levels within VHA, including the Secretary and Under Secretary for Health, the Office of Nursing Service, the National Nurse Executive Council, VISN directors and nursing leaders, and nursing staff. VHA must establish lines of accountability for achieving outcomes, and for those responsible, the Commission suggests that accountability be written into performance expectations. Fiscal resources must be allocated from within existing resources or through Congressional appropriation. As the recommendations are implemented, the Commission suggests that the Chief Nursing Officer establish and implement a communication plan to provide ongoing feedback to all stakeholders, from Congress through direct nursing care providers. Finally, VHA nursing leadership must encourage the use of effective partnerships within and outside of VHA to share best practices in each recommendation category so that VHA facilities and external partners, such as academe and healthcare organizations in the private sector, learn from one another.

In meeting its mission, VHA must recruit and retain knowledgeable, experienced, and educated nurses to provide care for the nation's veterans. Action is required now to address underlying issues contributing to the VHA nursing shortage. VHA must invest resources—human, fiscal, and technological—for recruiting and retaining nurses and proactively testing new and emerging nursing roles.

References

Advisory Board Company. (1999). *Reversing the Flight of Talent: Nursing Retention in an Era of Gathering Shortage*. Washington, DC: Author.

Aiken, L.H., Clarke, S.P., Cheung, R.B., Sloane, D.M., & Silber, J.H. (2003). Education levels of hospital nurse and patient mortality. *JAMA, 290* (12), 1-8).

Aiken, L.H., Clarke, S.P., Sloane, D.M., & Sochalski, J.A. (2001, November). An international perspective on hospital nurses' work environments: The case for reform. *Policy, Politics, & Nursing Practice*, 255-263

Aiken, L.H., Clarke, P.H., Sloane, D.M., Sochalski, J., & Silber, J.H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction, *JAMA, 288* (16), 1987-1993

Aiken, L.H., Havens, D.S., & Sloane, D. (2000). The magnet nursing services recognition program: A comparison of two groups of magnet hospitals. *American Journal of Nursing, 100* (3), 26-36.

Aiken, L., Smith, H., & Lake, E. (1994). Lower Medicare mortality among a set of hospitals known for good nursing care. *Medical Care, 35* (9), 948-962.

American Association of Colleges of Nursing (2002). *Hallmarks of the Professional Nursing Practice Environment.* Retrieved November 4, 2003, from http://www.aacn.nche.edu/Publications/positions/hallmarks.htm

American Association of Colleges of Nursing. (2002). *Though Enrollments Rise at U.S. Nursing Colleges and Universities, Increase Is Insufficient to Meet the Demand for New Nurses*. Retrieved August 14, 2003, from http://www.aacn.nche.edu/Media/NewsReleases/enrl02.htm

American Association of Colleges of Nursing. (2003). *Working Paper on the Role of the Clinical Nurse Leader*. Retrieved March 24, 2004, from http://www.aacn.nche.edu/Publications/WhitePapers/ClinicalNurseLeader.htm

American Hospital Association's Commission on Workforce for Hospitals and Health Systems. (2002). *In Our Hands: How Hospital Leaders Can Build a Thriving Workforce.* Chicago: Author

American Nurses Credentialing Center. (2003). *Magnet Recognition Program.* Retrieved August 26, 2003, from http://nursingworld.org/ancc/magnet.html

American Organization of Nurse Executives. (2000). *Nurse Recruitment and Retention Survey*. Washington: Author.

Buchan, J. (1999). Still attractive after all these years? Magnet hospitals in changing health care environment. *Journal of Advanced Nursing, 30* (1), 100-108.

Buerhaus, P.I., Staiger, D.O., & Auerbach, D.I. (2003). Is the current shortage of hospital nurses ending? *Health Affairs, 22* (6), 191-198.

Congressional Research Service. (2001, May 18). *A Shortage of Registered Nurses: Is It on the Horizon or Already Here?* (CRS Code RL30974). Washington, DC: Library of Congress.

Department of Veterans Affairs. (2001a). *A Call to Action: VA Response to the National Nursing Shortage.* Washington: Veterans Health Administration.

Department of Veterans Affairs. (2001b). *FY 2003 VHA Baseline Health Care Demand Model.* Washington: Veterans Health Administration.

Department of Veterans Affairs. (2001c). *Service Line Management Evaluation Project Final Report.* Washington: Veterans Administration. Health Services Research & Development Service.

Department of Veterans Affairs. (2001d). *Succession Planning Final Report.* Washington, DC: Veterans Health Administration National Succession Planning Task Force.

Department of Veterans Affairs. (2001e). *VHA Nursing Staff Fact Sheet.* Veterans Health Administration. Retreived January 24, 2003, from http://www.va.gov/ncvan/docs/Nursing_fact_sheet.htm

Department of Veterans Affairs. (2001f). *Workforce Planning and Restructuring 01-07.* Washington, DC: Veterans Administration Office of Management and Budget.

Department of Veterans Affairs. (2002). *Annual Report on Nurse Staffing.* Washington, DC: Veterans Administration. Report to Congress in accordance with Title 38 Chapter 1, Section 116.

Department of Veterans Affairs. (2003a). *Annual Report.* Washington DC: Veterans Health Administration Office of Health Care Staff Development and Retention Health Professionals Educational Assistance Program.

Department of Veterans Affairs. (2003b). *Computer Output Identification Number Personnel Accounting Information.* Washington, DC: Veterans Administration.

Department of Veterans Affairs. (2003c). *Information.* Veterans Health Administration Office of Academic Affairs. Retrieved January 7, 2004, from http://www.va.gov/oaa/

Department of Veterans Affairs. (2003d, May 19). *Nurse – Physician Workforce Collaborative Initiative and Budget Proposal.* Unpublished manuscript.

Department of Veterans Affairs. (2003e). *Issue Paper: Locality Pay System, Advancement Process and Professional Standards Board, Nurse Qualification Standards, and Employee Concerns.* Washington, DC: Veterans Health Administration Department of Management Support. Unpublished manuscript.

Department of Veterans Affairs. (2003f). *Nursing's Strategic Plan.* Retrieved February 29, 2004, from http://www1.va.gov/nursing/docs/nursingstrategicplan.doc

Department of Veterans Affairs. (2003g). *Strategic Human Capital Management Plan.* Washington, DC: Veterans Administration.

Department of Veterans Affairs. (2003h). *The VANOD Connection.* Washington: Author.

Department of Veterans Affairs. (2003i). *Veterans Administration Handbook 2002).* Washington: Veterans Administration.

Department of Veterans Affairs. (2003j). VA/VAST and VSSC. Washington: Veterans Administration.

Department of Veterans Affairs. (2003k). *VHA Vital Signs.* Washington: Veterans Health Administration.

Department of Veterans Affairs. (2003l). *VHA Vision 2020.* Washington: Veterans Health Administration.

Department of Veterans Affairs. (1999). VA Directive 5102.1, November 1999. Washington: Veterans Health Administration.

Havens, D., & Aiken, L. (1999). Shaping systems to promote desired outcomes. *Journal of Nursing Administration, 29* (2), 14-20.

Institute of Medicine Committee on Quality of Health Care in America. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academy Press.

Institute of Medicine Committee on Quality of Health Care in America. (1999). *To Err Is Human: Building a Safer Health System.* Washington, DC: National Academy Press.

Institute of Medicine Committee on Quality of Health Care in America. (2004). *Keeping Patients Safe: Transforming the Work Environment of Nurses.* Retrieved November 19, 2003, from http://books.nap.edu/books/0309090679/html/index.html

Institute of Medicine Committee on Quality of Health Care in America. (2003). *Leadership By Example: Coordinating Government Roles in Improving Health Care Quality.* Washington, DC: National Academy Press.

Institute of Medicine Committee on Quality of Health Care in America. (2003). *Health Professions Education: A Bridge to Quality.* Washington, DC: National Academy Press.

Joint Commission on Accreditation of Healthcare Organizations. (2002, August). *Nursing Shortage Poses Serious Health Care Risk: Joint Commission Expert Panel Offers Solutions to National Health Care Crisis*. Retrieved March 11, 2004, from http://www.jcaho.org/news+room/news+release+archives/nursing+shortage.htm

Joint Commission on Accreditation of Healthcare Organizations. JCAHO: the staffing effectiveness standards. (2003, June). *The VANOD Connection: Linking Technology to Nursing Practice, 1* (1).

Kennedy, R. (2003). The nursing shortage and the role of technology. *Nursing Outlook, 51* (S33-34).

Kimball, B., & O'Neil, E. (2002). *Health Care's Human Crisis: The American Nursing Shortage.* Princeton, NJ: The Robert Wood Johnson Foundation.

Koerner, J.G., & Karpiuk, K.L. (1994). *Implementing Differentiated Nursing Practice.* Gaithersburg, MD: Aspen.

