

HEARING BEFORE
THE NATIONAL COMMISSION ON VA NURSING

MARRIOTT SCHAUMBURG
50 NORTH MARTINGALE ROAD
SCHAUMBURG, ILLINOIS

TRANSCRIPT OF PROCEEDINGS had in the
above-entitled cause on the 24th day of April,
A.D. 2003, at 9:00 a.m.

BEFORE:
MR. DAVID GORMAN,
MS. ANN ADAIR,
MS. ANN CONVERSO,
Commission Members.

ALSO PRESENT:

MS. OYWEDA MOORER,

Director, Department of Veterans

Affairs, National Commission on VA

Nursing.

PRESENTERS:

MS. BARBARA BOLLENBERG,

MS. JERI BURNS,

MS. HOLLY DESPIEGELAERE,

MR. LARRY DEBUHR,

DR. SHEILA HAAS,

MR. ROBERT HOBAUGH,

MS. KAREN ISHMAEL,

MS. TERI JAMES,

MS. SANDRA JOHNSON,

MR. PATRICK KEARNS,

MS. WANDA LOCKHART,

MS. JAN LOTTMAN,

MS. LUCINDA MARSHALL-DOWDELL,

MS. KAREN MAYS,

MR. GREGORY MILLER,

MR. JOHN MILLS,

MS. MONICA MOORE,

PRESENTERS (Continued):

MS. ALICE NIED,

MS. JANE NYGGARD,

MS. AMIE POUNDS,

MS. SHAWNA REID,

MR. ROY ROMANS,

MS. CONNIE SHIVERDECKER,

MS. MARY WALKER,

OPEN FORUM PARTICIPANTS:

MR. RICHARD ADE,

MS. KAREN ANDERSON,

MR. GEORGE BARNES,

MS. THELMA D. BOYD,

MS. DIANE CLINES,

MR. BRUCE DETTY,

MS. DANNA FRANCE,

MS. ALISA GWYNN,

MR. RICHARD HOMER,

MS. LINDA HALVERSON-BEITER,

MR. BRYCE HENSON,

MS. MARGARET KRUCKEMEYER,

MS. JUDITH LEMNA,

MS. TAMMY LEPLEY,

OPEN FORUM PARTICIPANTS:

MR. CHARLES KERN,

MS. RUBY MALONE,

MS. JUDY MCCUTCHEON,

MS. DAPHNE OSBORNE,

MS. JOANN PAGE,

MS. CYNTHIA PENDELL,

MS. MICHELLE REED,

MR. PATRICK RUSSELL,

MS. JACKIE RUST,

MR. LARRY SMITH,

REPORTED BY:

SHARYN A. EVERMAN, CSR NO. 84-2315.

MR. GORMAN:

Good morning, everyone. My name is Dave Gorman. I'm a member of the National Commission on VA Nursing, and I also work for the Disabled American Veterans in Washington, D.C. Seated with me today is Ann Adair and Ann Converso, who are also commission members. Ann Adair is the associate director of medical services with the Paralyzed Veterans of America in Washington, D.C. She is also a former VA nurse and major in the United States Army. Ann Converso is a registered nurse at the VA Western New York health care system. She also represents the United American Nurses of ANA. Oyweda Moorer sitting over here to my right is the director of the National Commission on VA Nursing and is the former nurse executive at the Washington, D.C. VA medical center. Our court reporter today is Sharyn Everman. Let me ask before I go any further: Are there any veteran service organization representatives here today? And if there are, would you please introduce yourself. None? Okay. Before we start today's session, I would like to give a brief background of the Commission, its tasks and its progress to date. The Commission was established by the Congress and appointed by the Secretary of the Department of Veterans Affairs. Duties of the Commission are as follows: First, assessment -- consider the legislative and organizational policy changes to enhance the recruitment and retention of nurses and other nursing personnel by the Department of Veteran Affairs and assess the future of the nursing profession within the department. Secondly, recommendations -- to recommend legislative and organizational policy changes to enhance the recruitment and retention of nurses and other personnel in the department. A 12-member Commission made up of VA and non-VA staff as designated by Congress was appointed to carry out this charge. The first meeting of the Commission was held May 8th of 2002. Since the May 8th meeting the Commission has held three additional meetings. During this time, the Commission is using various methods to obtain feedback from VA nursing staff in order to make our assessments. The Commission will then submit an interim report in July of 2003. A complete report will be submitted to the Secretary of the Department of Veterans Affairs by May of 2004. The Secretary will then have 60 days to submit to Congress a report, first providing the Secretary's views on the Commission's findings and recommendations and, secondly, explaining what actions, if any, the Secretary intends to take to implement the recommendations of the Commission and the Secretary's reasons for doing so. The purpose of this hearing today is to obtain input from VA nursing staff on recruitment and retention issues. The Commission places a high priority on obtaining feedback from all levels of VA staff. Over the coming months, the Commission will continue to gather data and to hear from various VA staff. We would encourage you to visit our web site at -- I'm going to give it to you -- www.va.gov/ncvan or to e-mail the Commission at vhaconcvan@hq.med.va.gov. Having given that brief background, we will move the agenda forward by laying the ground rules for conducting the hearing today and answering any questions concerning this process that you may have, and the rules and the process is pretty simple and straightforward. Scheduled oral testimony will take no longer than ten minutes. Written testimony must have been submitted prior to the oral testimony being given today. Witnesses will be cautioned with a yellow card

when there is 3 minutes left to give testimony. Witnesses will promptly step down once time has been called. When appropriate, Commission members may ask questions of the witnesses. Witnesses may not ask questions of the If issues in a witness's testimony Commission members. Have been expressed in previous testimony, in the interests of time, subsequent witnesses may give an introduction and verbalize their agreement. A 20-minute open forum will be conducted in the morning and afternoon as indicated on your agenda. Anyone wishing to speak must complete the form on the registration table outside and submit it to the Commission members just prior to speaking. Persons speaking in the open forum will be selected on a first-come/first-served basis and will have the opportunity to speak for 3 minutes. I will notify the speaker when their time is up. We would ask that witnesses promptly stop talking and be seated when time is called. Does anyone have any questions regarding the process we are going to use? It's pretty straightforward, I think. If there are -- let me just make a couple of announcements. First we have two photographers over here to my left. One is from the AFGE, and the other is from United American Nurses. Also there are a couple of changes to the agenda itself, if I can give you those. The first occurs at 10:25 this morning, and Alice Nied will give testimony from the National Organization of Associate Degree Nurses. The second change occurs at 2:00. That witness is not here, and we will use an open forum for those ten minutes and try to hear from three individuals. And at 3:35, Karen Mayes will be testifying, and she is with the American Association of Community Colleges. At 2:50 there will also be an open forum in which we will try to get three witnesses in. We will now take our first witness, please, and that is Wanda Lockhart from the Tomah, Wisconsin VA Medical Center. We would also ask that each witness give his or her name, the title, and facility prior to starting their testimony. Anybody that may wish to respond to anything said during the oral testimony given by any of the witnesses may do so, and please feel to do so during the open forum process.

MS. LOCKHART:

My name is Wanda Lockhart. I'm an RN at Tomah VA Medical Center. I would like to thank the committee and its members for giving me this opportunity to present testimony in regards to the educational waivers. As a registered nurse of 40 years with expertise and experience in different areas of nursing, I'm infuriated by the VA's use of RNs to balance the budget. Over the last ten years, Veterans Affairs has been balancing its budgets on the backs of the nurses. I started my VA career as a staff nurse in 1963. Each year I have acquired continuing education and additional nursing college credits to broaden my expertise in nursing. In 1994, at the Tomah VA I was promoted as a nurse manager in an acute psychiatric unit. At that time, my grade was a Nurse II. The Nurse Professional Standards Board looked at my proficiency and the responsibility imposed to me as a nurse manager and recommended promotion by waiver of education. A request was forwarded to Veterans Affairs central office for educational waiver, and it was granted. I was a Nurse III. During my years at the VA, I have left for different periods of time to practice in the private sector. Prior to 1997, when I was rehired at a VA, it was always at the same grade level as when I left. In 1997, I left Tomah VA and took a job in the private sector. At that time, I was a

Nurse III. In July of 1999, I reapplied at the Tomah VA. I had learned there were nursing positions available; and although there were openings and nurses were hired, I was not rehired until October of 2000. After I had left my position as a district manager for a home health agency, I was made aware that I was rehired as a Nurse I due to the new qualification standards. I was demoted from a Nurse as a Diploma nurse. III to a Nurse I because I stayed in the position, but expected with my clinical expertise and my management skills that I would be promoted as the waiver processed remains in the new qual standards. To my dismay, I have learned otherwise. In 2001 and 2002, the Nursing Practice Standards Board, a board of my peers, has determined I've met the nine dimensions for promotion and have recommended promotion by waiver of my education. By the way, our local Nursing Practice Standards Board, which I'm a member of, has 40 subordinate standards that we have to meet; so, in actuality, we have 49 dimensions to meet for promotion. The waiver process for the last two years has not worked for me. I have faced denial for promotion by management. In my own visits, other VA facilities are granting promotion by the waiver process. All VAs are not treating nurses the same. I will quote the Director's response from Congressman Kind. "Ms. Lockhart is highly thought of regarding her clinical skills. The Nursing Practice Standards Board -- based on observed performance and outstanding clinical performance ratings, the Nursing Standards Practice Board recommended a waiver of the educational standards and has done so for the last two years. "However, Ms. Lockhart does not possess the academic degree required by the national VA nurse qualification standards. Therefore, she is not eligible for promotion without the Director's approval. "Ms. Parks and I agree that it is important to support the intent of the national nurse qualification standards of trying to increase the Baccalaureate or higher educated nurse in the VHA system. Therefore, I disapprove the recommendation for waiver," end of quote. The same director granted an educational waiver to an ADN nurse with one year of experience in January of 2001 from a Nurse I to a Nurse II. I am a qualified registered nurse with many years of accomplishments. I qualified for promotion. My peer group has recommend me for two years for promotion. Both times the director and the nurse executive has denied my promotion for educational reasons. When I first questioned this denial, I was told that the director had the final say in this decision. I then went to my exclusive representative to have them file a grievance over this issue. They, in turn, were told by management that Title 38, Section 7422, does not allow this action. Management uses Title 38, Section 7422, to hide from view when questioned on the ethical and the legality of denying promotion to nurses that have educational preparation as Associate Degree nurses or Diploma nurses. When I questioned this denial by the nurse executive and the facility director, I was told I did not meet the educational requirements for the next grade. My supervisor recently wrote me up for a step increase. That was denied. I was also -- I was informed that I cannot get a step increase as I'm at the end of the step in Nurse I at our facility, so I'm stuck in a system without anywhere to go. I'm 60 years old, and I wanted to continue to help the nursing shortage with my experience and expertise. I am still feeling really good, so that's what I want to do. I want to help the VA. What can I conclude from this? No. 1, the promotion system should be simplified. No. 2, the educational waivers should be automatic if the Nursing Standards Practice Board

recommends promotion. No. 3, an impartial qualified observer assigned by mutual consent from the union and management be present at the nursing practice standards meetings. No. 4, the Nursing Practice Standards Board should be the final decision for nursing promotions. No. 5, a process for nurses to have some recourse if there are questions arising out of a board action. At the present time, Title 38, Section 7422 does not allow the nurse to proceed with any form of grievance. This statute should be rescinded by this Commission in its entirety and completely done away with, allowing nurses to grieve issues related to conduct, competence, patient care, peer review, or employee pay. No. 6, promotions for nurses should be the same at all VAs. Thank you. And do you have any questions?

MR. GORMAN:

Thank you, Wanda. Patricia LaSala? Is Patricia here? No? Then we will move to -- and I apologize if I don't get this name right -- Holly.

MS. DeSPIEDGELAERE:

Good morning. My name is Holly DeSpiegelaere, and I am a registered nurse at Omaha VA. I work in clinical research. I have a Bachelor of Science degree in nursing and a Bachelor of Arts in sociology. I've been a nurse for ten years and have worked in different states in the private sector as well as a major academic center and for the past three years have been proud to care for veterans as a floor nurse, an operating room nurse, and most recently as a pulmonary clinical research nurse. The Nurse Professional Standards Board is peculiar to the VA system, and I have never encountered this type of system or heard of this system for review in any other place that I have worked. The Nurse Professional Standards Board is an antiquated and unjust system of review that operates virtually in secret like a cabal. The members are sworn to secrecy and instructed to destroy all notes taken at board meetings. Ironically, the members are appointed and removed at the discretion of one manager, the chief nurse; and to think that there isn't a good old boy network that exists or that many members don't know who the hierarchy thinks is okay to promote simply is not realistic. This is a classic example of cronyism at its finest. The standards for promotion are not only confusing and open to subjective interpretation; they are applied inequitably and the dissensions that exists among nurses of all levels is as much about who does get promoted as who does not. For example, there is a staff nurse who was promoted to a Nurse III while she was under investigation by the state nursing board. Just after her promotion, this nurse received a letter of caution from the state nursing board. Her supervisor sat on the very board that promoted her. This same supervisor was aware of this investigation, but had not corrected the situation that necessitated this outside investigation. Ironically, this same supervisor had also recently been promoted to a Nurse III by her supervisor, who was also aware of this entire situation and more. On the other hand, there is a nurse who has consistently received very favorable reviews from her supervisors, has done high quality work that has gone above and beyond her regular job, and has been a strong patient advocate; but it seems she is being unjustly denied promotion to Nurse III by the board because

she has spoken out to management, including the ones involved in the above incident, about problems such as patient safety and patient abuse. Consequently, she has been branded a trouble-maker. This is just one case in point. There are other good nurses who provide excellent patient care or excel in other areas of nursing, but never get promoted because they just never seem to fulfill the requirements for promotion; or perhaps it's because they're just not in that good old boy network. Because the standards for promotion are so subjective, the board can make the shoe fit for those they want to promote. Conversely, they can and do also use the same subjective standards to deny promotions. When asked to explain or clarify why one did not meet the standards for promotion, the chairperson's standard answer is to say, "This is what we have been told by Audrey Drake." Not only does one person or office have power over all VA nurses across the country; the board blocks nurses from even appealing or having any contact with the mysterious central office. And no matter how unjust the outcome of the board's decisions, nurses have absolutely no appeal rights if they are not deemed to have met all the standards and the board's decision is final. This seems more like the Supreme Court than a board of one's peers. After all, even defendants found guilty by a jury of their peers have appeal rights. The question that begs to be answered here is if this is a board of one's peers, why aren't there more rank-and-file nurses serving on the board? Very few, if any, of the board members ever actually visit the workplace to observe those that they are evaluating, nor would most of them be able to benefit through evaluations by observation because it has been so long since many of them were actually in the field. It's amazing how a nurse's status can be determined by a select group who have most likely never spoken to this nurse, observed his or her work or capabilities. This is a self-defeating system that drives high quality nurses out of the VA system, which, in turn, affects the care and services provided to the veterans and ultimately victimized the veterans we seek to serve. There's no easy solution to this complex problem, but the system can certainly be improved. Creating an appeal process for the employee would be one option; but with the appeal process, there's an inherent presumption that the appellant is wrong and he or she has to prove that he or she is right, much like guilty until proven innocent. While not every nurse should be indiscriminately promoted, the standards for promotion must be clear, objective, precise, and not left open to subjective interpretation and confusing ambiguity. A system that lacks controls lacks legitimacy. An additional alternative is to make the board an independent board that is elected, not selected, and whose rules and code of conduct are transparent. Employees should be totally anonymous to the reviewers -- possibly assigned a number -- and should be evaluated by a board that is not in their surrounding network. In conjunction with this, the standards for promotion should be revised to reflect objective standards that nurses are given for their respective positions when they are hired. Not until the bias, either real or perceived, is removed from the board will nurses believe that they are truly being evaluated on their merits and quality of their work, not on their willingness or suitability to fit into the back slapping good old boy network. The current system must be either drastically changed or abolished. Thank you.