Kramer, M. (1990a). The magnet hospitals: Excellence revisited. *Journal of Nursing Administration, 20* (9), 35-44.

Kramer, M. (1990b). Trends to watch at the magnet hospital. *Nursing 90, 2* (4), 67-74.

Kramer, M., & Hafner, L.P. (1989). Shared values: Impact on staff nurse job satisfaction and perceived productivity. *Nursing Research, 38* (3), 172-177.

Kramer, M., Schmalenberg, C., & Hafner, L.P. (1989). What causes job satisfaction and productivity of quality nursing care? In T. Moore & M. Mundinger (Eds), *Managing the Nursing Shortage: A Guide to Recruitment and Retention.* Rockville, MD: Aspen.

Kramer, M., & Schmalenberg, C. (1988). Magnet hospitals. Part II: Institutions of excellence. *Journal of Nursing Administration, 18* (1), 13-24.

Kramer, M., & Schmalenberg, C. (1993). Learning from success: Autonomy and empowerment. *Nursing Management, 24* (5), 58-64.

McClure, M.L., & Hinshaw, A.S., Eds. (2002). *Magnet Hospitals Revisited: Attraction and Retention of Professional Nurses.* Washington, DC: American Nurses Association

McClure, M.L., Poulin, M.A., Sovie, M.D., & Wandelt, M.A. (1983). *Magnet Hospitals: Attraction and Retention of Professional Nurses.* Kansas City, MO: American Nurses Association

Miller, L.J. (2003, June). Workforce challenges at VA: Preparing for the Future. *Forum: Translating Research into Quality Health Care for Veterans.*

National Information Center on Health Services Research and Health Care Technology. (2004). *Definitions.* Retrieved February 27, 2004 from http://www.nlm.nih.gov/nichsr

National Institute of Standards and Quality. (2003). *Baldrige National Quality Program.* Retrieved August 26, 2003 from http://www.quality.nist.gov/

Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. *New England Journal of Medicine, 346* (22), 1715-1722

Office of Personnel Management. (2003). *Federal Civilian Workforce Statistics, VSSC.* Washington: Author.

Peter D. Hart Research Associates. (2001, April). *The Nurse Shortage: Perspectives from Current Direct Care Nurses and Former Direct Care Nurses.* Washington, DC: Author.

Peters, R.J. & Waterman, R.H. (1982). *In Search of Excellence.* New York: Harper & Row, Inc.

Pronovost, P.J., Dang., D., Dorman, T., Lipsett, P.A., Garrett, E., Jenckes, M., & Bass, E.B. (2001). Intensive care unit nurse staffing and the risk for complications after abdominal aortic surgery. *Effective Clinical Practice, 4,* 199-206

Rosenstein, A.H. (2002). Nurse-physician relationships: Impact on satisfaction and retention. *American Journal of Nursing, 102* (6), 26-34. Retrieved October 11, 2003, from http://www.nursingcenter.com/library/JournalArticle.asp?Article_ID=278949

Scott, J., Sochalski, J., & Aiken, L. (1999). Review of magnet hospital research. *Journal of Nursing Administration, 29* (1), 9-19.

Sherman, G. (2000). *Report to Nurses for a Healthier Tomorrow on Perceptions of Nursing as a Professional Career among Students in the United States.* (Available from Sigma Theta Tau International, 550 West North Street, Indianapolis, IN 46202)

Spetz, J., & Given, R. (2003). The future of the nurse shortage: Will wage increases close the gap? *Health Affairs, 22* (6), 199-206.

Spratley, E., Johnson, A., Sochalski, J., Fritz, M., & Spencer, W. (2000). *The Registered Nurse Population March 2000: Findings from the National Sample Survey of Registered Nurses.* Washington, DC: Department of Health and Human Services, Health Resources and Service Administration, Bureau of Health Professions, Division of Nursing. Retrieved August 26, 2003, from ftp://ftp.hrsa.gov/bhpr/rnsurvey2000/rnsurvey00-1.pdf

The Gallup Organization. (2002, December). *Effects of Year's Scandals Evident in Honesty and Ethics Ratings.* Retrieved August 14, 2003, from http://www.gallup.com/subscription/?m=f&c_id=12854

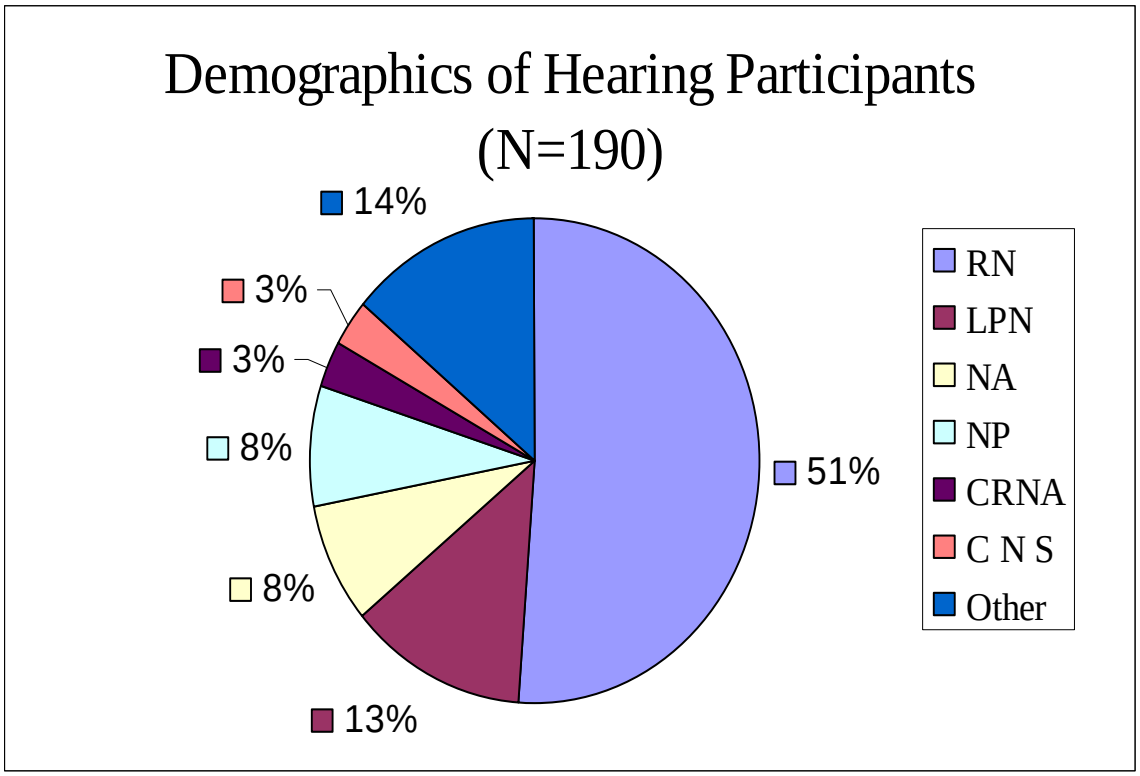
Upenieks, V.V. (2002). Assessing differences in job satisfaction of nurses in magnet and nonmagnet hospitals. *JONA, 32* (11), 564-575.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, National Center for Health Workforce Analysis. (2002). *Projected Supply, Demand, and Shortages of Registered Nurses: 2000-2020.* Retrieved August 10, 2003 from ftp://ftp.hrsa.gov/bhpr/nationalcenter/rnproject.pdf

U.S. Census Bureau. (2001). *Census 2000 Shows America's Diversity.* Retrieved August 14, 2003, from http://www.census.gov/Press-Release/www/2001/cb01cn61.html

U.S. Office of Disease Prevention and Health Promotion. (1999). *Healthy People 2010: A Systematic Approach to Health Improvement.* Retreived August 14, 2003, from http://www.healthypeople.gov/Document/html/uih/uih_2.htm

Appendix A



Source: National Commission on VA Nursing staff hearings, April 2003
New Orleans, LA; Philadelphia, PA; Chicago, IL; Long Beach, CA

Hearing Demographics of Scheduled Participants
New Orleans, LA
Total =27

Nursing Level		
	#	%
NI	1	3.7%
NII	3	11.1%
NIII	8	30.0%
NIV	1	3.7%
NV	0	3.7%

Years of employment	
Range	5-27yrs
Mean	12.1 yrs
Median	16 yrs
Mode	20 yrs

Position		
	#	%
No Data	7	26.0%
CNS	1	3.8%
CRNA	1	3.8%
LPN	4	15.0%
NA	4	15.0%
NP	1	15.0%
RN	9	33.3%

Education		
	#	%
No Data	6	22.2%
AD	5	18.5%
BSN	2	7.4%
Diploma	1	3.8%
HS	2	7.4%
MBA	1	3.8%
MSN	4	14.8%
Other	3	11.1%
PhD	1	3.8%
Technical	2	7.4%

Years of Experience		
	#	%
No Data	5	19.0%
6-10	4	15.0%
11-20	8	30.0%
21-30	6	22.2%
>30	4	15.0%

Assigned Areas		
	#	%
Ambulary Care	5	19.0%
Dementia/LTC	1	3.8%
Med/Surg	3	11.1%
Mental Health	5	19.0%
Nurse Recruiter	1	3.8%
Operating Room	1	3.8%
Other	1	3.8%
Prim Care	4	15.0%
No Data	6	22.2%

Hearing Demographics of Scheduled Participants
Philadelphia, PA
Total =23

Nursing Level		
	#	%
NI	1	4.4%
NII	6	26.0%
NIII	6	26.0%
NIV	0	0.0%
NV	0	0.0%

Years of employment	
Range	2-28 yrs
Mean	13.5 yrs
Median	16 yrs
Mode	14 yrs

Position		
	#	%
No Data	3	13.0%
CNS	1	4.4%
CRNA	1	4.4%
LPN	1	440.0%
NA	2	8.7%
NP	1	4.4%
RN	13	57.0%

Education		
	#	%
No Data	3	13.0%
AD	4	17.3%
Bachelor's	2	8.7%
BSN	4	17.3%
Diploma	2	8.7%
HS	2	8.7%
MA	1	4.4%
MCH	1	4.4%
MSN	3	13.0%

Years of Experience		
	#	%
No Data	3	13.0%
11-20	7	30.4%
21-30	10	43.4%
>30	3	13.0%

Assigned Areas		
	#	%
No Data	4	17.3%
Ambulatory Care	2	8.7%
Case Manager	1	4.4%
Long Term Care	1	4.4%
Med/Surg	1	4.4%
Mental Health	7	30.4%
Operating Room	1	4.4%
Other	3	13.0%
PACU	1	4.4%
Primary Care	2	8.7%

Hearing Demographics of Scheduled Participants
Chicago, IL
Total =25

Nursing Level		
	#	%
NI	4	16.0%
NII	5	20.0%
NIII	7	28.0%
NIV	0	0.0%
NV	0	0.0%

Years of employment	
Range	2-30 yrs
Mean	10.18 yrs
Median	12 yrs
Mode	2 yrs

Position		
	#	%
No Data	4	16.0%
LPN	5	20.0%
NA	1	4.0%
NP	2	8.0%
RN	13	52.0%

Education		
	#	%
No Data	4	16.0%
AD	2	8.0%
Bachelor's	1	4.0%
BSN	6	24.0%
Diploma	1	4.0%
HS	2	8.0%
MBA	1	4.0%
MSN	3	12.0%
Other	4	16.0%
PhD	1	4.0%

Years of Experience		
	#	%
No Data	4	16.0%
<3	2	8.0%
6-10	5	20.0%
11-20	4	16.0%
21-30	6	24.0%
>30	4	16.0%

Assigned Areas		
	#	%
No Data	4	16.0%
Ambulatory Care	3	12.0%
Critical Care	4	16.0%
Emergency Room	2	8.0%
Long Term Care	1	4.0%
Med/Surg	4	16.0%
Mental Health	1	4.0%
NFFE member	1	4.0%
Operating Room	1	4.0%
Other	1	4.0%
Primary Care	2	8.0%
Spinal Cord Injury	1	4.0%

Hearing Demographics of Scheduled Participants
Long Beach, CA
Total =27

Nursing Level		
	#	%
NI	1	3.7%
NII	12	44.4%
NIII	7	26.0%
NIV	0	0.0%
NV	0	0.0%

Years of employment	
Range	1-30 yrs
Mean	13.1 yrs
Median	13 yrs
Mode	13 yrs

Position		
	#	%
No Data	2	7.4%
Asst. Dean	1	3.7%
CNS	1	3.7%
CRNA	1	3.7%
LPN	3	11.1%
NA	1	3.7%
NP	1	3.7%
RN	17	63.0%

Education		
	#	%
No Data	3	11.1%
AD	5	18.5%
Bachelor's	4	14.8%
BSN	5	18.5%
MSN	8	29.6%
Other	2	7.4%

Years of Experience		
	#	%
No Data	2	7.4%
6-10	3	11.1%
11-20	10	37.0%
21-30	7	26.0%
>30	5	18.5%

Assigned Areas		
	#	%
No Data	2	7.4%
Ambulatory Care	4	14.8%
Long Term Care	2	7.4%
Med/Surg	8	29.6%
Operating Room	2	7.4%
Other	6	22.2%
Primary Care	1	3.7%
Spinal Cord Injury	1	3.7%
Telephone Triage	1	3.7%

Appendix B

Report to VA Commission on Nursing
Input from Nursing Leadership Forum
June 11, 2003

I. Process:

A meeting was held on March 31, 2003 with 90 Nursing Leaders from throughout the VHA to discuss four specific questions related to the recruitment and retention of VA nurses. Ninety nursing leaders participated and were divided into 9 separate groups. Time was provided for each group to discuss a list of prepared questions. After the group discussions, a group leader reported responses to all 90 participants. Following are the questions and trends that were discussed and identified during this Nursing Leadership Forum. Trends are categorized according to the "key drivers" that the VA Nursing Commission has identified as critical to nursing recruitment and retention.

II. Questions and Trends:

#1 Describe how you think VA Nursing will look in the future.

Key Driver: Work Environment / Control of Practice

- Development of New Care Models
  More support staff
  Proper utilization of the RN Role
  Telemedicine
  Care Coordination
  Health Promotion
  Increased Home Health Roles
  Models to work with increasing hospital acuity levels

- Use of enhanced technologies
  Hand-held computers
  Universal sign on's

Key Driver: Work Environment / Concern for Patient is Paramount

- Increased emphasis on patient safety

Key Driver: Work Environment / Competent Nursing Staff

- Concerns with movement of inpatient staff to outpatient settings (drain on inpatient)

#2 How can the VA attract, develop and retain well-qualified nurse executives, associates and nurse managers?

Key Driver: Fair Compensation / Benefits and Pay Issues

- Monetary Rewards
  Competitive Pay Schedules

Bonuses

Key Driver: Professional Development / Support for Education

- Enhance Educational Opportunities
  Standardize Chief Nurse Executive and Nurse Manager Orientation
  Mentoring Programs
  Preceptorships
  Promote Health Care Leadership Institute
  More time to work within academic environment – ie joint faculty appointments

Key Driver: Respect / Recognition / Nurse Autonomy and Accountability

- Improve the image of nursing

Key Driver: Work Environment / Control of Practice Environment

- Collaborative relationships with other disciplines
- Flexible schedules
- Appropriate support resources for clerical, informatics and educator roles

#3 How can the VA ensure the veteran patient a comparable standard of nursing care across the VA system?

Key Driver: Work Environment / Control of Practice

- Increase use of evidenced based practice
- Increase networking among VA facilities to disseminate best practices
- Development of a nursing outcomes data-base
- Increase use of technology to improve patient care
- Increase number of VA nurse researchers at the facility level
- Standardize administrative structures – titles and role of Nurse Executive
- Standardize competencies

Key Driver: Work Environment / Staffing

- Increase diversity of workforce

#4a What three things would you like to see changed in the VA?

Key Driver: Work Environment / Staffing

- Improved support from Human Resources
  Ability to hire Nurse Aides like title 38 staff
  Support needed in disciplinary and termination processes
  Improve flexibility and "help" with personnel issues verses citation of regulations

Key Driver: Fair Compensation / Pay Issues

- Improve locality pay process

Key Driver: Respect and Recognition / Awards

- Use of comp time for unused sick leave

Key Driver: Respect and Recognition / Nurse autonomy and accountability

- Organizational Structure
  Chief Nurse Executive should manage own budget
  Chief Nurse Executive should report to the Director level
  Elimination of service line structure that removes nursing staff from nursing service
  Chief Nurse Executive should be a part of the triad (CEO, COO, CMO)
  Move back to traditional nursing service model
- Improved marketing of VA nursing

Key Driver: Respect and Recognition / Awards

- Change qualification standards

4b What three things would you like to see remain?

Key Driver: Professional Development / Support for Education

- Networking and sharing best practices
- Academic affiliations
- Qualification and education standards
- Executive sabbaticals

Key Driver: Leadership / Supportive Leaders

- Continue National Nurse Executive Council and Sub councils

Key Driver: Work Environment / Staffing

- Title 38

III. Summary / Highlights of Input from VA Nursing Leader Participants

The nursing leaders who participated in the forum discussed a number of issues related to nursing recruitment and retention within the VA. A strong trend is noted in the area of **work environment**. VA nursing leaders agree that work environment will be a primary determinant of recruitment and retention in the future. VA nurse leaders view new care models and enhanced use of technology as key necessities of delivering nursing care in the future. The need for appropriate resources in clerical service, informatics and nursing education were also recommended as areas to improve the work environment for nursing. The group discussed difficulties with current human resource policies and the need for flexibility with hiring and disciplinary processes. More support is needed from the Human Resource Department to improve work environments.