MR. GORMAN:

Thank you. Teri James?

MS. JAMES:

Good morning.

MR. GORMAN:

Good morning.

MS. JAMES:

My name is Teri James. I am an RN at the Indianapolis VA Medical Center. I've been an RN for 25 years and I've worked them all in the VA. Both my parents were RNs and retired from the VA system, so I grew up in the VA and I dearly love it. I think it's the best system in the world to work in. I currently work in a 23-bed inpatient surgical unit as a staff nurse, and I have for the last 7 years. We are having a retention and recruitment problem at our VA; and with the average nurse being in their 40s and reaching retirement age, our VA and other VAs need to continue to address the issue. Currently our facility has approved retention bonus for RNs who work in the 24/7 patient care areas as these areas are the most difficult to retain and recruit the RNs. The bonus is 2,600 a year, which is equal to a hundred per paycheck. The RNs who did not work the 24/7 areas did not receive the money at all, and it has caused them to feel like they're of less worth because they're working mostly in outpatient clinics and they're wondering why they're less worth to our medical center than other RNs. The retention bonus can be up to 25 percent of the base. Based on the current salaries of three nurses that I work with on my floor, the 2,600 retention bonus equals .044 of their base pay, which is a long way from 25 percent. Our facility does not use a recruitment bonus for the RNs. The recruitment bones has been and is being used by ancillary services such pharmacy and radiology. Nurses are your direct patient caregivers at the medical center. Yet only the ancillary services are receiving a recruitment bonus to maintain their staffing levels. Also RNs at a comparable grade and staff of the other ancillary services, we hire in at less money. An RN will hire in at \$36,600 while the other services begin at 43,500 up to 67,400. And even though there is not a quick fix with recruitment and retention, investing in recruitment must not cause a lack of resources for your retention problems. The Department of Veterans Affairs needs to assess the pay authorities and make them less cumbersome and more flexible. They also need to look at more competitive salaries. Retention of your nurses will come in many forms, and one the RNs like is recognition. Recognition in the nursing staff at the Indy VA is very poor. In December of 2002 an RN at our medical center did a nurse recruitment retention survey. Upon completion -- I'm going to give you a couple of the questions and the staff nurse responses. And I say staff nurse because she divided it into staff nurse, what they call the executive managers, and then nurse practitioners. One of the questions was, "How would you

rate the recognition and reward monetarily for outstanding performance accomplishments and special care?" 56.92 percent of the staff nurses rated it poor. When asked, "What is your opinion on how staff members are asked for input and ideas when important decisions are being made," 57.69 percent of the staff nurses rated it poor. When asked, "How would you describe the process of promotion and advancement," 50 percent of the staff nurses rated it poor. A recommendation could be a consistent awards budget and a method of fair distribution to be established, improved staffing to allow your staff members to attend the committees that establish the policies that affect them personally. Improve the education to your staff member of various educational opportunities and programs that are already in place for them and again improve the staffing to allow them to attend opportunities. And then we have the Nurse Professional Standards Board, which I'm sure you've heard a lot of. They're not timely in their boarding at our medical center, and they're very inconsistent with interpretation of the standards or the dimensions. I myself have been waiting four months to be boarded. The board is a closed session. It doesn't allow any of the staff nurses to attend and question the board as to why their decisions are being made on the proficiency. I have an Associate's Degree in nursing. I'm a Grade II. I've never received an educational waiver for a Nurse III, nor have I ever been informed that I'm eligible for a waiver. The VA nurse interpretive guidelines for the nurse qual standards states clearly, "If a registered nurse has accomplished the performance elements for promotion at the next grade, the lack of required degree should not be an impediment to their promotion." Another RN at our facility received her boarding action in 2001 and 2002. The qualification standards last dimensions that she met in 2001 were not accepted for the year 2002, so it is not progressive. How can the board be considered fair when they do not look at a nurse's progression and are expecting RNs to meet each standard or dimension every single year? The Nurse Professional Standards Board should not be closed to us. We should have a right to hear what is being said about us. We should be available at that board to discuss any questions the board may have of us because they do not work with us. And it also should be -- how can an RN understand how the current board is interpreting the dimensions when at the next year the board will be a different mix, the RN won't be there, and she is not going to meet them because each board interprets the dimensions differently. It's an unfair system. Educational waivers should be automatic. Current waiver denial has no appeal rights. If the RN is meeting the dimensions and your education is not waived, you're set up for failure. You're going nowhere. The boarding process must be a negotiable right for us RNs. We also have a problem with nurse practitioners dealing with their pay. We have a special pay band for our nurse practitioners. Not all the practitioners are on this pay band. At our VA, the Indianapolis VA decides if a practitioner will use his or her prescriptive authority based on where they will work. Management has determined some of the practitioners do not need prescriptive authority as resident and interns write the scrips. Management decided if the practitioner does not need to write the scrips, they do not need the APN pay. These practitioners are on the regular nurse pay scale. Their clinical skills and judgments in caring for the patients are being used, but they do not receive the APN pay. We also have several nurse practitioners who received financial assistance from the VA to go to school and receive their APN

degree. Upon graduation, they have interviewed for various practitioner job within our medical center. Each time each one of them have been denied selection because each time they were told you have no experience as an APN. To receive experience, these nurses will have to leave the VA system, get experience, and come back. What is the purpose of the VA spending funds on an RN for a higher education and then denying them jobs? All APNs need to be paid at the same pay scale. We need a mentoring program for newly graduated practitioners to enable them to gain experience. We also have a staffing shortage problem. It costs poor morale and safe working environments for everyone. Currently our medical center doesn't have mandatory overtime. The cost of overtime is high at our facility. One quarter at our facility we were told our overtime for the nursing staff was \$350,000. On my ward alone from March 5 to April 24 there were 96 posted overtime openings for my floor alone on a 23-bed surgical -- this is overtime known in advance and doesn't include call-ins. So currently we have RNs who are working 24 more hours in overtime. Management, if there is no one to fill the gap, we have a shortage, we take a double assignment. Staffing shortage also creates a burden in work load. Our recruitment retention surveys that I 40.77 percent of ward nurses believe the work mentioned earlier reflected that load is distributed poorly within the service. On my ward alone I have an assignment of 11 to 12 patients. On a medicine floor, an RN has an assignment of up to 12 patients. At our medical center also the RNs are doing non-nursing functioning. We cover for the ward clerk. We provide all ancillary services such as escort. We do phlebotomies, et cetera. And some of the recommendations could be to help eliminate the shift rotation, decrease your dependence on overtime, hire more ancillary staff to support us to keep us from doing routine non-nursing functions, and to assess and determine if LPNs can increase their job functions. Again, I'd like to thank you for allowing me to testify. We care -- I love these people. We are VA. I hope the Commission learns that from us. We really genuinely care about our patients; and when our quality is decreased, we are demeaning veterans. That's all I have to say. Thank you.

MR. GORMAN:

Terry, the survey that was done, you have the percentages that rated -- that responded poor to the question. Do you know the percentages that rated -- I don't know what other categories you had; good, outstanding, fair?

MS. JAMES:

You had outstanding, and then it went all the way down. Good was the middle and then a poor. And these are -- what I did was these are the highest ones that were rated. The lady who did it, Jackie McCormick, when she gave us the survey, she went through and highlighted the highest ones that were rated poorly to see where we needed to improve and these stood out.

MR. GORMAN:

Okay.

MS. JAMES

Again, this is just staff --: this is just the staff nurses. It's not the practitioners or the managers.

MR. GORMAN:

Okay. Thank you. Jan Lottman?

MS. LOTTMAN:

Good morning. I thank you for taking the time to listen to my testimony my name is Jan Lottman. I have been an LPN at the VA in Sioux Falls, South Dakota, for seven years and I've been an LPN for over forty years. For the most part of the seven years at the VA, I have worked on what we call a transitional care unit, and that is what I'll be referring to as TCU from now on. Most of the veterans are newly diagnosed with strokes. They're new amputees, dementia, or other medical and surgical problems. The average of these men and women -- yes, we are serving more women now than we have in the past -- are between 70 and 80 years of age. We also have on our TCU beds for respite care which are able to come in for a limited amount of time while their family needs to take a rest from them. These are like demented patients or who have a lot of physical problems that are taken care of at home. Also when they did our remodeling at our TCU unit, they added two rooms for respite care. And here they are provided a place where they can go for their last days with us or the families are able to be near them also. The TCU veterans either come from the acute care side of our hospital or can be direct admits from another non-VA hospital or community nursing home or also from their own home. Our goal rehabilitate them so that they will be able to while they are on TCU is to return to their home or to a nursing home. Because our veterans are getting older, their diagnoses are becoming more complex and their needs are greater. At present, most of our vets have three to four appointments per day. This can range from their recreational therapy, physical therapy, occupational therapy, to a dentist appointment or podiatry. All of these appointments are very important in preparing them for discharge. If there is a shortage of staff, whether it was because of sick calls or just staffed inadequately, the veteran suffers. Sufficient staff ensures that the veteran is fed, washed, properly dressed, and is able to make these appointments. This past weekend is an example of poor staffing. The ratio for the RNs that weekend was 2 RNs to 30 patients, and one of the RNs was only in the VA system for approximately 6 months. There was no other licensed personnel on duty, and there were 5 nursing assistants. An LPN was scheduled, but they gave her annual leave because she needed the day off. I had offered to exchange hours with her, as another LPN did, but management didn't think that was necessary; that the two RNs could handle this. The RNs had to work charge,

were team leaders, did IVs, meds, and also had patient care. The nursing assistants also did patient care. It happened that a veteran became critical and needed to be transferred out of our facility to a non-VA hospital because our intensive care unit was filled at the time. This meant added calls to different doctors, added paperwork because of transferring out of the VA system, contacting an ambulance to take the veteran over there. Also this weekend there were two other critical veterans that these RNs had to take care of, and naturally one of our demented patients became abusive and required more one-on-one care. Therefore, meds and IVs were late getting started, and the RNs were late getting out of work. Usually when emergencies arise, more people need p.r.n. meds to handle it; so it just became a roving thing there. When TCU was functioning as a nursing home, their practice was to have fewer nurses on weekends and holidays. Now that we are a transitional care unit, management is still doing this, even though there has been a change in the type of care the veterans needs. In addition, the union is unable to negotiate staffing levels so there can be more consistency for the care of our veterans. We are fortunate at our VA to have proper lifts for transferring our veterans from bed to chair and chair to bed. With these lifts, there is less chance of back injuries, but I realize that this is not the case in all VAs. I think it should become a law requiring all VAs to have the right type of lifts for their veterans. It is much safer for the veterans and staff if they use these lifts. Back problems are one of the main injuries in nurses. The pay scale at the VA for LPNs and nurse assistants does not compare to what our community in Sioux Falls, South Dakota, is paying. Three years ago, management did an LPN survey on wages. At that time, it was determined that LPN wages were below that average. At that time, management declined to give us the raise, and so far we still have not seen it. Recently, I did receive the Saturday premium pay, and the reason I am receiving this premium pay is that Congress recently changed the law demanding that all LPNs receive this extra pay. Thank you. With this extra pay I was able to pay for increased health insurance. Now we need to give the nursing assistants also the Saturday premium pay. After all, they do work side-by-side with the RNs and LPNs and have to do a lot of our grunt work when we are doing meds, IVs, and/or paperwork. If they were able to get this extra pay, they would also be able to afford the rising cost of health insurance and also maybe they would be more likely to come in if there was a shortage on Saturday to work for us. As LPNs, we are roles to include more complex nursing skills. Now expanding our these will include establishing IV lines, assessments of the IVs, monitoring and setting the flow of IVs, assisting RNs with transcribing doctor's orders, and completing requests for routine and special diagnostic studies. Because of these added assignments, I believe that we should be offered the journeyman Grade VII position. It is my understanding that the VA has set the standards pretty high for us, that not too many will be eligible for this. The only ones would be the specialty LPNs, and I honestly do not know what specialty LPNs are. A new graduate now starts at -- an LPN starts at a Grade III, which is lower than what a nursing assistant starts at. LPNs put their license on the line every time they come to work. They have passed their boards, and I think they need to be started out higher. Recommendations, we need to be fully funded so we can hire qualified staff from the janitors, lab techs, clerks, nurses so we can give the veterans the care they deserve. Give all hospital staff Saturday premium pay. Because our roles are

expanding, give the LPNs the journeyman Grade VII. Thank you for listening to my testimony.

MR. GORMAN:

Thank you, Jan. Thank you. Jane Nyggard?

MS. NYGGARD:

Good morning. My name is Jane Nyggard. I'm a registered nurse at the Minneapolis VA Medical Center. I became a registered nurse through the VA upward mobility program. I have an Associate Degree in nursing. I was first employed by the VA as a ward clerk. I began taking night classes so that I could become a nurse. This was at a time when the VA used upward mobility to recruit and retain nurses. Six employees were chosen for this program. Unfortunately, this program has not been utilized within the VA for many years. Prior to the implementation of the new qualifications standards, I was able to as an Associate Degree nurse meet the qualification standards and be promoted to the Nurse III by receiving a waiver. The policy at the time was to allow nurses who met the standards to receive a waiver of education and be promoted. Since the implementation of the new qualification standards, there is much confusion amongst the rank-and-file nurses. No one is ever willing to share with them expectations of what they need to accomplish in order to meet the standards nor give specific examples of how to meet the standards. They are constantly told that their scope of practice limits them regarding their accomplishments as bedside nurses. In other words, if you are a staff nurse, expertise in your area is not considered broad enough for you to even attain a Nurse II or a Nurse III. This mindset has not only demoralized our nurses nationwide, but it has stifled innovation from rank-and-file nurses. The nurses feel that why should I continually give 110 percent if no one is willing ever to recognize my contribution because I am only a staff nurse. Daily nurses complain about being denied promotion. They are seldom given a reason why they were not promoted. They go through the process of reboarding. They elaborate on what they have done and forward it to the board and are denied again. They do not understand how one nurse who is their peer got promoted, but they did not. They see the process as unfair, that nurses are promoted by what their position and education is rather than by what they have accomplished. This process is discouraging, especially when they have no recourse. The interpretive guidelines allow educational waivers when the performance standards have been met. Management has opted not to request waivers. When we ask our managers for data to allow us to see how many nurses met the standards and were waived, they state they do not have that information or that it would take too much time to retrieve it. Depending on what facility or division you are in could determine your promotion or lack of promotion. This has adversely impacted recruitment and retention during a time when the VA desperately needs to retain our staff nurses. VA and central office most recently has scheduled training for their managers so that they can understand the qualification standards. They have denied any union representatives to attend this training, not even the national representatives. Why would they not want us to understand the role

of the board in reviewing the standards? Could it be that they're afraid that we will find out what their true agenda is? Now the central office has notified the field not to promote nurses who are Associate or Diploma to Nurse II or III, the result being that we have nurses that are at the end of their grade and will remain at the end of their grade until they retire or move on. Many just move on. I believe that the only way that we can resolve this problem is to remove the educational requirement out of the realm of the qualification standards. In other words, if you meet the standards, you get promoted. What level of degree you hold should not be relevant. I believe the VA should applaud those nurses who work hard to attain the standards and promote them regardless of their degree. All RNs nationwide take the same boards, whether they're Diploma, Associate, or Baccalaureate. The requirement for entry level RNs should be dealt with in another arena, but not within the VA system. There should be clear, objective, measurable standards that every nurse can understand and achieve regardless of their scope of practice. The law governing this process, 38 U.S. 7422, needs to be changed so that our nurses and their representatives can negotiate a fair process that is objective. This process should be negotiated and agreed to by both management and labor. Educational levels should not be the sole criteria for promotion. Nurses should be allowed to go to an objective third party in order to review the decisions by the board. Our Title 5 counterparts -- psychologists, pharmacists, and LPNs -- are allowed to review their proficiencies if the VA does not follow the procedures correctly. They are allowed to propose changes that arise out of patient care or clinical competencies. Why would we want any less for our registered nurses? Our Title 38 RNs should have the same recourse as our Title 5 co-workers. The Minneapolis VA Medical Center does not have a four-to-one ratio for staff in acute med/surg areas. There have been multiple studies done on the impact that staffing has on the outcome and mortality rate of patients, most recently the Akin study. Our patients have multiple symptom problems, which makes caring for them more complicated than the private sector patients. They should have the right to have adequate nursing care that would ensure the best outcome for them. If the nurses complain that staffing is unsafe and they need more help, management responds by mandating one of their co-workers. Staffing levels within the VAs nationwide change depending on the number of staff that is scheduled each day. Multiple times patients that fit the one-to-one criteria in the intensive care units are suddenly switched to two-to-one because of short staffing. Criteria are no longer important. Policies are violated. All charge nurses at our facility have a patient assignment. The shortage of adequate nursing staff is further exacerbated by the inability of the VAs to recruit and retain qualified support staff. Because of this shortfall, nurses are then expected to answer phones, clean garbage, escort patients, or run from ward to ward looking for supplies. All of these other duties as assigned remove them further from the bedside of their patients. If the law allowed the VAs to pay Title 5 employees Saturday premium pay, we would be able to compete with the private sector and retain qualified support staff. In the outpatient areas there is no criteria on how they should be staffed. Most recently our dialysis nurses and our GI nurses were working so much overtime because of short staffing that many wanted to quit. They have outside interests; and while they love their job, they realized it was taking too much of their time. Management did increase staff in both areas, but only after months of the union

and nurses complaining. There continues to be no staffing methodology used in the clinic, just management efficiencies -- do more with less. This is at a time when patients are being discharged from the inpatient arena to the outpatient clinics much quicker, which makes it more critical for our clinics to be staffed to adequately and properly care for them. The VAs have created a vicious cycle of short staffing created by constant turnover of support staff and nurses. This revolving door has been created by the educational requirements of the qualification standards as well as the inability of the VA to pay support staff Saturday premium pay. The VA must allow frontline employees that are experts in their areas to have input into the staffing levels. 38 U.S.C. 7422 must be changed to allow our nurses to be heard. Saturday premium pay should be guaranteed for all Title 5 employees who work to support our nurses. As a federal employee for 33 years and a VA employee for 29 years, I thought I had seen it all; but most recently in a time of severe nursing shortages, the VA has decide to utilize 38 U.S.C. 7422 to prohibit RNs from having any say in their own jobs, performance reviews, staffing, or pay. Over the last few years, VA management has negotiated with union representatives over issues such as reassignments, tours of duty, and technology. VA management has recently changed its position on the ability of nurses and their representative to have input into their working conditions. They have recently decided to stop honoring previously negotiated agreements over RN working conditions. Management has even gone so far as to refuse to discuss what electronic templates RNs will utilize in documentation. This change in management practice is a result of narrower interpretation of 38 U.S.C. 7422. This decision by management has had the result of excluding the frontline VA doctors and nurses from being involved in the decision-making and collective bargaining. Again, Section 7422 needs to be changed to alleviate this situation. Another area of great concern for our nurses is that part-time nurses hired under 38 U.S.C. 7405 remain as probationary nurse employees forever unless they change to a full-time status. This also includes nurses who have completed a satisfactory probationary period as a full-time nurse and then choose to go part-time. They convert back to a probationary status. They remain in this status until they retire or resume full-time employment. This group of employee can be terminated or laid off without due process. This practice is biased and does not mirror the private sector. Our Title 5 counterparts do not remain probationary indefinitely, so why should our Title 38 RNs be held to a different standard? This is a huge morale issues for our nurses who feel they are being penalized for going part-time. The law, 38 U.S.C. 7405, must be changed to state that after the equivalent of one year or 2,040 hours these nurses should be removed from a probationary status and have the same rights as their full-time counterparts in regards to Civil Service laws, rules, and regulations. Thank you.

MR. GORMAN:

Thank you. I have a couple questions, if I can. The part-time nurses you just talked about, are there any benefits they lose out on by virtue of being part-time versus converting to full-time?

MS. NYGGARD:

Well, they pay more for their health benefits, quite a bit more, unless they -- they either have to remain like at a .9 or .3. If you're either a .3 or .9, the benefits are the same as -- you know, you pay the same amount as a full-timer. If it goes anywhere in between there, your benefits, your health benefits, you pay quite a bit more.

MR. GORMAN:

And help me understand this. The Saturday premium pay, that's given to Title 38 employees, but not Title 5?

MS. NYGGARD:

It's not given to Title 5 employees.

MR. GORMAN:

And Title 5 employees primarily consist of?

MS. NYGGARD:

Nursing assistants; it could be lab technicians, pharmacy technicians.

MR. GORMAN:

Okay.

MS. NYGGARD:

Dietary, housekeeping.

MR. GORMAN:

Okay. Thank you, Jane. Appreciate it. Is Patricia LaSala in the room? No. It's about 10 minutes of ten. We are scheduled to take a break at ten. Perhaps we can use these extra ten minutes and conduct some open mike. And what we are going to do is go by a first come/first served basis for those who signed up. Is Judy McCutcheon in the room? Judy, you have three minutes. And we are just going to do the red card. When the red card comes up, you're out of here.

MS. McCUTCHEON:

Good morning, Chairperson, members of the National Commission on Nursing. My name is Judy McCutcheon. I work in the Chillicothe, Ohio VAMC as a registered nurse in mental health. I have been a registered nurse for 30 years and have worked

at the VA for 15 years. I would like to address this Commission regarding the nurse qualification standards. As I am sure you're aware, there are nine dimensions of the qualification standards. An interpretive guideline was published in 1999 as an appendix to the qual standards. Quote, "The development of the interpretive guidelines grew out of a recognition that there was a variance in the strictness of interpretation and application of the standards across facilities and a desire to reduce this variance," end of quote. Not only is there a variance from facility to facility, but there is a variance in the interpretation of these standards from board member to board member and from boarding session to other boarding sessions. I have observed boards give credit for the same accomplishment to one nurse as meeting the standards and two weeks later deny another nurse. This is not due to any malice; just to each board member seeing the standards differently and personal bias influencing their interpretation of the standards. The standards are not applied objectively, nor consistently. The board members attempt to apply them fairly, but standards are just too vague and leave too much room for misinterpretation. A nurse can be given the rating of outstanding on their annual proficiency year after year, and yet not meet any of the standards for promotion to the next grade. This is especially true for nurses who are being looked at for the Nurse III level. This is often because the board interprets that the impact of a nurse's accomplishments do not impact a broad enough area, such as the entire facility. When a nurse works at a facility, as most do, that has more than one specialty or type of health care occurring, it is very difficult to implement accomplishments that impact all or even more than one specialty. Nurses who work primarily on the evening or midnight tour of duty have very little chance of ever being promoted beyond the Nurse I or Nurse II level -- not based on their quality of nursing; just because they do not have the opportunity to participate on local and visiting committees. Many of these nurses are excellent nurses that care for our veterans in an outstanding manner; but because they work the 16 nonadministrative hours, they sit stagnant. I have heard nurse executives say they believe the staff nurse cannot be a Nurse III; that only those in supervisory roles should obtain this level. This is one of the roadblocks in a VA nurse's career that is causing morale to be at a very low point. When a nurse works hard year after year to care for our nation's veterans and continues to receive a letter every year that tells them they are just not good enough to be promoted and in some cases do not meet any or very few of the standards, it weighs on their mind and self-esteem to the point that it begins to cause burnout and has to affect the quality of the care that nurses came to the VA to provide to our nation's heroes. The law and directives that regulate these standards need to be changed to make this process a fair and equitable peer review process. Thank you for your time.

MR. GORMAN:

Thank you, Judy. Appreciate it. Tammy Lepley? Is Tammy in the room?

MS. LEPLEY:

My name is Tammy Lepley, and I am an RN at the Veterans Affairs Medical Center in Iowa City, Iowa. I work in the intensive care unit, and I have been with the VA since 1995. I have always worked in the inpatient direct patient care setting. My family and friends who are not nurses visualize nurses as caregivers, meaning direct handling care. At the VA, there are currently no incentives for staff nurses to stay in direct patient care. The qualification standards in their present state are not set up for staff nurses to have upward mobility. The opportunities to complete projects required for promotion are difficult for staff nurses to attain. Projects that require one's physical presence at a facility and VISN levels are often out of reach for staff RNs because of their commitment to provide care at a patient's bedside on an often inadequately staffed unit. I believe that direct patient care is truly the backbone of the nursing profession. Every nurse I know and work with entered the profession of nursing specifically because they wanted to be involved in caring for patients. Their career track for upward mobility is designed to drive these valuable and experienced caregivers away from nursing as we traditionally view it and force them into roles far removed from direct contact with patients. This is in my view an unacceptable change in the role of nurses and one that is perhaps a great part of the reason for the growing nursing shortage in this nation. It is my assertion that staff nurses, those professionals dedicated to the provision of care with compassion, are wholly unrecognized or compensated for their important role as a result of the standards applied. The nurse qualification standards need to be changed to reflect the significance and value of staff nurses as equally important players on the nursing team as opposed to a system which rewards furthering a critical shortage of patient care providers by enticing them to leave the direct patient care setting. I would like to request of the Commission to recommend changes in the qualification standards that would better reflect the role of the nurse as a caregiver. Thank you.

MR. GORMAN:

Thank you. Charles Kern? Good morning.

MR. KERN:

My name is Charles Kern. I'm a registered nurse at the VA in St. Cloud, Minnesota. There is an old adage -- don't fix it unless it's broken. The nurse qualification standards promotion system as it is broken; but if common sense and fairness are used, it can be fixed. The one-size-fits-all system does not work. It fails to take into account actual job description, thus making it flexible. It locks promotion boards into trying to match job performance of a staff nurse into a system that seemingly was written only to evaluate educators and administrators. It is a system that fails to neutralize board prejudice. Most people on our board know the people that they are evaluating. An individual's yearly evaluation should be viewed by board members without your name, your sex, and where you work, thus making -- thus muting the problem of prejudice. The system must be should be fewer criteria and that criteria

simplified. There should be based on the job description you hold, not a generic one. The system must be streamlined. It must be made less cumbersome. One way to do that is to only have two ratings, satisfactory or unsatisfactory, not the four we have now. I doubt anyone in this room truly meets the criteria of outstanding in every area. There must be more educational waivers granted. Boards must be urged -- even ordered -- to grant these. The education requirements for B.S.N. should be pushed back at least two years and funding for that goal must be continued or, in the best of worlds, that requirement be dropped. Length of service on the board should be reduced and it should include staff nurses and those staff nurses should be able to vote on someone going to a higher grade than they now hold. Allow me to be voted on by my peers also, not exclusively by those who do not know what I do. We cannot allow a promotion system to continue that includes only those farthest from patient care. Make it mandatory for peer representation and union representation on the board. If needed, have an objective third party doing the evaluation in the first place or be the reviewing system if you are turned down. Your evaluation and promotion should be based on your job performance, not on how many letters you have behind your name and on your i.d. badge. RN is the only thing that should count. To the veterans we care for, it does not matter whether we have an AA, Diploma, B.S.N., or M.S.N. All that matters is that he continues to receive the best care possible. My boss, who came into this system about two years ago with an M.B.A. and who has had many job experiences and is now on our local board, has been astounded by how complicated our promotional system is. She wanted to say make it simple, make it easy to interpret what is needed to promote an individual, make it user friendly. She summed it up by saying it should not take hours to write an evaluation. Thanks.

MR. GORMAN:

Right on time. That's either a great witness or a great timekeeper, one or the other. Thank you, Mr. Kern. We are going to take a break and reconvene exactly at 10:15 and we will start that session with Annie Pounds, who will be testifying.

MS. MOORER:

During the break, those of you who came in and did not register, would you please come up and register? I noticed that some people came in during the course of the testimony. (WHEREUPON, a recess was had.)

MR. GORMAN:

Okay. During the break I was told that Annie Pounds is not here, but Amie Pounds is.

MS. POUNDS:

Annie left the building.

MR. GORMAN:

Sorry about that.