Another area where focus is recommended is in **respect and recognition**. A need was identified to increase the autonomy and control of the practice of nursing in the VA. In order to recruit and retain qualified nursing staff and leaders, more control over nursing practice is needed from the nursing leadership through managing a budget, reporting relationships of the nursing staff to nursing leaders, Nurse Executives being a true part of the facility triad and remodeling organizational structures that blur the lines of authority of nursing leaders.

Fair compensation was also recommended. Locality pay structures that have been in place in the past have not been accurate due to the competitive nature of the labor market in nursing. In addition, facility budget issues have negatively impacted annual increases for nursing.

The nursing leadership participants strongly endorse **professional development** and support for education. Mentoring programs would be helpful for new nursing leaders, as well as participation in the VA Health Care Leadership Institute. Nursing leaders would appreciate more time to work within academic projects such as joint faculty appointments.

Finally, the group strongly recommended the continuation of the National Nurse Executive Councils and Sub councils. This structure has outlined a strategic plan for nursing and opened up lines of communication nationally. It has been a venue for strong nursing **leadership,** sharing best practices and improving nursing care.

The nursing leadership group provided positive comments in regards to the process and the opportunity to share their input and ideas to the VA Nursing Commission.

Appendix C

SUMMARY OF KEY INFORMANT INTERVIEWS

Linda Burnes Bolton & Joanne Spetz

Interviews of chief nurse executives, chiefs of staff and facility directors were conducted over a two-week period. The following themes emerged from the interviewee responses.

1. Most respondents were promoted within the VA system from staff to management positions. There is evidence of a "promotion from within" system in VA across disciplines. There was no evidence that this system is advantageous or disadvantageous.
2. All institutions had received nurse satisfaction data. Facilities that placed staff satisfaction on the executive agenda had implemented specific strategic and tactical plans to improve staff satisfaction, retention and recruitment.
3. The average ratings of perceived staff satisfaction varied by several factors. Institutions with triad or quadrad structures had overall staff satisfaction ratings with medical staff, nursing administration and facility administration of 2.3 on a scale of 1-4 . Institutions with traditional nurse executive roles had overall staff satisfaction ratings with medical staff, administration and facility administration of 3.6. The very small sample size precludes the drawing of conclusions. The information was helpful in understanding the recommendations from nurse executives, chiefs of staff and facility directors.
    A. Staff satisfaction assessments were generally consistent among the Director, Chief of Staff, and Chief Nurse. In some cases there were discrepancies, and these were typically reflective of significant differences in views of the site among these leaders. In many cases, administrators cited specific units that had morale problems, and/or specific issues that had caused problems. In most cases, activities were underway to address unit-level or policy problems.
    B. Some respondents identified the transition to a service line structure as a problem for employee satisfaction, and were making concerted efforts to expand the role of nursing leadership. Some sites were creating a nursing reporting structure in parallel with the service line structure.
4. All of the respondents identified specific efforts to improve staff retention, recruitment and satisfaction. The top retention and recruitment issues identified across facilities were- salary, staffing and scheduling, VA image in the community, service line structure, VA regulations related to promotion and compensation, medical staff and nursing staff relationships and workload imposed by technology.
    A. Specific salary problems included difficulty meeting prevailing RN wages due to wage inflation, and difficulty meeting prevailing LVN wages because LVN wages do not follow a locality pay system.
    B. Many respondents noted that the hiring system for nursing assistants is problematic, because the nursing assistants must be qualified through a regional office. The process is time-consuming, and in a competitive job market, puts the VA at a disadvantage. Low retention rates for nursing assistants compounds the problem.
    C. Rural sites tended to state that they had little problem recruiting and retaining staff. These sites are often major employers in the community and hold a valued

role in the community. Urban sites tended to have difficulty recruiting and retaining staff for a variety of reasons.

D. Most respondents stated that they actively seek input from employees. Strategies to obtain information include doing rounds with the other leadership on a regular basis, having town-hall meetings, and offering an anonymous complaint/question service. Most respondents use email and the web for communication with staff.
E. The nurse professional standards board was cited by some respondents as being problematic. Some leaders viewed the board as making arbitrary decisions and working against efforts to retain staff.
F. Recruitment and retention is more difficult in mental health and SNF units.
G. Many sites have reward systems for nurses to recognize them when patients write complementary letters, the nurse makes a suggestion for improved quality of care or efficiency, or other contributions. Many of these rewards are monetarily small but the recognition is viewed as beneficial.
H. Sites in the most competitive labor markets reported that they offer a variety of tours and shift schedules in order to recruit.

5. New technology in the VA generally was identified as a satisfier for nursing staff. Specific technologies cited as beneficial to staff were ICU monitoring and patient record systems, patient lifts, and CPRS. BCMA was cited as problematic by several respondents. Specific problems with BCMA include the rollout method, difficulty in using the system in ICU, waste of medications due to scanning errors. The lack of beta-testing and uniform rollout of the system were the most often cited problems.
6. All respondents stated that they had a large amount of data available to them at the management level. Many recommended simplification of data reports to share with staff. Respondents indicated concerns regarding the lack of planning and adequate support in the deployment of technology used by staff and managers. VA information systems were identified as task laden, requiring significant nursing and management time to utilize.
    A. Some respondent sites had created “dashboards” to summarize data from DSS on a monthly basis. These are made widely available to leadership. All sites that have dashboards stated that they were very helpful to decision making and communicating information to staff.
7. The respondents had the following recommendations for the commission.
    A. Nursing must have a strong practice and management environment.
    B. Nursing should report to nursing administration, not within service lines.
    C. Nurse executives should have the authority to make financial and quality decisions and play an integral role as a member of the executive team.
    D. All VA sites should use a nursing dashboard to track performance on retention, satisfaction and recruitment.
    E. Decrease the amount of central office control over promotions, salaries and education reimbursement.
    F. Provide more support for nursing education.
    G. Listen and value the contributions of nurses.
    H. Improve MD/RN nursing relationships.
    I. Provide quality support services. Decrease the amount of no valued work conducted by professional nurses.
    J. Strengthen the nurse professional board review process. Remove the subjectivity.

K. Mandate that pay for all types of nursing staff be competitive.
L. Create a system for determining staffing levels on a real-time basis.
M. Change the categorization of nursing assistants to streamline the hiring process and allow for more competitive salaries.
N. New technologies should have nursing staff on development/testing teams, should be introduced gradually across the system, and introduced gradually within sites. Formal opportunities for feedback from nursing staff and adjustments after implementation must be created.

Appendix D

Leadership Recommendations

The facility nurse executive should have line authority, responsibility, and accountability for nursing practice and personnel. [Facilities wishing to be excluded from this recommendation should submit a waiver to the Secretary of Veterans Affairs office through the Office of Nursing Service.]

Implementation Strategy	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Assure facility nurse executive responsibility and accountability at local level.	Chief Nursing Officer. (Organizational)	Six months after approval; directive established	Evidence that nurse executive is member of leadership team at facility/VISN level
Assure facility nurse executive accountability and responsibility for standards of nursing care and practice.	Under Secretary for Health, VISN, and facility directors. (Organizational)	May 2005	Facility nurse executive performance plan. Facility report. Results of consistent, positive nurse sensitive patient outcomes measures.
Provide for budgetary accountability with the facility nurse executive for management of resources.	VISN and facility directors. (Organizational)	One year after approval; directive established	Policy mandating nurse executive budgetary accountability and responsibility with evidence of compliance
Give facility chief nurse executive hiring authority and personnel budget to hire for approved budgeted positions.	VISN and facility directors. (Organizational)	October 2004. Policy in place.	Report from VISN and facility nurse executives to Central Office.
Implement an effective facility nurse executive communications plan	Facility nurse executive. (Organizational)	May 2005	Performance plan report annually. Include provision in each report that individuals must engage their nursing staff. Include facility nurse executive's communication effectiveness as part of nursing satisfaction survey.
[For waived facilities]: [Assure a process is developed and implemented for waiver of facility nurse executive line authority]	[VISN and facility directors, with Full concurrence of the facility nurse executives and the opinion of the majority of nursing staff.] (Organizational)		[Results of consistent, positive nurse sensitive patient outcomes measures]

The facility nurse executive should be a member of the executive body at the VISN, and facility levels.

Implementation Strategy	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Direct the facilities to implement this recommendation.	Under Secretary for Health (Organizational)	October 2004. Development and implementation of directive.	Reports from executive bodies at Central Office, VISN, and facility levels, with 100% compliance

The facility nurse executive should be accountable for (a) the effective performance of nurse managers, (b) leadership development of all nursing staff, (c) development and implementation of clinical leadership roles at the point of care, and (d) compliance with standardized Nurse Professional Standards Board (NPSB) protocols.