MS. POUNDS:

That's okay. Good morning. My name is Amie Pounds. I would like to welcome this Commission to Chicago for such an important undertaking. I thank you for the opportunity to address key issues that impact nursing personnel within VA. I work for the Danville VA Illiana Health Care System where I've been a licensed practical nurse for nearly 20 years. I've been an LPN since 1977 and have found that we are now in very uncertain times in regards to the nursing employment environment. VA is not exempt from that uncertainty, and we must move quickly from a system of old traditional practices to a more flexible, unique system to ensure VA will be able to recruit and retain these nursing staff who provide high quality care to our veterans. As I'm sure that you know, by the year 2005, 35 percent of VA registered nurses, 29 percent of VA licensed practical nurses, and 34 percent of VA nursing assistants will be eligible for retirement. This could potentially be devastating for this health care environment, and I respectfully request this Commission act on this without delay. Fewer nursing personnel along with more complex patient demands will require more flexibility and innovative recruitment and retention tools. For LPNs, recruitment bonuses are being offered at some facilities. However, these recruitment bonuses are specific to the type of area where they will be working in. What retention and recruitment tools are being used to retain those LPNs who have reached the top of the GS-6 grade level and wish to remain within VA as an LPN providing high quality nursing care? Very few are offered, and those that seem to be are geared more to the advancement to the RN status. On April 15, 2003, the Department of Veterans Affairs made changes to VA Handbook 5005 Part 2, Chapter 3, for licensed practical nurse and vocational nurse qualification standards. One significant change to this handbook is that LPNs and vocational nurses in select positions may now be appointed at or advanced to the GS-7 grade level. After careful examination of these new standards, I feel the VA has set the bar so high that only those LPNs or vocational nurses in specialty areas such as surgery could ever possibly meet these standards. There is no equity for these nurses who because of the RN shortage are expected to exercise independent technical judgment and be able to apply comprehensive working knowledge of practical nursing. These nurses are expected to consistently be responsible for the complex care of complex patients. This includes having skills in specialized procedures, organizing/ assisting in implementing specialized patient care, serve as a role model, and be well-versed in customer service standards. These are but a few of the many hats that they must wear. They're required to substitute for ancillary staff such as housekeepers and clerical support day after day and still be paid at the GS-6 level. These new standards are so high that individuals in areas

where there is the RN support may very well never be afforded the opportunity to reach the higher grade. Such utilization of these nurses is not only costly, but it's counterproductive and very frustrating. As an LPN, I have many times considered furthering my education to an RN degree, but consistently run into one major hurdle that is a deterrent and impacts all LPNs who have many years of service within this VA. That's the pay disparity that occurs when an LPN with many years of service and experience reaches the top of that GS-6 level, returns back to college, receives an RN licensure. I have found that when they reenter back into VA as a new RN at Nurse I, Level I, there's a pay decrease of approximately, for the first year anyway, from \$7- to \$10,000. No consideration is given for the years of devoted service and valuable, valuable experience that individual has gained as a licensed practical nurse. This shows no commitment to those individuals by the agency for all the years of hard work, time away from their families, and devotion -- I repeat, devotion -- to our veterans. An LPN with multiple years of experience and knowledge who furthers their education and decides to return to VA as an RN must be compensated and paid as a new RN at the same salary that they were as an LPN. This pay disparity is a strong employment dissatisfier that impedes both recruitment and retention of those high quality nursing health care providers within VA. One other very grave area of concern is the dangerous practices that occur within medical centers throughout VA. This is the practice of mandatory overtime as a means of staffing. From September of 1995 through September of 2000, VA cut registered nurses by 10 percent and licensed practical nurses by 13 percent. As a result of this action, nursing personnel are being forced to work up to 16 hours a day or more. This practice causes nurses to make complex judgments about the care of critically ill patients when they are fatigued and overwhelmed from working so many hours in stressful settings day after day. Patients need alertness and a high level of concentration from nurses to identify subtle changes in their conditions, such as changes in increase of heart rate, decreased blood pressure, which could signal a potential condition. OMB must be required to review existing overtime policies and practices and recommend changes in mandatory overtime. In conclusion, this Commission must recommend changes to existing policy and/or legislation that compensates LPNs and vocational nurses for years of experience and knowledge in VA-specific nursing. This Commission must recommended changes to VA Handbook 5005, Part 2, Chapter 3, that allows LPNs and vocational nurses from all areas within VA to reasonably be expected to be able to obtain the GS-7 grade level. This Commission must recommended changes in policies that disallow mandatory overtime as a means of staffing and that adequate staffing levels are negotiable. I thank the Commission for being afforded the opportunity to speak publicly on key issues that have a great impact on VA nursing. Thank you very much.

MR. GORMAN:

Thank you. Could I ask a question?

MS. POUNDS:

Absolutely.

MR. GORMAN:

To your knowledge, the issue you raise about an LPN going back to school to convert to an RN and the pay difference, has that issue been addressed in the past, do you know, by either VA headquarters or the Congress?

MS. POUNDS:

Not that I know of. I have many fellow co-workers that did as LPNs go back to school and came back as an RN Nurse I, Level I, and ended up having to leave VA because they could not continue to support their families, single-parent families, at that kind of a pay cut.

MR. GORMAN:

Does the VA have discretion to go to a higher level?

MS. POUNDS:

I'm not sure, but I don't think so. They have come back at that level because they have no experience as an RN, but I do not believe they have that ability to move within that system.

MR. GORMAN:

Thank you, Amie. Alice Nied?

MS. NIED:

My name is Alice Nied, N-i-e-d. I'm a registered nurse. I have my Master's Degree in nursing. I am also the director of nursing at Highland Community College in Freeport, Illinois. I am also the treasurer of the National Organization for Associate Degree Nursing. I am the president of the Practical Nursing Council of Illinois, and I am also a board member of the Illinois Organization for Associate Degree Nursing. I think you can tell by what I said about myself, my college and myself supports nursing at all levels. I'm very happy to have followed the LPN because we are strong supporters of LPNs at my college. We have at my college beginning with the CNA all the way through the AD program. We also have on our campus a B.S.N. completion program through Northern Illinois University. Having said this, you can tell that we support nurses at all levels and we also support nurses who have chosen not to go back to school in a formal manner, but have chosen to continue their education

through informal means, such as attendance at seminars, journals, and networking opportunities. It's important to remember that graduates of all professional nursing programs -- two-year Associate Degree grads, three-year Diploma grads, as well as graduates of four-year B.S.N. programs -- all take the same NCLEX exams. In Illinois, as in most states, those who are successful in passing the exam receive a license that states that they are a registered professional nurse. There is no differentiation in Illinois by our governing body based on our educational preparation. My college, Highland Community College, my professional organizations, and myself all support life-long learning for all nurses. This is not something that is the ideal; far from it. Life-long learning is essential to maintain safe nursing practice regardless of the initial educational preparation. I will always be proud to be a Diploma graduate, but I knew the day that I graduated that all I really had was a solid foundation and the rest was up to me. In this time of severe nursing shortages, it is imperative that together to support the nurses we have and to we work find creative ways to increase the numbers of nurses at all levels. My college has recently partnered with our local hospital, the Freeport Health Network, and this fall we are going to go to an all evening RN program. And that's something that's very unique in the northwest corner of Illinois, and it's not real common anywhere in the country; but it's innovative programs like this that are going to help us meet the needs for nurses that we have in our country. This is not the time for divisive practices that are designed to enhance the standing of a minority of nurses while excluding nurses who have proven their ability to meet the needs of the health care seeking public. Our recommendations from the national organization and my state organization include the following: To hire nurses based on need, not based on an artificial barrier that has no empirical data to support it; to support continuing education for all nursing personnel regardless of their credentials; to promote nurses based on demonstrated abilities; and if the VA determines through an objective measurement of objective data that nurses need to earn higher credentials, they need to support this through generous tuition reimbursement and the time off required to pursue further education. Thank you very much.

MR. GORMAN:

Thank you.

MS. CONVERSO:

Can I ask a question? Do any of your schools partner with four-year schools to try and bridge that gap to have RNs get their Baccalaureates in any way? Do you partner with somebody to do that? I heard you partner with a hospital to get RNs. Do you partner with other four-year facilities to advance to a Baccalaureate?

MS. NIED:

Yes. As I said, we have a B.S.N. completion program on our campus, and they take a number of courses. They actually come back and take more courses from Highland,

and then they articulate into the B.S.N. program. They take their gen.ed's -- things like sociology, the arts, things like that -- from Highland, and then they articulate into the B.S.N. program; and it only take them one more year to get a B.S.N. So we have been very strong in that area, too.

MS. CONVERSO:

Thank you.

MR. GORMAN:

Thank you, Alice. Roy Romans?

MR. ROMANS:

Good morning. My name is Roy Edmund Romans II. I am a licensed practical nurse at the Department of Veterans Affairs Medical Center in Iowa City, Iowa. I am a veteran of the United States Army with a service-connected disability. I was recruited while hospitalized at the Iowa City VA and accepted employment in great part due to the care I received there. I received my training as a 91 Charlie 30 having graduated on the commandant's list from the Academy of Health Sciences practical nurse program at Madigan Army Medical Center in Ft. Lewis, Washington. I am husband to a former Army Nurse Corps officer with a service-connected disability and the son of a 100 percent service-connected Vietnam veteran. As a member of a family of veterans, I am proud to serve as an LPN at the Department of Veterans Affairs Medical Center in Iowa City, Iowa. It is truly an honor to be able to care for our nation's heroes on a daily basis and to be able to work among the heroes who have dedicated their lives to the health and welfare of our nation's veterans. I thank the chair and the members of the Commission for the opportunity to offer my testimony. I am concerned about the issue of Saturday premium pay for all hospital personnel not presently receiving it. While as an LPN I am thankful to now be getting Saturday premium pay, I am troubled that other VA staff members who keep the hospital running 24/7 are not receiving it Nurse's aides, health care technicians, med techs, and others who work side-by-side with nurses in providing care to our veterans are coming in on Saturdays when child care often costs more and when they could be spending valuable time with their families to work alongside other care providers who do receive a premium for their time. The present situation is, at a minimum, insensitive and is demeaning in that the denial of premium pay for those care providers, while offering it to their co-workers, sends a message that the time and efforts of these personnel is somehow not as valuable as that of their colleagues. This message is being received loud and clear by many of my co-workers who in our interactions have consistently expressed their disdain of the present situation. Many have articulated their anger and entertained thoughts of leaving the VA, citing this inequity as the principal point of their frustration. Further, many institutions do, in fact, offer Saturday premium pay to their civilian counterparts, a fact that makes recruitment and retention of these very valuable members of the health care team an issue of increasing importance. A change in the law administering the distribution of

premium pay is necessary to rectify the current situation. I would also like to address the qualification standards for the newly developed GS-7 LPN position. While I am pleased that the VA is recognizing the need for GS-7 level LPNs, I am concerned that the language used in the qualification standards allows for potential arbitrary and capricious application of the standards, particularly due to the breadth and scope of the language. Complying with language such as "more complex," "broader knowledge," and "considerable difficulty" may prove to be an insurmountable task for LPNs whose supervisors are the final arbiters of how this language is to be interpreted and defined. The opportunity to advance beyond a GS-7 pay grade is something that I personally welcome and that I frankly feel is somewhat overdue. However, I am sincerely concerned about how many LPNs based on conditions such as where they are assigned or who their supervisor is may actually be able to attain the GS-7 pay grade. We as LPNs have been witness to the myriad complaints and problems with the qualification standards for RNs and do not want to be involved in any such difficulties. To combat vague, subjective, and inconsistently applied standards, I would recommend that a joint labor/management group be organized to ensure a reliable, objective standard is developed that can be valid, and consistently and equitably applied. In the interim, perhaps other objective standards, such as outstanding performance ratings and time in grade as a GS-6 LPN, could be used to promote deserving LPNs to the new pay grade. Finally, I would like to address the issue of barriers to advancement from LPN to RN within the VA system. Were I as an LPN to aspire to acquiring licensure as an RN, I would have to be willing to sacrifice my years of experience as a member of the VA nursing team and accept an RN level of pay that may well represent a pay cut. To shift from the higher end of the GS-6 pay scale to a Nurse I, Step 1, would actually represent a decrease in pay, and the de facto state of affairs is such that there would be no recognition for my VA-specific nursing experience when considering my pay level as an RN. Many of my colleagues have stated that the present milieu offers them no incentive to go back to school, particularly those who are career LPNs and have advanced to the highest pay levels and carry years upon years of invaluable nursing experience within the VA system. I feel that this failure to offer credit for VA-specific experience is an impediment to upward mobility and that provisions should be made for growing our own, recognizing the experience and expertise demonstrated through years of providing care to our specific patient population and allowing that recognition to be taken into consideration when establishing pay levels for LPNs who wish to advance to the RN ranks within the VA. LPNs within the VA system know and comply with VA-specific policies and procedures, function daily in the clinical setting, pass medications, perform innumerable other duties specific to nursing, all while bearing the responsibilities that go along with this precious undertaking. Many LPNs are cardinal resources for new nurses and are relied heavily upon by the nursing team as a whole. This knowledge and experience must be recognized. I would recommend that the necessary policy or statutory changes be made to ensure just compensation and classification for LPNs who wish to advance to the RN ranks. In doing so, the VA would be active in helping to eliminate what I believe to be a significant barrier to professional advancement that exists at present. In conclusion, I would like to thank you all for your time and attention to issues impacting the practice of nursing within

the VA system and for affording me an opportunity to share with you some of the issues that I feel have a significant impact on myself and my colleagues as members of the VA nursing team. Issues such as Saturday premium pay, the qualification standards for GS-7 LPNs, and barriers to professional advancement particularly as applied to LPNs who may aspire to obtaining their RN are so substantial in their scope as to urgently demand consideration. I ask that you please take this testimony into consideration when making recommendations to Secretary Principi and our representatives in Congress. I would be happy to address any questions you may have at this time.

MR. GORMAN:

This issue of converting from an LPN to an RN status, do you know the starting salary of an LPN to the top end of an LPN salary-wise?

MR. ROMANS:

I'm not positive, but as a GS-6/7, it's somewhere in the 33,000 range.

MR. GORMAN:

And for RN Step 1, do you know?

MR. ROMANS:

No. It's somewhere in that area.

MR. GORMAN:

Okay.

MR. ROMANS:

I would happily supplement my testimony with a more detailed response.

MR. GORMAN:

Thank you. Karen Ishmael? Did I say that right?

MS. ISHMAEL:

Yes. My name is Karen Ishmael. Thank you for giving nurses like myself, an intensive care nurse from Ft. Meade, South Dakota, an opportunity to tell you our ideas on how to improve the retention and recruitment of the VA nurses. The Qualifications and Nurse Professional Standards Board holds out the promise to assist each RN in their individual development and education preparation in nursing. The education waivers is key to the balance between recognizing nursing expertise

developed through years of bedside practice and the benefits of education credentials for nursing. The ability to waive the B.S.N. and M.S.N. educational requirements is a recognition that a particular education credential does not in itself make a good nurse. Each RN is to be evaluated on objective and consistent criteria and will be given a waiver if they meet all of the other clinical dimensions and are promoted accordingly. In reality, the standards of the promotion process have failed to deliver on this promise. The boards are inconsistent in their interpretations of the standards, the standards are vague, and the education waivers are not being given at my facility. RNs are not told clearly what they specifically need to do to meet the standards. I have asked the chair of the board and my nurse manager what more I need to do to get advanced to Nurse III, but they gave me no input. The chair of the board just handed me the nurse qualification standards and told me to read them. That is not nurse leadership. I'm a teacher of advanced cardiac life support, appointed regional faculty with the American Heart Association. I was appointed to the nurse clinical practice committee, nurse coordinator of an acute coronary syndrome research study. I mentor other nurses on understanding basic arrhythmias, and I also train nurses on the VA's medication error reduction system. On my last proficiency, I felt humiliated when the board action showed I had not met a single dimension. This occurs frequently to RNs in the VA system. Even though I am supposedly grandfathered and not needing to credentials for Nurse III, it is widely meet the M.S.N. understood no Associate Degree nurse will be advanced to a Nurse III in the South Dakota VA system. Under VA promotion rules, I cannot appeal a denial of the education waiver. For Nurse I's trying to obtain a Nurse II level without B.S.N. credentials, this same scenario is repeated. A nursing assistant can appeal a denial for promotion, but not an RN. This promotes frustration and discourages the nurses from trying harder in obtaining their goals. In reality, the standards and education waiver become tools to hold down nurses, denying promotions and the recognition that they deserve. I am here to voice my concerns about the Nurse Professional Standards Board. It appears what is more important to the board is how well you write the proficiency and not how well you take care of the patients. Promotions should be based on what a person's supervisor observes, their work, and how that nurse has contributed to the VA and the care of the veterans. First line supervisors are in the position to note the individual contributions of staff nurse on a daily basis. The Nurse Professional Standards Board is an archaic, antiquated system. As nurses, we submit a log or journal to our nurse managers as our input to yearly proficiencies. We are challenged in a sense to prove we walk on water. If the nurse can embellish their accomplishments in the proficiencies, then they receive promotions from the board members. It's the creativity of the writing that gets a nurse promotion, not the actual skill of the nurse. There are currently some nurses fighting to get their promotion to the next level. Most of these nurses are at the top of Nurse Level I and will stay in that level for years. They top out at that level and never advance or receive higher compensation except an annual nationwide pay raise and the locality pay raise if it is given each year. There are numerous nurses who have an outstanding rating in their proficiency, but the board will send back a reply of noneligibility for promotion. Each year RNs in every level are put through this humiliating process. There is never any explanation of why the levels have not been met. The nurse doesn't know what

she has done right or wrong and what areas need improvement. In some cases the RNs involved were part-time RNs and they were told that, since they hold part-time positions, they have no avenue to fight the process. All nurses have no right to appeal the denial of the education waiver. The VA is fixating on the type of education credentials and using this fixation as an excuse to deny outstanding nurses recognition for the promotion. Most of the nurses who stay at the bedside are in a sense penalized by the standards which focus more on management than bedside care. The nurses who stay at the bedside are in a sense like the frontline troops who take the heavy hits. In smaller states like South Dakota that are more rural than urban, it is hard to get the additional education requirements for advancement. The education system is expensive, inconvenient, and has multiple drawbacks. Not all the colleges or universities have the same requirements for the B.S.N. or M.S.N. Some nurses have had to relocate while taking classes to further their education; and in my experience of higher education, when I got to the new school, none of the nursing credits were transferred and I had to start over. This is frustrating. We have lost multiple nurses in several years due to nonpromotion of nurses that have excellent experience, but have not furthered their education. If the VA is demanding its nurses have a B.S.N. and M.S.N. to advance to a Nurse II or Nurse III, then the VA should use its agreements with nursing colleges to provide classes at the VA and particularly in rural areas. The VA should also establish direct articulation programs so that nurses like myself will have our nursing credits transferred. I also believe that if the nurse demonstrates proficiency in the standards, an automatic waiver of the education performance requirements should be required. At a minimum, nurses should be able to appeal the denial of the education waiver to an independent neutral third party. When an RN is denied a promotion, the board should be required to provide the RN with a plan that describes in clear detail the specifics that the RN must do to achieve the clinical competencies. If the board is unable to write such a plan, the nurse should not be denied a promotion. In conclusion, I propose the following legislative and policy changes: If unable to remove or dissolve the Nurse Professional Standard Boards, then let the nurse that is being evaluated be present during the boarding process. This would enable that nurse to answer any questions or expand on their accomplishments and maybe understand what the board is looking for. The board needs to give examples of how to achieve the standards of each step of each requirement for each level. If a nurse tops out at any level, I, II, or III, there should be options for automatic promotion to the next level after 3 or 5 years, especially if the nurse continues to show outstanding performances. The standards need to be improved so they are crystal clear and be applied consistently, reliably, and objectively. The same form is used to evaluate multiple areas of nursing. For example, an OR RN does not have the opportunity to provide group patient education, but she is penalized for not meeting this unattainable goal. Nurses should not need creative writing degrees or legal degrees to understand and write for proficiencies. The promotion process and the board system needs to be revised and improved. I beg the Commission to recommend that bedside staff nurses have a real say in revising the process. The process is humiliating and lacks credibility. Staff nurses that are subject to this process need to be an equal partner in revamping the promotion process. Change Title No. 38 of the United States Code, Section 7422, to

allow nursing staff through their union to sit down with nurse executives to improve the promotion process through negotiations. Some of the LPNs in my facility wanted me to bring these issues to you. Most LPNs that work with patients are dealing with life and death situations, but they receive less than most housekeepers or respiratory personnel. The grade level for LPNs should be expanded beyond the Grade 6 level they currently have. Most LPNs with experience and those with expanded role training should be able to achieve grades as high as 10 depending on their area and level of responsibility. The amount of accrued and annual leave to be carried over from year to year for LPNs should be raised higher than 240 hours. RNs accrue over 600 hours. LPNs should be able to achieve more than 4 hours of annual leave per pay period after the first year of probation, maybe as high as 8 hours per pay period as for a Title 38 RN. Thank you again for listening to my concerns about the VA nurses.

MR. GORMAN:

Thank you, Karen. I hope I'm not as naive as this question may sound. A thread of what's being said today is the concept of not being able to get promoted by the board. Is it a money issue? Is that --

MS. ISHMAEL:

A lot of times I hear it is a money issue. Like I said, when I went to my chair, I asked her three times to explain to me what the guidelines were and all three times she said, "Read And I kept saying, "It does not make it." sense to me." "Read it." I even asked for it." examples. "Read

MR. GORMAN:

Absent that, I mean, is the underlying reason here a funding issue?

MS. ISHMAEL:

I think so, yes.

MR. GORMAN:

Do you think that it holds not only a promotion down individually, but holds funding down collectively? That seems to be a common thread.

VOICE FROM THE FLOOR:

The standards seem to set people up for failure, not for ongoing promotion.

MS. ISHMAEL:

Just recently in our VA system, we have what they call a Heart of Gold. Just in the last year I've been written up four times by patients -- not by staff members; by patients. And then I get this proficiency back, and, I mean, literally every one of them was marked no.

MR. GORMAN:

Thank you. Dr. Sheila Haas?

DR. HAAS:

My name is Sheila Haas. I am the dean of the School of Nursing at Loyola University in Chicago. Loyola University is located in the slightly western area of Chicago, and we work collaboratively specifically with Hines Veterans Administration. I am here speaking both as dean at Loyola, but also speaking for the American Association of Colleges of Nursing, so I would like to speak in favor of the nurse qualification standards. I must preface this not only with my knowledge of the standards as a dean, but also I am a Diploma graduate who has gone on for a Baccalaureate, a Master's, and then a Doctorate. I'm also a formal military nurse, a former Navy nurse. I served during Vietnam. So I do appreciate the fact that the VA has gone on record stating that education does make a difference. I've learned through my own life that education makes a difference, and I've learned through 25 years of teaching that education does make a difference. And I do believe that what the VA has done has not disenfranchised anyone in that they will have Level I nurses come in with an Associate Degree or a Diploma, but the expectation is that the Diploma-prepared nurse or the Associate Degree nurse goes on for continuing B.S.N. And this is right and appropriate. before they can move forward. education and that they achieve the We live in a complex health care system. The requirements of that system demand that, in fact, nurses are continually developed, and education does make a big difference. Part of the reason for education is our extreme concern today with patient safety. The last three Institute of Medicine reports have spoken to the issues of patient safety. Patient safety has much to do with, again, a complex system where there are complex patterns of communication, and it has much to do with the nurse's ability to communicate with multiple different disciplines when nurses are not prepared at the same level as the other disciplines in health care. And it's pretty much now nursing is the only professional person in that interdisciplinary team who can be prepared at an A.D., Diploma, or Baccalaureate level. Every other discipline has moved to at least Baccalaureate and many to the Pharm.D. or the M.D. or the Master's as preparation for the physical therapist. So nurses need to be prepared in the same way that their interdisciplinary colleagues are if, in fact, we are going to communicate and collaborate with them at a level that provides for patient safety and if nurses are going to be able to work with fact-finding that needs to be done with issues that occur in terms of errors in the health care system that have a lot to do with the high level of complexity that patients and nurses and the rest of the health care team are facing. I

think that what the VA has done in terms of the career ladder as a methodology for moving nurses through levels of performance is appropriate. When ACN asked me to give testimony, they did not realize that my dissertation research and years of consultation had to do with clinical ladders or career ladders. That was my dissertation topic. I put clinical ladders in place in those institutions, and I've helped those institutions evaluate the clinical ladders. There is always a problem. Change is perceived by all people when change comes about as a loss to the persons that are involved in the change, but the reality is that education does make a difference and a career ladder allows persons the opportunity to see what the performance expectations are at each level. Education is but one piece of the performance expectation at each level. When I have worked with clinical ladders or career ladders in institutions, we have found that performance markedly increased in terms of practice of the nurses at each level in terms of the career ladder. So, again, a career ladder is right and appropriate and has served the institutions well that have implemented it. It has become one of the expectations for the magnet hospital program; so that what magnet hospitals have seen from the early 1980s, that form of magnet hospital, to today's magnet hospital is that you need nurses prepared. You need a blend of nurses prepared at the Baccalaureate, the Master's, and Associate Degree level. You cannot have a predominance of any one level of preparation. And those nurses need to collaborate with each other, and the career ladder specifies how the nurse can move from a Level I to a Level II to a Level III and what are the base requirements, which are the education, and then what are the performance requirements that grow out of that education. Experience alone is not sufficient. It is helpful in terms of preparing nurses. I would also like to speak to the previous testimony where there was discussion of problems with getting a Baccalaureate degree or getting a Master's degree. There are now step-wise programs for nurses moving from Associate Degree, Diploma degree. At Loyola, we offer nurses seeking a Baccalaureate the option of a portfolio that they prepare that gives them up to 15 credit hours for their experience as nurses, and that's not unique to Loyola. Other schools do the same thing. We also have our RN B.S.N. completion courses. Some of answers the need for the 24/7 schedules of them are on-line, so this nurses. I personally work with the nurse executives in the city so that we schedule the RN B.S.N. completion course work and also the course work for the Master's students on days when staffing is heaviest, because what we do know is with the nursing shortage there are difficulties with nurses getting freed up from their clinical responsibilities to go to class. So we collaborate with the nurse executives so that nurses that are trying to go to class, if they're going to an on-site class, we do it on the days or evenings when the staffing is best in that organization. I think that, again, the VA is to be commended in terms of the funding that they have given continuing development. It's impressive that nurses get up to \$11,000 for tuition and the cost of their education. That is highly irregular in this environment. So, again, I think the VA needs to be commended on that. And I think the VA is in line with the recommendations of the PEW Health Commission in terms of enhancing the education of nurses and also in terms of the -- the requirements and the needs of the nursing officers in a complex health care system where they are looking for a blend of Baccalaureate nurses with Associate Degree nurses. Here in the Chicagoland area, I have been working with the

nurse executives, and they are all looking to recruit Baccalaureate nurses to work with their Associate Degree nurses. You cannot have a preponderance of one level of preparation over another level of preparation. They do recognize that the Baccalaureate-prepared nurses have a view of the patient not just from an acute care perspective, but also as to where the patient is in terms of the community so that they can do early intervention and prepare the patient to return to the community and to the role that they have. They also recognize that the Baccalaureate-prepared nurse is prepared for leadership to be able to be an effective team member and to be a team facilitator or team leader in a complex health care system, so I will leave it there.

MS. ADAIR:

I have a question. At Loyola, have you given or do you know of any other universities that are considering on-line reaching out to people -- as the woman from Ft. Meade said, they don't have that access to school. Other places don't have that access as well, and that's one of the things that I think nursing needs to look at is how do we go on-line. A numbers of programs that are health-related are on-line except for maybe a few things. Have you considered something like that?

DR. HAAS:

Yes, we have. We have the pathophysiology course that's a requirement for the RN B.S.N. completion. It went up on-line for RNs this semester, and we are working sequentially into it taking the highest demand courses first and then working through them. We are also looking at moving our courses from 14-week courses to 7-week courses because the RNs in a clinical situation appreciate finishing a course in 7 weeks rather than having it stretch out over 14 weeks and it's a little bit easier to get the scheduling done for those courses. So that we don't want to compromise the quality that is the B.S.N., but at the same time we want to make it as user friendly as possible for the nurses. I will say that one of the biggest challenges is to take and to have an B.S.N. completion program at every hospital. At this point in time, many hospitals are looking at doing that. There aren't enough faculty. There's a huge faculty shortage currently. So putting courses on-line begins to solve some of that problem. It isn't a total answer, though, because students -- they drift away from the program when it's completely on-line and they don't have face-to-face contact, so you have to have a blend of on-line and face-to-face. We do a very effective program for this VISN of the VA. We prepared two cohorts of post-Master's nurses to be nurse practitioners, and we did it using videoconferencing with bringing the participants back for some face-to-face. So I think that we are learning as we go how much face-to-face time we have to have with the nurses that are in the programs to keep them connected, and we are looking -- there used to be an old bias that you couldn't do your clinical in the facility where you worked. Well, we have relooked at that and some of that is also changing. And coming up -- if you switch to an outcomes-focused curriculum, then you can look at what is it that you want to achieve and then come up with the ways you want to achieve it. So some of those old rules are falling by the wayside.

MS. CONVERSO:

Is there -- is there some literature that supports -- B.S.N., are their NCLEX exams coming in at a higher rate of pass, or is there some literature to support the fact that after five years or two years or three years that registered nurses, no matter where they graduate from, are at different levels? Like does that level off at a certain period of time where you are all experiencing the same level at your particular facility? Is there some literature that supports B.S.N.s would do that better after a certain amount of years?

DR. HAAS:

The first question in terms of the NCLEX, the map or the plan for the NCLEX is based on practice of nurses in current practice, and there's about a six-month lag time. So the NCLEX is base performance, base safe performance. And it really depends on how a curriculum is organized. Most Baccalaureate programs do not teach for success with the NCLEX. What they tend to do -- and I can speak for what we tend to do at Loyola -- is we want the students to have the test-taking skills to be able to do well on NCLEX, and you certainly want to do well on NCLEX; but NCLEX is not the be-all and end-all. The expectation is that, if you have a strong curriculum, that your students are going to do well on NCLEX if they have the test-taking skills, because it is a computerized exam and it uses the drop-down calculator and that sort of thing. So they have to have a level of proficiency with test-taking, but the actual content per se is not in most Baccalaureate programs geared to what NCLEX is testing because NCLEX is testing the base. And I think programs like Loyola, we really have -- from a mission-driven point of view, we really have a diverse student population; and even though NCLEX says that it has no biases relative to ethnic or cultural backgrounds, my personal belief is that there probably is.