Implementation strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Develop nurse leaders at all levels of nursing through formal and informal leadership development activities.	Under Secretary for Health. (Organizational)	2005. Legislation passed; 2006. Program developed and implemented.	Annual report of nurses' participation in leadership development activities.
Hold nurse managers and other nurse leaders accountable for performance standards related to leadership development.	Chief Nursing Officer; facility director and facility nurse executive. (Organizational)	December 2005, establishments of performance measures	Standardized performance measures and reporting out with 100% compliance
Demonstrate increased levels of participation of all levels of nursing in formal leadership training.	Chief Nursing Officer and facility nurse executives. (Organizational)	December 2005; Policy implementation.	Standardized performance measures with 25% increase in leadership training at all levels of nursing.
Structure NPSB membership so that there are sufficient numbers that reflect the total roles, grades, diversity of the nursing staff	Chief Nursing Officer. (Organizational)	Three months after approval. Policies and procedures in place.	Evidence of new policies and procedures. Annual report? How?
Create standardized NPSB policies and procedures to be implemented across the VHA system that are consistent standardized, and equitable.	Chief Nursing Officer; (Organizational)	Three months after approval. Policies and procedures in place.	Evidence of new policies and procedures.
Include in the NPSB policies: rotation of members on a consistent timetable and	Chief Nursing Officer (Organizational)	Three months after approval. Policies and	Evidence that facility nurse executive has the authority to approve recommendations.

Implementation strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
training and orientation of new board members.		procedures in place.	
Empower the facility nurse executive with the authority to approve recommendations of the NPSB.	Secretary and Under Secretary for Health (Organizational).	October 2004; policy developed.	Report to Secretary and Undersecretary for Health from facility directors.

Nurse qualification standards should be clearly defined to facilitate consistent interpretation across VA.

Implementation Strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Create and implement policies aimed at removing inconsistencies in interpreting Nurse Qualification Standards within VHA.	Chief Nursing Officer and facility nurse executives. (Organizational)	One year after acceptance of recommendation. Policy and procedures in place.	Report to Chief Nursing Officer.
Ensure that supervisors and employee understand the Qualification Standards, the professional standards board process, and the proficiency rating system.	Chief Nursing Officer and facility nurse executives. (Organizational)	One year after acceptance of recommendation. Policy and procedures in place.	Report to Chief Nursing Officer.

Appendix E

Professional Development Recommendations

The Chief Nursing Officer should structure career development opportunities to assure that every nurse in VHA can actualize his or her goals within one or more career paths with the opportunity for professional growth and advancement.

Implementation Strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Secure funding mechanism to assure that each nurse has an individual career plan and that the plan includes the assignment of mentors, provision of resources, and release time to be able to pursue a career path.	Under Secretary for Health; Chief Nursing Officer. (Organizational)	October 2004. Funds allocated.	Funding stream included in strategic plan priority for VHA.
Create policies and procedures for a national career development program.	Chief Nursing Officer. (0rganizational)	January 2005. Plans developed.	Evidence of policies and procedures in place.
Implement national staff education plan regarding career pathways.	Chief Nursing Officer. (Organizational)	October 2005. Plans implemented.	Report to Chief Nursing Officer on: Career pathways in place Numbers of nurses seeking to advance their career pathways Percent of staff with career development plans.

VHA should establish national policy guidelines for schools of nursing comparable to the medical school model in policy memorandum Number 2 and actively promote nursing school affiliations.

Implementation Strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Secure comparable financial support for nursing education.	Under Secretary for Health (Organizational)	January 2005. .	VHA funding allocated.
Develop collaborative model for educating	Chief Nursing Officer and Office of	October 2005.	Evidence of collaborative model.

Implementation Strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
future nurses.	Academic Affiliations. (Organizational)	Model in place.	
Develop program guide, implementation policies and procedures, and pilot in 20 VA facilities.	Under Secretary for Health, Chief Nursing Officer, and Office of Academic Affiliations. (Organizational).	October 2006. Policies and procedures. Pilot program.	Evidence of pilot in at least 20 facilities with report to the Undersecretary for Health and the Chief Nursing Officer.

VHA should assure that the VA's Health Professionals Educational Assistance program (VAHPEAP) is funded and maintained.

Implementation Strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Consider funding an education program comparable to other federal programs such as military scholarships.	Healthcare Staff Development and Retention Office, Office of Nursing Service (Organizational)	January 2005 Funding in place	Evidence of education program that is comparable to other federal programs through reports and other implementation metrics.
Establish a nursing scholarship program for non-VA employees to promote recruitment.	Under Secretary for Health, Chief Nursing Officer (Legislative)	November 2004 Program created through Congressional authorization	Reports on nursing scholarship program for non-VA employees. Statistics on numbers of program participants who are recruited and retained at VHA facilities.
Continue funding all current programs supporting nursing education including the NNEI	Under Secretary for Health (Organizational)	September 2004 for FY 2005 Funding in place	Reports of funds expended under NNEI and other programs supporting nursing education. Numbers of program participants. Retention rates among program recipients.

Appendix F

Work Environment Recommendations

VHA should develop, test, and adopt nationwide staffing standards that assure adequate nursing resources and support services to achieve excellence in patient care and desired outcomes.

Implementation strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Develop and test staffing standard that includes a technology driven acuity system linked to staffing data and other variables.	Under Secretary for Health Office of Nursing Service (Organizational)	December 2005 Staffing standard developed and tested	Evidence of staffing standard with data on relationships among factors included in standard; evidence of cost estimates for implementation
Fully fund and implement standards in each facility that assures adequate nursing resources and support services to achieve excellence in patient care and outcomes.	Facility chief nursing executive and VISN directors. (Organizational)	At least six months following implementation.	Evaluation of effectiveness of staffing standards through VANOD data.
Eliminate the performance of non-nursing tasks by nursing staff.	Facility and VISN directors and facility nurse executives. (Organizational)	January 2006. Elimination of non-nursing tasks by nurses.	Increased staff nurse satisfaction on survey. Report on assessment and implementation of policies and procedures to shift non-nursing tasks to non-nursing personnel.

VHA should review and adopt appropriate recommendations outlined in the Institute of Medicine report, *Keeping Patients Safe: Transforming the Work Environment of Nurses,* to determine specific strategies for implementation across VHA

Implementation strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Convene a work group consisting of representation from Central Office, VISNs, facilities, and all levels of nursing.	Chief Nursing Officer (Organizational)	December 2004 Work group convened.	Evidence of work group with representation from Central Office, VISNs, facilities, and all levels of nursing.
Review and recommend implementation of selected IOM report recommendations, using agreed-upon procedures.	Facility chief nursing executive and VISN directors. (Organizational)	June 2005 Implementation of plans.	Evidence that plans are being implemented through annual report of facility nurse executives.
Implement and evaluate effectiveness of recommendations from IOM report.	Facility and VISN directors and facility nurse executives. (Organizational)	January 2006. Elimination of non-nursing tasks by nurses.	Increased staff nurse satisfaction on survey. Report on assessment and implementation of policies and procedures to shift non-nursing tasks to non-nursing personnel.

Appendix G

Respect and Recognition Recommendations

VHA should expand recognition of achievement and performance in nursing service.

Implementation Strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Initiate a "best practices evidence-based" collaborative program in which facilities and VISNs share information on rewards and recognition strategies.	Facility nurse executives. (Organizational)	October 2004 Procedures.	Evidence of best practices program sharing through modalities such as web, minutes, proceedings of meetings.
Develop, fund, and monitor a standardized recognition process at the facility level.	Chief Nursing Officer and facility nurse executives. (Organizational)	May 2005 Standardized recognition program and funding	Program developed. Report of honorees annually.

VHA should create a sense of value and culture of mutual respect for nursing through all levels of VHA to include physicians and other colleagues, management, and stakeholders.

Implementation strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Support specific nurse-physician collaboratives that are designed, implemented, and evaluated for their effectiveness.	Chief nursing officer (who from the medical side?) (Organizational)	October 2004 for implementation and ongoing. Collaboratives	Report on collaboratives. Increased nurse satisfaction on surveys. Others?
Increase visibility of nursing contributions facility wide and community wide; i.e., hospital newspaper and television; local newspaper and nursing publications.	Facility nurse executives (Organizational)	December 2004 and ongoing. Newspaper articles, appearances on television, journal articles.	Baseline established on media contributions and features and journal submissions. Increase by 10% annually as noted in facility nurse executive reports.
Increase awareness and fully implement, monitor, and track a code of conduct for all VHA employees, veteran patients, and other stakeholders.	Under Secretary for Health. Chief nursing officer (Organizational)	October 2005. Code of conduct.	Reports demonstrating decrease in reports of verbal and physical abuse by all stakeholders. Decrease in perceived incidents on nurse

Implementation strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
			satisfaction surveys.
Expand the “VA Workplace Stress and Aggression Project” to include all VISNs and facilities.	Under Secretary for Health (Organizational)	October 2005. Implementation of the program.	Significant reduction in behaviors associated with aggression, equal-employment-opportunity violations, and injury-stress-related aggression as noted in reports.