MS. CONVERSO:

So is there any basic difference from --

DR. HAAS:

There is six months out.

MS. CONVERSO:

But when people take that, is there a difference between a B.S.N. graduate and an ADN on those exams?

DR. HAAS:

I watch the B.S.N. graduates and there have been fluctuations and it depends on what the national council is doing in terms of raising the bar. They raised the bar about four years ago and there was a decrease in the pass rates and now the pass rates are back.

MS. CONVERSO:

For both groups?

DR. HAAS:

For both groups, but the B.S.N., because they don't teach to the NCLEX, there was a difference in the pass rate. So now the NCLEX again wants to raise the bar and they are going to change their testing methodology and we are concerned at this point in time. The national is a separately incorporated group; and in a state of national shortage, the question becomes should you be raising the bar and for what purpose are you raising the bar. So the question -- the second part of your question was is there a difference in performance of the Associate Degree versus -- in Illinois, there are very few Diploma programs left, so it's really Associate Degree versus Baccalaureate Degree. Six months out there is a marked difference in the performance of the Baccalaureate Degree in terms of leadership, in terms of critical thinking, in terms of problem-solving relative to patient care.

MS. CONVERSO:

Is that around this area or is that overall and is there something that supports that? Because I haven't seen that, so I'm trying to get my hands on some information; so if you could provide that, we would greatly appreciate it.

DR. HAAS:

I will get information. I'll need before I leave someone to get it to.

MS. CONVERSO:

Okay.

MR. GORMAN:

I don't want to get too far behind, but I'm curious about something you said. You give 15 credit hours based on experience in the profession?

DR. HAAS:

The student establishes a portfolio, and the portfolio -- the previous speaker talked about the activities that she had been involved in and the fact that she teaches in certain areas; that she may be certified. There are certain areas you can be certified in without a Bachelor's degrees. There are nurses without a Bachelor's degree who participate in professional organizations; so leadership activities, professional continuing education and certifications, all of those are what the nurse puts together in the portfolio. So it's the person's resume as well as all of their certifications and participation, so it's demonstrated leadership. And they can put performance reviews from the career ladder or the clinical ladder for the place where they work. That's not a guaranteed 15 hours, but what we are trying to do is to recognize the professional experiences that a nurse has had coming into the program, because truly all nurses are doing -- if they work in a health system, are doing continuing education and development type activities, and many of them have gone on for certain levels of certification. We are trying to recognize that.

MR. GORMAN:

But life experience and work experience can count some toward the ability for promotion?

DR. HAAS:

Yes -- it's not life experience; it's professional experience.

MR. GORMAN:

Thank you, Dr. Haas. Shawna Reid?

MS. REID:

My name is Shawna Reid. I'm a family nurse practitioner. Thank you for the opportunity to speak. I'm here to represent the primary care nurse practitioners from the Topeka VA. There are six of us. All except for one are Master's-prepared and nationally certified. We are the group that all the current studies are speaking to. We are all baby boomers. We all came into the VA with at least ten years of nursing experience. All of us have at least -- the majority of us have at least 14 years before we plan to retire. As we currently are utilized as health care providers, we are utilized in clinic settings, nursing homes, urgent care, employee health, and to perform compensation and pension examinations for the VA. We are not pulled into inappropriate areas, and we are pleased with the way we are currently being utilized.

MR. GORMAN:

Could you speak up a little bit, please, so the reporter can get everything?

MS. REID:

Of course. I apologize. Multiple studies are going on nationwide to find out what will make us stay and speak to retention. We want to be valued for and compensated for what we do for the system, for our years of education, and the years of expertise that we bring to the nurse practitioner role. Nurse practitioners and physician's assistants are currently hired interchangeably. Nurse practitioners are required to have a minimum of a Master's degree and come in with years of nursing experience. Physician's assistants are only required to be educated at the Bachelor of Science level and are not required to have much, if any, experience at all in the medical field. Nurse practitioners are brought into the system at lower salaries than PAs. Physician's assistant raises are not at the discretion of the facility director and, therefore, occur on an annual basis, allowing for increased compensation over NPs. Nonmonetary benefits extended to the PAs are not always extended to the NPs. Physician's assistants do not have the same boarding process. The Nursing Standards Board is antiquated, steeped in its own mystique. The Nursing Standards Board has no standards by which to evaluate the unique role of the clinical nurse practitioner. Practitioners are currently required to spend hours writing trivial jargon to appease the current standards board that does not value the contribution the primary care nurse practitioners bring to the VA. Nurse anesthesiologists are not required to meet those boarding standards. They have their own separate board. The human resources department has no current interest in the retention of nurse practitioners as long as all vacant positions have been filled within less than one year.

MR. GORMAN:

Would you pull the microphone a little bit closer to you also?

MS. REID:

I'm sorry. I'm scared, and I don't speak loud to begin with.

MR. GORMAN:

You're doing fine.

MS. REID:

There are currently six primary care nurse practitioners at the Topeka VA. Since 1998, five nurse practitioners have left the primary care role. Two left over salary, two left for administrative positions within the VA, and one left for personal reasons. Primary care nurse practitioners are on a separate pay scale. Locality pay surveys are required to be done every year. The human resources department is under no obligation to obtain any data for the survey to be considered complete. To determine locality pay, human resources forwarded salary inquiries to facilities that historically have never provided data on nurse practitioner salaries. When the salaries are not

returned, zero is entered into the line indicating changes in locality pay, and, therefore, there is no locality pay difference and there has not been. This year, human resources will be able to purchase an outside survey. Again, there are no guidelines requiring that the survey be completed. Nurse practitioners are currently treated as the stepchild of primary care. We are considered by the general staff to be a part of the health care provider group, but not provided with the same pay and nonpaid incentives as our physician assistant counterparts. We are expected to retain RN license, but for educational loan reimbursement programs we are considered less than a nurse. Staff RNs will receive student loan compensation at a primary level, and NPs are considered below PAs, respiratory therapists, physical assistants, et cetera. We wish to be evaluated the same. We want to be hired on a scale that is commiserate with our level of education and experience to advance as rapidly as our PA counterparts and to be removed from evaluation by the Nursing Standards Board. We wish to be evaluated the same at our PA counterparts. We wish to have all mid-level providers, NPs and PAs, on the same scale. As it is currently, NPs cannot go above a Level III, which maxes out their salary at \$68,000. PA's can go up to a GS-13. They can max out at \$80,000. If NPs leave the clinical role, they can become administration and go to a Level IV, at which point they have a maximum range of \$84,000. Those two who left to go to -- the two nurse practitioners who left since 1998 to go to administrative positions were not considered a loss. Human resources said that since they stayed within the system, they are not nurses lost to the system and, therefore, they do not consider that there has been a change in the number of NPs. In conclusion, our physician supervisors are clear that seeing patients in the clinic, nursing home, urgent care, and employee health are what make us a value to them. The system in general persistently declines to provide locality pay along with nonmonetary compensation to NPs while continuing to hire less experienced and less educated PAs at higher levels of compensation. The Nurse Standards Board is an antiquated system unable to evaluate the current complexity of the varieties of nursing roles. It currently adheres to a written set of guidelines with very rigid concreteness, none of which speak to the unique role of the primary care NP. We had one NP who -- part of what she didn't pass on her Boards to become a nurse practitioner was she did not meet the criteria for being in a committee that affected nationwide -- she had completed the project; her and another nurse had completed the project. It had been approved by their supervisor. It was on hazmat, and the purpose was to hang in the urgent care a hazmat poster. The poster was not hung. Therefore, she had spent hours along with a another Master's-prepared nurse, had gone through every step required at the VA, the poster was completed, they decided not to hang it after all, and, therefore, it does not qualify. She did not meet the step. We have now forwarded it on the Undersecretary of Health. We are asking to be valued for and compensated for what we bring to the system. Years of experience, high levels of education, the flexibility to provide primary care in the clinic, urgent care, employee health, and on the nursing home unit. And I personally have done each of those jobs all within the same day, and we are not valued for what we do. I was hired into a PA role. I do exactly what the PA before me did. When we had an NP who left, a PA was hired into that role. They are used interchangeably, but the salary is -- there's a lot of difference in the salary and there's a lot of difference in how fast they are

promoted. Their locality pay is not at the discretion of the director. Therefore, they receive their locality pay on an annual basis. Thank you very much.

MR. GORMAN:

Thank you. Did I understand you to say that if you lose a nurse practitioner staff to an administrative position, then the facility doesn't consider that staff -- that person to be lost as far as staffing purposes?

MS. REID:

They don't consider the NP to be lost for any staffing purposes, that's correct, so they consider that there is no changeover because all NPs have been hired within a year's period of time. Therefore, if they leave for whatever purpose, it doesn't count, that's correct.

MR. GORMAN:

All right. Thank you. Robert Hobaugh? Can I remind everybody that when you come up, speak into the microphone, please, and loud enough so that our court reporter can pick up everything you say because it's very important to us.

VOICE FROM THE FLOOR:

I don't think the mike is turned on. (WHEREUPON, discussion was had off the record.)

MR. GORMAN:

Please.

MR. HOBAUGH:

Good morning. My name is Robert Hobaugh. I work at the VA Roudebush Hospital in Indianapolis. I'm also a disabled veteran rated at 50 percent. The reason I'm telling you that I am a disabled veteran is because I can afford to go wherever I want for private health care, but I choose to go to the VA because I believe that the VA is the best health care that there is. My father receives VA benefits, my mother receives VA benefits, health care, and so does my father-in-law. We all believe that the VA is the best place to go. I also work at the VA as an LPN because I have pride in my country, and I also believe that the veterans of the United States deserve to have somebody there. If the veterans are going to stick their hands up and say that they promise to defend this country and protect against all enemies, foreign and domestic, then I believe that nurses can do the same thing. In regards to retaining and recruiting for nurses, I just have a few suggestions. As far as the education, I suggest that the VAs hold classes in their local facilities for LPN to A.S.N. and A.S.N. to B.S.N. They

could be able to have courses held there and clinicals held there. I believe that the VA would benefit because they would graduate, the nurses would be more apt to stay and have loyal nurses. Once they are within the VA as a career. You would also receive experienced nurses because the nurses have gone through your own course at the VA. You would also receive nurses that are accustomed to the unique VA population, such as patients with posttraumatic stress syndrome, Gulf War, et cetera. You would also receive a nurse that would need a shorter orientation time from graduate to floor nurse. They could be on the floor weeks faster than nurses coming out of school. On the second part of that, I also believe that an LPN that's in the VA system that does try and succeed to receive their RN should be hired at a Nurse I, Level II, or higher, as everybody has said due to the pay cuts. I was just informed that I would lose between \$5- and \$7,000 by the time I complete my RN. I have friends that have completed their RN that have gotten out of the VA system and left and gone to private hospitals just because of the money part of that. I believe that's -- you can't have a family and go to a pay cut. It just will not work. Also, I suggest the Saturday premium pay for all staff. It's hard enough to get quality nursing aides, housekeeping, and other staff support staff in the hospital. When they find out that they do not get premium pay -- and at our hospital, it's not known that they can get premium pay unless we have told them. When I say "we," I mean nursing aides in general. We don't have enough nursing aides there, especially on weekends because they don't get paid well enough, which means that LPNs and RNs have to take time away from direct patient care to help make the beds, take the trash out, get the rooms ready to receive patient transfers. If they had the nurse's aides that had their premium pay, we'd have quality people there that would be able to help with colostomy bags, empty urine bags, or anything like that -- stuff that is important, but as licensed nurses we need to concentrate on the health of the patient instead of devoting all of our time to that. I also would like to suggest that -- and I do not know or have not followed all the way through this -- that LPNs should receive some type of technical training. Now, I'm not sure throughout the VA system; but at my hospital -- this is an example -- our RNs are the only ones that can flush pick lines. Once they flush the pick line, they have to add IV solution. Once that IV solution is running, we as LPNs can put medications into that pick line. Now, that sounds simple enough, but if you are an RN -- and this is typical on my floor particularly -- we usually have two RNs and maybe three LPNs and one nurse's aide assigned for 23 patients, which in itself doesn't really sound bad; but when you consider the quality care they need -- I mean, we just don't have patients that are walking and talking; we have patients that are sick, dying, medical patients, neuro patients, and all that. You have two RNs there. Both of those have to team lead each team and one of those has to be a charge nurse. So it could take that RN anywhere from five minutes to an hour and a half for that patient to receive their medication because the RN -- not because he or she is incompetent; it's because they do not have time to get to that patient. So I believe just little technical stuff like that, better management of using the nursing staff, would help out the RNs. The RNs are getting really, really burned out due to the staffing shortages at my hospital. Just as an example, yesterday one of the RNs that's a really good friend of mine, she had confided in me that after the next three shifts, she is quitting. It's not because of one day that happened yesterday when we were short staffed. It's because

of everything that's led up to that time. The nurses are so short staffed that they are stressed out. They do not take it out on the patients, but you can -- there's a point where they break and they start complaining in front of the patients and the patients are starting to feel that they are not as needed. The here is for the veterans. The veterans are the most important reason that we are patients. Due to short staff, in my facility we have had patients that have missed medications, that have had medications given extremely late. We have had patients that have missed procedures because we did not have the personnel to actually physically pick the patient up, put them on a wheelchair or in a bed, and get them to CAT scan or whatever. They have actually missed those procedures. They have had to shut down that because their staff on the CAT scan side is slow and we didn't get the patient there on time. Once again, that may sound really small, but that patient would have to stay overnight. That patient has to stay again over the weekend, which means that other veterans from the hospital -- or that needs those beds are getting pushed aside. Patients also have an increase in aspiration. This has happened at my facility. They have aspirated. They did not die luckily. We have had staff there, but we did not have enough staff to actually watch all the patients, not enough licensed staff. We have had patients that have fallen. We also have two nurses right now in my own little world that are on light duty due to patient falls or picking up patients. I'm just trying to let you know that the RNs are getting really burned out and you're not going to have them. So in conclusion, I suggest that education classes be given for LPNs for a -- for the LPN to A.S.N. program and A.S.N. to B.S.N. program. I suggest -- one thing I didn't hit on. I believe we need retention bonuses for LPNs -- standard retention bonuses for LPNs and RNs. I was told by my management that LPNs are easier to hire on the outside than the RNs. Therefore, we do not offer LPNs any bonuses, and that's degrading. If I did not love working for the veterans, I would be gone just for that comment alone. I suggest premium pay. I really suggest you -- suggest that they receive premium pay for all staff on Saturdays. I suggest that there would be standard technology for the LPNs to relieve the RNs -- not necessarily trying to take their job away, but every little thing helps the RNs give them time. One minute of helping them gives them another ten minutes due to the pressure that's on them. And I also suggest that hiring the LPNs that are able to go from LPNs to an RN should be hired at a higher rate. That's all. Thank you.

MR. GORMAN:

Thank you, Robert. Barbara Bollenberg? Good morning.