Appendix H

Fair Compensation Recommendations

VHA should amend Title 38 to establish procedures for assuring that RN locality pay policies are competitive with local RN employer markets.

Implementation Strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Establish a standardized process that includes the Central Office's contracting to obtain salary data for all localities in which VHA has facilities.	Under Secretary for Health and Chief Nursing Officer. (Organizational)	December 2004. Process in place.	Regional salary data reports Report on changes in pay system to facilities Process for adjudicating variances with facility directors in place. Documentation of use.
Establish a committee to examine pay progression scales for nurses and recommend policy alternatives to include creating more steps (particularly in the Nurse II rank) and other financial incentives to retain nurses.	Chief Nursing Officer. (Organizational)	October 2004. Policy alternatives and recommendations.	Evidence of more steps in Nurse II rank. Evidence of other compensation retention strategies, such as annual bonuses to senior nurses and/or expansion of pay range for Nurse II.
Provide each facility/VISN with funding to accommodate the full cost of pay increases.	Under Secretary for Health and VISN directors. (Organizational)	October 2004	Ability of VISNs to increase wages as dictated by Management Support without harm to other budget priorities
Systematically evaluate the effectiveness of the revised locality pay policy.	Under Secretary for Health (Organizational)	Annually in October beginning October 2005	Annual report on changes in pay rates, hiring, retention, recruitment

VHA should change hiring and compensation policies to promote recruitment and retention of licensed practical nurses and nursing assistants.

Implementation Strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Add licensed practical nurses to the list of occupations not covered by the limitations on special salary rates in 38 U.S.C. 7455**.**	Secretary for Health. Office of Nursing Service (Legislative)	January 2005. Amended list of occupations not covered by limitations on special salary rates in 38 U.S.C. 7455.	As noted on the published list and reflected in VHA policies.
Consider previous LPN experience for new RNs when establishing grade and step.	Under Secretary for Health. Office of Nursing Service (Organizational)	January 2005. Policies and procedures developed.	Evidence in report to the Secretary that policies and procedures are developed and implemented.
Implement direct hiring authority for NAs.	Under Secretary for Health Office of Nursing Service (Legislative	*March 2005* Direct hiring authority for NAs	Evidence of the development and implementation of new VHA directive.

.

VHA should strengthen human resources systems and departments to develop an active hiring and recruiting process for nursing staff that is consistent, to the extent possible, across facilities and VISNs.

Implementation Strategy	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Restore the HR expertise to assure responsiveness to nursing's needs to recruit, hire, and retain the nursing workforce.	Secretary and Under-Secretary for Health (Organizational).	October 2005. Evidence of increased resources allocated to HR departments	An assessment of the strengthening of HR departments and expertise in Title 38. Annual evaluation by the end-user.

Appendix I

Technology Recommendations

VHA should give priority to the continued rollout of the VA Nursing Outcomes Database (VANOD) as the data repository for nursing performance standards and the evaluation of effective patient care delivery models.

Implementation Strategy	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Use grant funds to develop plans in each facility for adopting clinical practice models that assure adequate nursing resources and support services to achieve excellence in patient care and outcomes using performance standards recommended by National Quality Forum and VANOD.	Chief Nursing Officer (Organizational)	October 2005 Plans for adopting clinical practice models.	Evidence of plans for adopting clinical practice models.

VHA should engage experts to evaluate and redesign nursing work processes to enhance patient care quality, improve efficiency and decrease nurse turnover through the use of technology.

Implementation Strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Develop plans to apply throughout VA settings	VISN directors (Organizational)	October 2004 Plans.	Evidence of development of plans.
Use technology and related research findings in the development, implementation and evaluation of plans for safe efficient patient care.	Facility nurse executives (Organizational)	October 2005	Evidence of the development, implementation and evaluation of patient care plans using technology and research findings.

The Agency for Healthcare Research and Quality (AHRQ) and VHA should partner in applying findings from information systems and technology research projects into patient care delivery.

Implementation Strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Focus research initiatives on safety and efficiency	Office of Nursing Service (Organizational)	October 2005. Research initiatives focused on safety and efficiency.	Annual report of research initiatives (VISN, facility nurse executives, central office)
Partner in a grant program	Office of Nursing Service (Organizational)	October 2005. Grant program.	Evidence of partner activities.

Appendix J

Research/Innovation Recommendations

The VA should establish a Center for Excellence in Quality Nursing Care to create and implement a research agenda consistent with the VA mission.

Implementation Strategies	Accountability (Organizational/Legislative)	Timeline and Deliverable	Metrics
Establish the Center through a competitive process.	Under Secretary for Health Chief nursing officer (Organizational)	October 2004 Establishment of the Center	Evidence that the Center is established through a competitive process.
Establish and implement an agenda of research priorities that are consistent with the VA mission.	Under Secretary of Health Chief nursing officer and (Organizational)	October 2005 Research agenda	Research agenda published. System in place to evaluate and update the agenda.
Allocate competitive grant funds to facilities proposing to engage in research consistent with research agenda.	Chief nursing officer (Organizational)	January of each year	Competitive grant process policies and procedures in place with awarding of grant funds on regular, systematic basis.
Provide technical assistance to develop competitive grant applications and designate accountability for implementation.	Chief nursing officer (Organizational)	October 2005 and ongoing	Annual Center report on technical assistance offered.
Support the development of nurses to become researchers who will improve the quality of patient care.	Chief nursing officer and facility nurse executives (Organizational)	October 2005 and ongoing	Facility annual reports include annual benchmarks that increase the number of nurses who participate in research.

Appendix K

Academic Partnership Policy #98-01 (June 1998)

Review of Associated Health Professions Affiliations and Re-Signing of Affiliation Agreements
Office of Academic Affiliations
Veterans Health Administration

1. **PURPOSE:**

a. This policy document provides instructions to Department of Veterans Affairs (VA), Veterans Health Administration (VHA), facilities and Veterans Integrated Service Networks (VISNs) for the review of associated health affiliations and re-signing of related affiliation agreements. Reassessments of VHA affiliations with associated health professions education programs are now needed to ensure alignment with the current and future health care environment, the recommendations of the Associated Health Professions Review Committee, and the changes in VHA.

b. Associated health professions are defined as all clinical health care professions other than allopathic and osteopathic medicine. Podiatry, optometry and dentistry affiliations are included under this policy.

c. Affiliations are defined as arrangements between VA health care facilities and academic institutions for the provision of clinical education or training of students. Affiliation agreements are required for all clinical education experiences that involve direct patient contact. However, a memorandum of affiliation is not necessary for students whose portion of education or training is at a VA facility for: 1) shorter than 40 hours per year; 2) only for observation with no patient contact; or 3) laboratory research purposes only. These students, however, must be appointed by the facility Director on a Without Compensation (WOC) basis (M-8, Part II, Chapter 2, Par. 2.04b).

d. Memorandum of Affiliation, Educational Program Agreement between VA and Non-VA Health Care Facility/Agency (Attachment C) implements changes in the liability protection for VA-sponsored trainees while they are obtaining required educational experiences at non-VA health care facilities/agencies. (See paragraph 3.g. of this policy document.)

2. **BACKGROUND:**

a. VA is the nation's largest provider of health professions education and training and, as such, it is obligated to lead in the development of a health professions work force that meets the current and future needs of both veterans and the nation. The educational impact of VA relies on its partnerships with many of the nation's leading academic institutions. The basic foundation for VA partnerships with academic health care programs was espoused in Policy Memorandum Number 2 issued in 1946. The key objectives of this unique document were to maintain and improve health care for veterans, to assist in recruitment and retention of the highest quality staff

at VA facilities, and to create a patient care environment characterized by an academic atmosphere of inquiry. Much of that document is as applicable today as it was when it was conceived 50 years ago. Nonetheless, health sciences, the manner in which health care services are delivered, the training of health care professionals, the health care personnel needs of VA and the nation, and the structure and operation of the veterans health care system all have dramatically changed since Policy Memorandum Number 2 was implemented.

b. In December 1996, the Under Secretary for Health appointed the Associated Health Professions Review Committee as a subcommittee of the Special Medical Advisory Group. The Committee was charged to provide recommendations on VA's role in educating associated health professionals and its use of these personnel in delivering VA health care. On September 16, 1997, the Committee completed the review and submitted its report. The report was accepted by the Under Secretary for Health on December 3, 1997.

The Associated Health Professions Review Committee identified six-cross cutting recommendations:

I. Associated health education programs should be patient-focused. Emphasis should be placed on programs that address areas of high priority to VA and the nation, for example, primary care, geriatrics, mental health and rehabilitation. Professions that address the greatest needs of veterans will be given preference for training.