MS. BOLLENBERG:

Good morning, members of the commission. I'm very please to be here and I'd like to welcome you to our area. I am Barbara Bollenberg, and I'm an emergency department staff nurse. I am Level III, Step 12, at Hines VA Medical Center here in Chicago. As an emergency nurse, I am proud to be on the front line of care for our nation's veterans. I also serve as tri-chair of our 500-nurse bargaining unit at Hines, and I'm a director of the Veterans Health Council of UAN. I've been a staff nurse at Hines since

1984 and a VA nurse for 30 years. In that time, I've seen an increasing number of extremely talented nurses choose to take their skills elsewhere. Last year on one of my units seven nurses left within a five-month period, so clearly we are slipping in our mutual goal to make the VA employer of choice for nurses. And all the while I'm seeing that our national VA population workload is going up by about 25 percent, and the current war in Iraq is only nurses. going to increase those numbers for VA That's why I think that the work that this Commission is undertaking is going to be invaluable as we strive to make the VA a place where new nurses are going to want to work and, equally important, a place where experienced nurses will be fairly rewarded for their years of service, dedication, and knowledge. One thing I think we need to work on is to standardized the promotion product for staff nurses. More often than not, it does seem to be driven by budget constraints, number of people already in a particular grade, and the overall subjectivity of the merit system. There seem to be nationwide disparities on how managers interpret and how boards interpret as they relate to the granting of promotions. For certain managers, this is an education and training issue. I've had board members say to me some head nurses are very flowery, they're very complimentary, but they don't write to the falls, so it does the nurse no good. In our facility last year, out of the 500 nurses only 17 were promoted, and not a single educational waiver went forward at my facility. For example, I worked with one nurse who was hired as a Level I nurse at Hines. She got her Master's while working as a Hines employee, and she was stuck at the Level I level. She could not get off of that. She was a very talented nurse. She had a lot of documentation from the nurse practitioner on her ward, from patients, from her co-workers and special projects that she had done, and she remained a Level I nurse. I actually helped her to rewrite a sample proficiency. We worked with the Nurse Professional Standards Board chair on numerous occasions, and we ended up having to go to our executive nurse to get that so that she could be promoted to Level II; and I wonder if she is going to want to try to make it to Level III. I can't imagine that she would. We do need to focus on proficiency writing, and we need to have specific examples, as others have said, of the proficiency and outcomes for those proficiencies. At Hines this year we have had a one-day workshop for managers to better understand how to objectively interpret and apply qual standards for promotion, but time will tell how well that works. Also, the UAN's national VA council has developed a one-hour continuing education program entitled "Title 38 RN Promotions," which has been highly acclaimed, and this is the kind of model that the Commission should support and encourage. Also working against nurses who seek promotion is that lack of opportunities. I have nurses in the cath lab, for example, who are the world's most wonderful cath lab nurses; but, again, if the nurse has to work outside of her unit to have that impact on the service or on the VISN or on the facility level, there's no opportunity for the nurse just because of that important role that they do. When would these busy staff nurses have an opportunity to work outside? Now, we have been told at our VISN that there will be no Level IV nurses. We had two nurses at Hines that were Level IV, but were forced to return to Level III with pay reduction because of that philosophy. But at a similar VA in Minnesota three years ago, there were 14 Level IV nurses. In fact, there are bargaining level Nurse IVs at several facilities across the country. Where is the justice in this kind of inequity? A nurse

practitioner at Hines told me that she has heard that for a Nurse III to be promoted to Level IV she has to demonstrate skills that a chief nurse would have at smaller facilities, but nurse practitioners who manage large case loads don't have that opportunity. They don't qualify as administrators or managers under the qual standard as interpreted in our facility. So it doesn't make sense that managing patient care is not as important and challenging as managing staff members or pushing papers, as some of our staff like to say. Another nurse practitioner at Hines said to me that people think that nurse practitioners are given the least challenging, most simple patients to take care of while the physicians have the more complex. But, in fact, these patients are assigned in kind of a random pattern. There is no assessment of the patient's level of care and need for care until the first clinic visit. So for approximately a \$2,000 difference a year, the nurse is handling a very comparable panel of patients to that of the physician, so that's a misnomer that needs to be appreciated. I would ask this Commission to look seriously at how qual standards apply to promotion, both in standardizing their application and in making them truly reachable and relevant to the work staff nurses do every day. More and more the standards are being used to nail down a glass ceiling that blocks nurses from advancing, and I don't think that was their purpose. As Dr. Haas said, I applaud the concept of the standards. They were truly a great idea, and they are concepts that all of us in nursing espouse; but when they are applied subjectively the way they are being applied now, that's when they need to be overhauled before we can truly be proud of our nurse qual standards. We need to return to the basic philosophy of a true peer review, rank in person recognition, and many types of activities can satisfy the intent of the qualification standards. There needs to be more flexibility. These standards should provide more and not fewer opportunities for advancement within the VA system. Another area where I think this Commission can help is monitoring whether staff nurses have real input into daily work issues that affect us. I find that increasingly staff nurses have minimal or no input into decisions that affect us at the bedside, and that's counterproductive for patients as well as nurses. At Hines, as at many facilities, we have switched to the electronic record-keeping system, and it now takes me two to three times as much time as it used to complete the necessary records and data I have to do for each patient. BCMA has doubled and tripled medication pass times, but there has been no decrease of duties or additional help to compensate for these changes. A final point is the top of the grade caps at Nurse II and Nurse III. While it's been easy to extend Level I to keep those salaries competitive, there are many nurses like me who are stuck at the top of the grade. Resulting salary compression at Nurse II and Nurse III is very problematic for your VA nurses. In the many years I've been at the VA, I've come to love my job and I really thrive on the positive feedback I get from my patients and co-workers. As a professional, I do take pride when I come to work and they say, "Thank God you're here," from the patients and the staff. But staff nurses deserve more than compliments and personal pride in a job well done as they invest their lives and career in the VA. Standardizing our promotion process, soliciting and implementing input from staff nurses, and removing the top of grade caps would go a long way toward making experienced nurses feel that they are recognized and valued for the hard work that they do and the expertise

and skills they bring to the job. Nothing less than that will make VA nursing an attractive career option for experienced or new RNs. Thank you. Any questions?

MR. GORDON:

Thank you, Barbara. I don't think so. Thank you very much. Right on time thanks to our timekeeper. It's 11:35. We are going to go into the open forum as the agenda calls for, and the next person on the first come/first served basis is Michelle Reed. I would again remind everybody to please keep your remarks to the three-minute time frame.

MS. REED:

Good morning. My name is Michelle Reed, and I present this testimony as a registered nurse with over 21 years experience at the Minneapolis VA medical center. Even with all this experience, my job caring for veterans is overwhelming some of the time, and I will admit at times has reduced me to tears. The first point I would like to address is staffing. I provide direct patient care to 4 to 5 or sometimes more veteran patients on an acute 40-bed surgical unit. I am also frequently accountable for LPNs' patients, directing nursing assistants, and working as the charge nurse all at the same time. My patients have multiple health problems that complicate their postoperative recovery. My assignment usually includes caring for two to three patients that have just arrived from the postoperative recovery room. These patients require frequently monitoring, are still sedated, and oftentimes are confused. Postoperative pain control is also a labor-intensive priority. In addition, I must deal with concerned family members and provide comfort and reassurance to them as well. With the focus on earlier discharge, patients are sicker and hospitalized a shorter period of time. The technology has increased and so have my duties. Software such as bar code medication administration and the computerized patient system, although they're supposed to provide safer patient care, takes more time to use and takes me away from direct patient care. Staffing ratios have not improved. It is not uncommon for nursing staff to work without breaks and then be faced with mandatory overtime. Only a nurse with super powers could provide safe and adequate care under these circumstances. The solution would be that we need legislation that mandates a safe nurse/patient ratio and allows us to negotiate staffing levels. The second issue is the nurse qualification standards. Imagine working as hard as you can in the above situation on a daily basis and not being eligible for advancement. This is what has happened with the new nurse qual standards. The new qualification standards are looking only at education for advancement and not at performance or experience. The whole nurse needs to be considered just as we as health professionals look at the whole patient. Although we have been informed that there would be waivers for education, these have not be applied. The new standards are subjective and being applied differently at different facilities. How is the VA going to be a leader in health care, an employer of choice, and recruit and retain registered nurses if the only criteria for advancement is education? We must have qualification standards that look at all aspects of being a nurse experience, education, and performance. -- My third

issue is Saturday premium pay. It takes many, many people to staff our medical center 24 hours a day. Unfortunately, not everyone that works there receives premium pay for Saturdays. All weekend staff are essential to provide care for our veterans. We must have legislation to provide Title 5 nursing assistants with premium pay. Health insurance is my last point. Isn't it can't afford the high cost of health insurance ironic that some of the staff that provide direct patient care to our veterans premiums. We must have legislation that allows our union to be included in the negotiations with the insurance companies and legislation that caps the employee portion of premiums at a maximum of 20 percent. Thank you for the opportunity today.

MR. GORMAN:

Thank you, Michelle. Judith Lemna?

MS. LEMNA:

Good morning. I'm Judy Lemna. I'm a staff nurse at the VA in Minneapolis. I'm a graduate of a three-year Diploma program. I'm a Nurse III. I was promoted prior to the implementation of the new performance standards. I am that unusual thing, a staff nurse on the Nurse Professional Standards Board. It is clear to me that under the current interpretation of the standards, I would not be promoted; that, in fact, no staff nurse can or will be promoted to Nurse III. A nurse can meet all the standards, but still be denied based on scope of practice if his or her job title is staff nurse. Scope of practice is described as "executes position responsibilities that demonstrate leadership, experience, and creative approaches to the management of complex client care." It goes on to say that "the effect of the nurse's practice must go beyond an individual unit or team to encompass a program or a service or a service line." It then lists a number of job titles which may meet that standard, none of which is staff nurse. I believe this was designed to eliminate staff nurses from this level. If this is the case, it reverses many years of the VA's philosophy of keeping very skilled nurses at the bedside. What's the reward for a nurse who returns to school, obtains a B.S.N. or an M.S.N., and wishes to stay at bedside? There is none. I offer two examples of the impact of these guidelines. Three staff nurses in Minneapolis identified a number of problems with frequent delayed discharges. They set up a demonstration project which utilized a nurse discharge planner. It was so successful that the position of nurse discharge planner was added to all three primary care service lines. In addition to increased patient satisfaction and decrease of rapid readmissions, there has been a cost savings of over \$300,000 in the past two years. They were not promoted. The nurse executive assured them that they would be given a step increase or a bonus. This has not happened. Another case which calls into question the independence of the board is of a staff nurse who set up a telephone clinic to manage diabetic clients who have difficulty with compliance. The clinic receives referrals from all service lines. She has used falling glycosylated hemoglobin levels as a marker for success. Her clinic was presented during our most recent Jayco visit as an example of innovative care. The reviewers strongly encouraged her to publish. She was recommended for promotion by the board twice. The nurse executive returned the

recommendation each time based on scope of practice. The third time she was not recommended for a promotion. One wonders what changed. This shows even when a staff nurse goes beyond an individual team or unit -- is that my stop?

MR. GORMAN:

That is your stop. We apologize. Would you be kind enough to give us a copy of your comments so we can have them in the record?

MS. LEMNA:

I will.

MR. GORMAN:

Thank you. Jackie Rust?

MS. RUST:

Hello. My name is Jackie Rust. I am a nurse practitioner at the VA in Minneapolis. I work in the renal transport department. I'm just going to touch on two subjects. One is patient panel size. I'm not sure if you're aware what panel size is, but it's the number of patients that a provider will be considered a primary provider for. Right now we are talking about 800-plus patients for nurse practitioners, a little over that for physicians. The reason I'm bringing up physicians is because this is also a problem for our physicians as well as nurse practitioners. Right now we are seeing patients at the VA who are living longer with multiple comorbidities. The average range is 70 to 80 years old. They have polypharmacy issues, social and finance situations. We are now dealing with electronic data entry. We are dealing with these complex issues that we don't necessarily have time to deal with in the amount of time that we have been given, 20, 30 minutes. Because of that, patients are not being seen on a timely basis. We have 10,000 patients that are still trying to get into the VA, and we don't have the time or the staff to see them. Why is this a concern? Because we have to now put in our lab orders ourselves. We have to put in our x-ray results. We have to follow up with labs. We need to follow up with phone calls. There's just a barrage of things that we need to do and don't have the time to do it. What could we recommend? We recommend that APRNs, advanced practical nurses, as well as physicians form a committee to find out what the proper size of a panel would be. On top of that, we want the labs, x-rays, those types of things that clerical workers have once done, to continue to do those things as this allows less time for us to see our patients. No. 2, supervision of APRNs. APRNs should be supervised by other APRNs, those who know the scope of practice. APRNs cannot be managed by other RNs who do not know the scope of practice, the complexity of the patients, nor the proficiencies, troubleshooting panel sizes. This has also been an issue with the collaborating physicians as they see it is a problem as well. So how do we rectify that? An ANPR should be in an administrative position where they will govern or

evaluate over APRNs as well as collaborating physicians. You certainly would not have an LPN governing an RN or an NA governing an LPN, et cetera. Thank you.

MR. GORMAN:

Thank you. Linda Halverson-Beiter?

MS. HALVERSON-BEITER:

Good morning. I'm Linda Halverson-Beiter from the Minneapolis VA Medical Center. I'm a B.S.N.-prepared registered nurse in the operating room providing direct patient care to our veterans. After 18 years I have reached a Nurse II, Step 12. I am at the top of my grade and step with little chance of promotion using the current interpretations of the nursing qualification standards. This will become even more difficult after 2004 when the Nurse III will be a Master's degree. educational requirement for For the past 14 years, I have assumed the role of service leader for four of the surgical specialties in the OR. This includes interdisciplinary work with surgeons, supply staff, OR staff, radiology, and research in the development of the new procedures and protocols, OR staff inservicing, inventory management, and educational resource material development -- all of which are above and beyond the expectations of a Nurse II, but which I have assumed as part of my professional development. Each year I am requested to and submit detailed input to my nurse manager regarding last year's accomplishments. However, upon meeting with my nurse manager for my annual review, my input has been reduced to one to two paragraphs. No attempt has been made to address each of the standards I need for promotion though my overall ratings are consistently outstanding. It is well-known that unless your immediate supervisor is willing to work with you and write a proficiency that reflects your performance, you will not be promoted. Peers who sit on the nursing board tell me that a proficiency with only a few paragraphs is considered to indicate that the supervisor does not see you as promotable. Following failure to be promoted, I have requested to be reboarded. I was subjected to a demoralizing meeting with the chair of the Nursing Standards Board, where she repeatedly stated that I am only a staff nurse doing outstanding work, yet still a staff nurse and "you do not meet the standards for a Nurse III due to the scope of your practice." Why is it that bedside nursing is no longer valued? Any ideas, innovations, suggestions for improving of the care of the veteran is not deemed important enough to warrant promotion to the Nurse III, even though these same ideas and suggestions are frequently implemented and have a profound impact on patient care. My suggestion is that we need to change 38 U.S.C. 7422 to allow nurses to negotiate the content and implementation of the qualification standards and to have the ability to grieve our proficiencies as our Title 5 counterparts do. The ability to write proficiencies that reflect performances accurately should be a performance standard for the managers, and qualification standards should be --

MS. CONVERSO:

Sorry. I don't want to do this next time.