II. The proposed trainee allocation methodology (for funded trainees as well as determination of unfunded trainees) has six over-arching principles: 1) education should reflect clinical practice realities; 2) education, and therefore trainee allocations, should be patient-focused with profession-specific input at local and national levels; 3) the allocation methodology should allow maximum participation of decision-makers in the VA health care system; 4) innovative program development should be promoted; 5) training programs should demonstrate interprofessional strategies and collaboration; and 6) a quality improvement cycle should be incorporated within the evaluation of all training programs.

III. Decisions regarding implementation of education programs should be made at the facility and VISN level. System-wide policy should be facilitated by the Headquarters' Office of Academic Affiliations. This Office should develop program policies and guidelines, monitor the implementation of the programs, allocate funding as appropriate, and evaluate program outcomes.

IV. Innovative academic partnerships should be established to create associated health education programs that best meet veterans' needs. Current academic partnerships that reflect those needs should be enhanced.

V. Prospective program evaluation and analysis of health care outcomes should be integral parts of all educational activities.

VI. Clinical education activities should be valued. To facilitate this, their implementation should be included as a productivity factor in VA.

3. **POLICY:**

a. The linked process of reviewing affiliations and re-signing Educational Program Agreement documents will take place under the guidance of the Chief Academic Affiliations Officer. The Network Director will provide guidance to health care facilities regarding VISN strategy and goals with reference to affiliations and the required agreements.

b. All associated health professions affiliations will be reviewed prior to re-signing the educational program agreements. **Attachment A** will serve as a guide for the initial and ongoing reviews. It is anticipated that during the review process VA and the educational programs will assess the value of the affiliation and develop strategies for quality improvement through ongoing planning, implementation and analysis of outcomes.

c. All affiliations with accredited associated health professions education programs are considered decentralized programs so that they do not need the approval of the Chief Academic Affiliations Officer's approval. Programs must be accredited by the nationally recognized accrediting body for the specific profession. New programs anticipating full accreditation within five years are also considered decentralized programs and may be provisionally approved until fully accredited. The new program must provide documentation of the plan for accreditation. Accredited programs are decentralized even if the profession is eligible for student funding from the Office of Academic Affiliations.

d. Nationally recognized accrediting bodies are designated by the United States Department of Education. VHA Manual M-8, "Academic Affairs," Part II, Chapter 2, Appendices 2A and 2B, list nationally recognized accrediting bodies for associated health professions education programs.

e. Associated health professions education programs that are not accredited or are not in the process of becoming accredited will continue to be centralized programs requiring approval by the Chief Academic Affiliations Officer. A program may be non-accredited for the following reasons:

I. There is no nationally recognized accrediting body for the profession,

II. There is a nationally recognized accrediting body for the profession, but the education program has not applied for accreditation, or

III. The program has applied for accreditation, but has not met the accreditation standards.

f. Educational Program Agreements (Attachments B, C or D) will be used for affiliations with associated health education programs. **Attachment B** is used when a VA medical facility helps train undergraduate and graduate students from academic programs. **Attachment C or D**

is used when another institution helps train students from an accredited VA-sponsored program. Master Agreements are NOT required. There shall be no informal or special arrangements that are not in accordance with VA policy or sound management practices as outlined by the template agreement (Attachments B, C or D). Any wording change from Attachments B, C or D must be approved by General Counsel in VA Headquarters.

g. Typically, the non-VA health care facility will cover VA trainees from VA-sponsored programs under its malpractice insurance when they are at its facility. In that case, Attachment D should be used when signing the memorandum of affiliation. Attachment D identifies the non-VA health care facility as the responsible party for providing protection of VA trainees from personal liability while performing professional services at the non-VA health care facility. However, if the non-VA health care facility declines to cover the VA trainees in a VA-sponsored program under its malpractice insurance when they are at its facility, Attachment C should be used. Attachment C defines the protection of VA trainees from personal liability while providing professional services covered by the agreement at the non-VA health care facility/agency. The liability protection is that which is provided under the Federal Employees Liability Reform and Tort Compensation Act, 28 U.S.C. 2679 (b)-(d). This means that VA-sponsored trainees going to non-VA health care facilities/agencies for required training will be provided the same liability protections as they would be provided at VA facilities.

h. The Educational Program Agreements shall be approved by the Network Director unless the approval authority is delegated to facility Directors or other individuals. Specific operational and logistical details will be negotiated by the facility. It is expected that all affiliation agreements will be approved by September 30, 1999.

i. The Office of Academic Affiliations does not require that written report of the review of the affiliations and signed Educational Program Agreements be sent to Headquarters. However, the dates of signing the Educational Program Agreements **must** be reported in the annual Health Services Training Report (RCS 0161) for any educational programs that send trainees to VA health care facilities during the period of time covered by the report. **It is expected that a thorough review of each affiliation, as appropriate, using the guidelines in Attachment A, will be completed prior to re-signing an affiliation agreement**. The review document should not be lengthy, but its content should reflect a discussion appropriate to the needs and complexity of the training program and facility.

j. Approved Educational Program Agreements, along with required supporting documents (see M-8, Part II, Chapter 2, January 26, 1990, paragraph 2.10 a(1) to(3)(c), must be kept on file at the VA facility for reference and inspection by appropriate site visitors.

k. Educational Program Agreements should be reviewed every five years from the date of signing or when updated with major changes, unless terminated earlier by either VA or the educational program.

4. **ACTIONS**:

a. The VISN Director shall:

I. Provide guidance to individual health care facilities regarding required affiliation agreements and related network strategy;

II. Delegate authority, if desired, to facility Directors for approval of Educational Program Agreements for associated health professions; and

III. Appoint an individual or delegate to facility Directors to appoint individuals to coordinate the review of all associated health affiliations and the execution of Educational Program Agreements.

b. The individual(s) appointed to coordinate the review of all associated health affiliations and signing of Education Program Agreements shall:

I. Meet with facility leaders of clinical professions that currently have, or wish to have, trainees at the facility to provide guidance on the process for reviewing the affiliations and signing the Educational Program Agreements;

II. Monitor the review process to assure completeness; and

III. Provide information regarding completion dates for input into the Health Services Training Report (RCS 0161).

5. **SCHEDULE**:

a. VISN Director: (1) provides guidance to individual health care facilities regarding required affiliation agreements and related VISN strategy; and, (2) appoints an individual or delegates to facility Directors to appoint individuals to coordinate the review of all associated health affiliations and the signing of Educational Program Agreements	July 17, 1998
b. Reviews and re-signing of Educational Program Agreements will be completed for all affiliations.	September 30, 1999
c. **Reports dates that Educational Program Agreements were signed on the annual Health Services Training Report (RCS 0161).**	**October 15, 1999 and annually thereafter**

6. **ADDITIONAL INFORMATION**: Questions concerning policies and procedures related to affiliations with associated health education programs should be directed to Linda Johnson, Ph.D., R.N. at 202.273.8372, Fortune Kennedy, Ed.D., R.N. at 202.273.8373 or Gloria Holland, Ph.D. at 202.273.8371.

7. **ATTACHMENTS**

a. Attachment A	Guidelines for Review of Affiliations
b. Attachment B	Educational Program Agreement (for use when academic program sends trainees to VA facility)
c. Attachment C and D	Education Program Agreement (for use when trainee in VA sponsored program goes to a non-VA facility)

Appendix L

January 30, 1946 POLICY MEMORANDUM NO. 2

SUBJECT: Policy in Association of Veterans' Hospitals With Medical Schools.

1. GENERAL CONSIDERATIONS

a. Necessity for Mutual Understanding and Cooperation. The Department of Medicine and Surgery of the Veterans' Administration is embarking upon a program that is without precedent in the history of Federal hospitalization. It would, therefore, be most unusual if numerous problems did not arise for which no fully satisfactory solution were immediately apparent. Such problems frequently can be solved only by trial and error; and, until workable solutions are found, both parties in the program must exercise tolerance if the program is not to fail.

There can be no doubt of the good faith of both parties. The schools of medicine and other teaching centers are cooperating with the three-fold purpose of giving the veteran the highest quality of medical care, of affording the medical veteran the opportunity for post-graduate study which he was compelled to forego in serving his country, and of raising generally the standard of medical practice in the United States by the expression of facilities for graduate education.

The purpose of the Veterans' Administration is simple: affording the veteran a much higher standard of medical care than could be given him with a wholly full-time medical service.

The purposes of both parties being unselfish, and there being no conflict of objectives, there can be no serious disagreement over methods. It will be recognized that the Veterans' Administration is charged with certain legal responsibilities in connection with the medical care of veterans which it cannot delegate, if it would. Yet the discharge of these responsibilities need not interfere with the exercise by the schools of their prerogatives in the field of education.

All medical authorities of the Veterans' Administration will cooperate fully at all times with the representatives of associated schools and other centers. It is the earnest desire of the Acting Chief Medical Director that our relations with our colleagues be cordial as well as productive.

b. General Division of Responsibility: The Veterans' Administration retains full responsibility for the care of patients, including professional treatment, and the school of medicine accepts responsibility for all graduate education and training.

2. THE VETERANS' ADMINISTRATION

a. Operates and administers the hospital.

b. As rapidly as fully qualified men can be had, will furnish full-time chiefs of all services (see par. 5 below) who will supervise and direct the work of their respective staffs, including the part-time attending staff furnished from the School of Medicine, insofar as the professional care of patients is concerned. Nominations by Deans' Committees for such full-time positions will be welcomed; and, unless there be

impelling reasons to the contrary, will be approved wherever vacancies exist. These service chiefs are fully responsible to their immediate superior in the Veterans' Administration.

c. Appoint the consultants, the part-time attending staff and the residents nominated by the Deans' Committee and approved by the Veterans' Administration.

d. Cooperate fully with the Schools of Medicine in the graduate education and training program.

3. THE SCHOOLS OF MEDICINE:

a. Will organize a Deans' Committee, composed of senior faculty members from all schools cooperating in each project, whether or not furnishing any of the attending or resident staff.

b. Will nominate an attending staff of diplomates of specialty boards in the numbers and qualifications agreed upon by the Deans' Committee and the Veterans' Administration. (See 6e)

c. Will nominate, from applicants, the residents for graduate education and training.

d. Will supervise and direct, through the Manager of the hospital and the Consultants, the training of residents.

e. Will nominate the consultants for appointment by the Veterans' Administration.

4. HOSPITAL MANAGERS:

a. Are fully responsible for the operation of their hospitals.

b. Will cooperate with the Deans' Committee, bringing to its attention any dereliction of duty on the part of any of its nominees.

5. CHIEFS OF SERVICE:

a. Are responsible to their superior in the Veterans' Administration for the conduct of their services.

b. Will bring to the attention of their superior, for his action, such cases as they are unable to deal with personally of dereliction of duty or incompetence on the part of any full-time or part-time staffs under their control.

c. Will, together with the part-time attending staff, under the direction of the Manager, supervise the education and training program.

d. When full-time employees of the Veterans' Administration, will be diplomates of their respective boards and will be acceptable to the Deans' Committee and to the specialty boards concerned. It is the urgent purpose of the Veterans' Administration to place full-time fully qualified and certified chiefs of

service for all services in each hospital associated with a School of Medicine. Except in cases where the chief selected has local affiliations, which might embarrass or prejudice his relations with one or another of the associated schools, his initial assignment may not be cleared through the Deans' Committee. In all cases, when it has been conclusively demonstrated that a chief

of service cannot cooperate with a Deans' Committee, he will be transferred (if efficient otherwise) and replaced by another. Until this purpose can be fully accomplished, however, in order that a hospital may obtain approval for resident training by one or another specialty board, it may be necessary to appoint part-time chiefs of services who meet the requirements of the boards. This will be done; but it will be done with the understanding that the part-time chiefs will be replaced with qualified full-time chiefs as rapidly as they become available. The duties and responsibilities of part-time chiefs will be the same as those of full-time chiefs.

6. PART-TIME ATTENDING STAFF:

a. Will be responsible to the respective chiefs of service.

b. Will accept full responsibility for the proper care and treatment of patients in their charge.

c. Will give adequate training to residents assigned to their service.

d. Will be veterans unless approval in each case has been given by the Chief Medical Director.

e. Will be diplomates of their respective boards and acceptable to such boards for direction of resident training. Exception may be made in the case of a veteran who has completed the first part of his board examination, but whose completion of the examination was interrupted by the exigencies of the military service.

f. Will hold faculty appointments in one or another of the associated Schools of Medicine, or will be outstanding members of the profession of the caliber of faculty members.

7. CONSULTANTS:

a. Will be veterans unless approval in each case has been given by the Chief Medical Director.

b. Will be members of the faculty, of professorial rank, of one or another of the associated Schools of Medicine.

c. Will, as representatives of the Schools of Medicine, direct and be responsible for the educational training of residents.

d. Will afford to the Manager and the proper Chief of Service the benefit of their professional experience and counsel.

e. Will conduct their duties through, and in cooperation with, the Manager and the proper Chief of Service, and also, in matters of education and training, with the part-time Attending Staff--always, however, coordinating with the Chief of Service.

August 22, 1980
ADDENDUM TO POLICY MEMORANDUM NO. 2

The following policy statement relates to the "GENERAL CONSIDERATIONS" portion of Policy Memorandum No. 2 dated January 30, 1946:

Historically the Department of Medicine and Surgery has been committed to provide quality care for its veteran constituency and to use all means possible to accomplish it. One highly desirable method, dating back to Policy Memorandum No. 2, has been to arrange mutually beneficial affiliations with medical schools. At the same time, affiliation with a medical school cannot be considered the only prerequisite for provision of quality care. High quality care can be and is provided by both affiliated and unaffiliated VA medical centers. DM&S remains committed to explore all avenues of providing quality care while continuing to contribute to the national requirement for health manpower production.

Appendix M

Acronyms

ANA	American Nurses Association
ANCC	American Nurses Credentialing Center
AONE	American Organization of Nurse Executives
BCMA	Bar Coded Medication Administration
CEO	Chief Executive Officer
CMO	Chief Medical Officer
CNE	Chief Nurse Executive
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CPRS	Computerized Patient Record System
EDRP	Education Debt Reduction Program
EISP	Employee Incentive Scholarship Program
EOD	Enter(ed) on Duty
HCSDRO	Health Care Staff Development and Retention Office
HPEAP	Health Professionals Educational Assistance Program
HSR&D	Health Services Research and Development
IDN	Integrated Delivery Network
IOM	Institute of Medicine
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
NAIS	Nursing Administration Information System
NCOD	National Center for Organization Development

NIIS	Nursing Integrated Information System
NNEC	National Nurse Executive Council
NNEI	National Nursing Education Initiative
NPSB	Nurse Professional Standards Board
VA	Veterans Affairs
VANOD	VA Nursing Outcome Data
VHA	Veterans Health Administration
VISTA	Veterans Health Information System and Technology Architecture

Appendix N

Glossary

Baldrige National Quality Program	Organizational assessment and improvement measured against a set of health care criteria designed to help organization use an integrated approach to organizational performance management. This performance management results in delivery of over-improving value to patients and other stakeholders contributing to improved health care quality; improve overall organizational effectiveness, and organizational and personal learning. (2003 Baldrige Health Care Criteria)
Chief Nurse Executive	The nurse who participates in the management of healthcare services delivery by directing and coordinating the work of nursing and other personnel and representing nursing services. This individual practices within the framework of ANA Administrative Practice Standards.
Health Care Technology	The application of scientific or other organized knowledge-including any tool, technique, product, process, method, organization or system-to practical tasks. In health care, technology includes drugs; diagnostics, indicators, and reagents; devices, equipment and supplies; medical and surgical procedures; support systems; and organizational and managerial systems used in prevention, screening diagnosis, treatment and rehabilitation.
Key Drivers	Most important elements to nursing staff attraction and retention identified among VHA nursing staff and through VHA studies/reports.

1. Leadership:
    a. *System*: The basis for and the way key decisions are made, communicated and carried out. It includes structures and mechanisms for decision-making; selection and development of leader and managers; and reinforcement of values (Baldrige 2003 Health Care Criteria)
    b. *Quality of Nursing Leadership*: Knowledgeable, strong risk-taking nurse leaders who follow an articulated philosophy in the day-to-day operations of the nursing department. Nursing leaders that convey a strong sense of advocacy and support on behalf of staff (McClure and Hinshaw, 2002).

2. Work Environment:
    Facility setting where care is delivered and quality is influenced by the organizational culture, models of nursing practice, nursing leadership and management, organizational policy/procedure making, work space/configuration, and resources based on patient care needs.

3. Professional Development:
    Value is placed on personnel and professional growth and development. Emphasis is placed on orientation, in-service education, continuing education, formal education and career development. There are

opportunities for competency based clinical advancement along with resources to maintain competency (McClure and Hinshaw, 2002).

4. Fair Compensation:
   Include promotion and advancements based upon performance, skills acquired, education and other factors. The staff performance management system is tied to compensation and recognition and incentives practices reinforce high-performing work and a patient health care focus (Baldrige 2003 Health Care Criteria)

Magnet Recognition Program	An accreditation program recognizing excellence in nursing service departments against a specific set of standards aimed to: identify excellence in the delivery of nursing services to patients/residents/clients; promote quality in a milieu that supports professional practice; and provide a mechanism for the dissemination of “best practices” in nursing services.