MR. GORMAN:

Thank you, Linda.

Margaret Kruckemeyer?

MS. KRUCKEMEYER:

Hello. I am a VA nurse from Dayton, Ohio, and I am working in an advanced practice role. I bring 33 years of experience to this table and I'm a retired Army nurse and service-connected and I have been maxed out at my grading step since 1992. What I'd like to address is how can we retain and recruit VA nurses? 40 percent of all of your VA nurses can retire by 2005. VA needs to capitalize on not losing this potential part-time VA experienced work force pool by breaking down the barriers of part-time utilization of Offering a national based contract employment. proposal to a retiree to capitalize on the federal sector use of an active one state licensure can be done to build a SWAT team around. We need to stop the extra burden on our nonexistent support system that says we need to yearly prove that we have a locality shortage of nurses. Abolish the yearly requirement of retired VA nurses working under the pension program to renegotiate. Right now, if they don't do this, then they could lose part of their pension by coming back to work and then this work time is taken out of your pension. I'm not that altruistic. VA also is needing to have more nurse educators. Why not utilize retired nurses to help our VA nurse graduates who are really new to this system to have mentors and clinical support through an internship program which will also enhance patient safety? Retired VA nurses also can bring to the thing a relief to overworked staff, and that is they can fill in these hard-to-work shifts or time that we have. For example, in Phoenix, Arizona, they're currently paying a commercial pool \$50 an hour to give a nurse and that nurse then receives \$35 an hour. Why waste the money? Let's just give them \$35 hour and save the \$15 for some other use. Utilization of retired nurses can also be used to be involved in a grow-your-own program; so like helping out the 4-H people, Girl Scouts, Boy Scouts with the student program, that we can bring in maybe student nursing assistants on the weekends to have them monitor, help feed patients, pass water, and everything else to get them exposed to what it is to be a health care team member that they might be then recruited into the work force of the future. Also these particular people can be used as SWAT teams nationally. Why not when you have Jayco -- you're already overwhelmed anyway with the current work load and then you've got Jayco. Have a SWAT team go in for two to three weeks, you know, prior to the Jayco to help the staff, get them up to snuff, and not be overburdened. The last thing I'd like to say is how can we decrease stress. Back in the mid-'90s we saw a Draconian downsizing of the VA work force; and with that we need to have -- oops.

MR. GORMAN:

Thank you. Larry Smith.

MR. LARRY SMITH:

Good morning. My name is Larry Smith. I'm a staff nurse at the Minneapolis VA Hospital. I've been employed as a surgical intensive care nurse by the VA for 23 years. I'm a veteran of the Vietnam war. I went to nursing school using my GI benefits in part. I'd like to dispense with my prepared notes and speak to some of the issues that have been raised here today. Specifically LPNs who go back to school and become RNs are not getting any credit for their VA time. I know when I was in the military, any enlisted personnel who attained a Commission by going back to school or going to officer candidate school, there was a special pay grade for what we called 01's over 4; and I think that's something that the VA could certainly look at as a role model. At a recent forum that was -- has been instituted at our facility between management and employees, I made a comment that seemed to come as quite a shock to my nurse executive and the chief of my product service line and my nurse manager when I stated to them that, much to their surprise, I don't work for them; that I work for the veterans who occupy the beds in my hospital; that they may be my supervisor, but not my superior. And I think it's quite inadequate that the value of work at my institution seems to be evaluated on the fewer people who hold a position, the more valuable that position becomes; that the top of the pyramid should be compensated an inordinate value. That reminds me -- to draw an analogy before my time is up, if you want work to be done, you need sharp teeth at the end of the saw, not a fancy handle at the top. I think we need more and brighter teeth doing the work at our hospital at the patient care level and not a top-heavy hierarchy, which seems to be the norm right now. At my hospital, we have interns, residents who come into my surgical intensive care unit that rely on my knowledge and my input at the direction of their superiors. "If you need to know what to do, ask Larry or ask some of the other experienced ICU nurses." I would just like to say bless Loyola University for allowing that my 24 years of nursing practice is worth 15 credit hours. To go back to the previous testimony, all nurses when we get out of school, whether we have an Associate Degree or B.S.N., come out of school with a license to learn. Now, she was quoting at six months out B.S.N. nurses perform better in a leadership role. I'd like to know if she has the statistics for two years out. If a typical Associate Degree nurse starts their education at the same day a typical B.S.N. nurse starts their education, at the end of four years, a B.S.N. nurse will have a B.S.N. degree and an Associate Degree nurse will have two years of schooling and two years of full-time experience at the role in which they are operating. And I would like to say I think the two years experience is worth a little more. Thank you.

MR. GORMAN:

That's a good point to end on. Richard Homer? I think Mr. Homer will probably be the last for this morning.

MR. HOMER:

I'm always that.

MR. GORMAN:

You could be first this afternoon.

MR. HOMER:

Good morning. My name is Richard Homer. I'm a licensed practical nurse from the Chillicothe Veterans Administration. I come before this Commission as a disabled veteran and a nurse on behalf of the nursing staff of the Veterans Administration. My concerns are many, but at this time I wish to only address one, and that is the following: Patients with lost mobility, patients laying in Gerry chairs for hours daily -- Gerry chairs are chairs that are reclining; they have wheels; you can push them throughout the hall -- medication errors, near errors; decreased mobility of the patient; doubling, tripling and close observation with homicidal and suicidal patients; staff personnel working scheduled and unscheduled hours for 12, 16, and 18 hours to maintain what the facility calls minimal staffing; staff being injured and off for extended periods of time; staff suffering from depression and stress. I ask this Commission and the Congress and the Senate to view these issues as if they were receiving the care or one of your loved ones. Chillicothe VA, as I previously stated, staffs at the minimal level; yet our congressman and our senators both present and the past have said, "We have no funds." We take and we send millions and millions and billions of dollars overseas, yet we cannot treat our veterans who bore the battle who are here. Some have come home as a shell. Some have come home without limbs. Some can't even remember home, but we say we can't treat you. Thank you very much for having me.

MR. GORMAN:

Thank you, Mr. Homer. Two minutes ahead of schedule, and I think we will end it on that note. We are going to start promptly at 1:30 and our first witness this afternoon will be Ms. Mary Walker and I hope everybody can return to hear the testimony. Thank you. (WHEREUPON, the hearing was recessed until 1:30 p.m., this date.)

MR. GORMAN:

Okay. Welcome back. It's 1:30 and we are going to try and start on time. The next person to testify is Mary Walker, please.

MS. WALKER:

Good afternoon. My name is Mary Walker. I'm a nursing assistant from the St. Louis VA Medical Center, and I would like to say that we are overworked, underpaid, never promoted to a GS-5 nursing assistant. I have been there 22 years, a GS-4, Step 10, and this is as high as we go, only to get a cost-of-living raise, and I would like to retire at a decent salary. I have worked for 22 years at the St. Louis VA Medical Center as a nursing assistant. I have been at the level since 1985 with small increments paid, adjustments in cost of living. To add insult to the injury, nursing assistants are not included in the Saturday premium pay allotted by the Department of Veterans Affairs Medical Program Act of 2001. We have many of the hardest job duties and continue not to be appreciated. We have families, too. The insurance premiums are the same, no matter who you are. I ask that you please do what you can to help this matter. As of myself, I will retire and I would like to retire at a higher grade and level of pay. I feel that my work effort and energy investment has not diminished. I have a positive contribution to the nursing group. Upgraded ability with the nursing assistant appears to be none. As nursing assistants we believe that our title should be changed to technician to allow greater upper ability in general. I love my job as a nursing assistant and I love taking care of the veterans and I would like to say that I thank you so very much for inviting me to give me an opportunity to give my testimony as a nursing assistant. Thank you.

MR. GORMAN:

Thank you, Mary. Sandra Johnson, please.

MS. JOHNSON:

I've given you all a copy of my oral testimony. I'd like to say, first of all, that I'm proud to follow a nursing assistant, just as someone else was proud to follow someone else. We all work together. Good afternoon. I am Sandra Johnson, nurse practitioner at the Minneapolis VA Medical Center. I'm very proud to be here today to talk to you about some issues we have in Minneapolis affecting advanced practice nurses as well as other nurses. The issues I'd like to talk about today are panel sizes, supervision, collaboration, pay scale, nursing qualification standards, of course, probation, and comp time/overtime. When referring to nurse practitioners and clinical nurse specialists, I will frequently use the term APRN, and now I'd like to start with some APRN issues. Patients panel size. APRNs have no control over our panel sizes for our very complicated -- and I mean very complicated -- VA patients. These panel sizes are now up into the 900s, and I've heard even higher. APRNs are not getting the amount of time we need to collaborate with our collaborating physicians on these complex issues, nor are we getting granted -- nor are we granted adequate administrative time for follow-up on labs, other diagnostics, and returning patient phone calls. Within the designated patient appointment time, the APRN needs to many times round within the patient; assess vital signs; sometimes toilet the patient; electronically order labs, other diagnostics, medications and consults; type the

progress notes; address the clinical reminders; and electronically complete the encounter form -- all this in addition to assessing the needs of the patient, and there's not always adequate ancillary or sometimes there's no ancillary help to provide help with this. Giving APRNs the ability to negotiate over panel sizes would exercise our best professional judgment as to effective and safe patient care. The current law governing VA collective bargaining is Section 7422 of Title 38 of the United States Code. This statute would need to change to enable APRNs to negotiate over panel sizes. Also ancillary staff needs to be provided in areas where this is lacking. Supervision is my second issue. Most APRNs at the Minneapolis VA are supervised by nonadvanced practice nurses. These are nurse managers who do not understand the advanced scope of practice, thus are not competent to be supervising an advanced practice nurse. This has led to many problems, including inadequate proficiencies, poor relationships between the APRN and her nurse supervisor, expectations of an advanced practice nurse that are more appropriate for staff nursing rather than the advanced role; for instance, being told that we need to request our vacation a year in advance. Sometimes complicated -- many complicated patients are scheduled into very short appointment slots that are not long enough for that patient's needs. I urge the Commission to recommend that VA change its policy to require that all APRNs are supervised by an APRN. This change in policy will lead to better communication between the APRN and her supervisor, who better understands the role and responsibilities of the APRN, as well as assuring more appropriately written proficiencies. It enhances professional development, including continuing education, evidence-based practice, collegiality, and above all good patient care. In addition to this, I recommend that there is APRN representation on all boards, task forces, et cetera, where decisions are made regarding our practice and that we have peer review and guaranteed time to meet as a group during business hours at least once a month so we are not so isolated from one another. We have found that it is within this isolation that we are most vulnerable to management and some physicians that are at times hostile to advanced practice nurses. Probation time for nurses is my third issue. Since the facts have already been stated on this, I won't reiterate them, but I do want to state that I urge the Commission to recommend the VA change its policy with regard to probation periods so that the probation period for all nurses is decreased to an accumulation of 2,040 hours. It is wrong for an RN who has worked for many years at the VA and then becomes part-time to go back to probationary status. It is also wrong for part-time people to be on probation forever. I don't know anywhere in the community where this exists except at the VA. Fourth, comp time and overtime, some APRNs are being told we won't be granted either comp time nor overtime, even when it's guaranteed under Statute 7453. When comp time is granted, it's granted as straight time rather than at time and a half. Also, nurses who are eligible for overtime and do receive overtime do not receive overtime when these hours extend into the next day. I urge the Commission to recommend VA clarification of its policy to be consistent with Statute 7453 and allow the union to grieve when the VA does not follow the law regarding comp time and overtime. Under the current law controlling collective bargaining, the VA is saying the units cannot grieve nurse pay issues even when the law says that we are entitled to that pay. I urge the Commission to recommend a change in the law so the union can help nurses get the pay Congress

says that we deserve; also that comp time be changed to one and a half times the hours worked over eight hours rather than at straight time. Lastly, pay scales and nurse qualification standards. Currently APRNs have great difficulty meeting the qualifications for a Nurse IV as we are for the most part in the majority of our practice patient care focused. This is what we were hired for. This is where we are most needed. The Nurse IV is more focused on administration than patient care. There is an education career development piece within the Nurse IV. However, some nurses are strongly discouraged from mentoring and precepting advanced practice nurses, and those who do don't get extra time to do that. These same nurses will be encouraged to mentor and precept medical students. Also, some of us who have gone back to school at great financial cost as well as other costs to ourselves to earn the advanced degree and practice at a higher level are not always rewarded adequately for our achievement. Many of us remained as Nurse IIs, even though practicing in the advanced role, until we could prove that we had met certain criteria on the Nurse III pay scale. Thus we were earning much less pay than staff nurses, yet practicing at a higher level. I am one of those nurses. I recommend that APRNs are given the option to precept and mentor advanced practice nursing students, just as physicians are mentoring and precepting medical students. I ask for equal options and time to do that. I also recommend the Nurse IV qualification standards reflect the practice of APRNs more so we can strive for this level. I recommend that all practicing APRNs are boarded at the Nurse III pay scale or above, and there's no delay in this board action. We need to be paid for what we do. After all, the literature states nurse practitioners do 80 percent of what physicians do. In summary, APRNs need control over our panel sizes, guaranteed adequate time for collaboration with our collaborating physicians -- and they want this, too -- equal-to-position administrative time, and time granted to mentor and precept advanced practice nursing students, supervision by APRNs rather than nonadvanced practice nurses, APRN representation at all tables of decision-making that affect the APRN practice, guaranteed time to meet together during regular work hours at least one hour per month without being penalized to use this as administrative time, to be boarded as a Nurse III or above when practicing as an APRN, Nurse IV qual standards reflecting the practice of APRNs as well as nurse administrators, and for all nurses probation time needs to be decreased to 2,040 hours. Comp time and overtime must be granted as it is guaranteed in Statute 7453, and overtime must be granted for any continuous hours over eight hours, even when these hours move into a different calendar day. Thank you for your time.

MR. GORMAN:

Thank you Sandra.

MS. JOHNSON:

Thank you for listening to nurses.

MR. GORMAN:

Lucinda Marshall-Dowdell.

MS. MARSHALL-DOWDELL:

Hello. My name is Lucinda Marshall-Dowdell. I want to give you a quick background on my nursing career. I've only been a nurse full-time since February of 2000. I have worked at Ft. Benjamin Harrison in computers for years and years and never finished my college degree because I had gotten married, et cetera, et cetera. So I decided to go back and grab a degree, and I decided I would do that in nursing while I still stayed on at Ft. Harrison because it was a conducive work environment and I decided I was going to go back to school to either get a Master's Degree or I was going to go to law school. My sister said to me, "Before you invest any more money either way, why don't you try nursing full-time and see if you like it? Then if you don't, you can go into law, of course in areas related to nursing. Or if you decide that you like it, you can go ahead and get a Master's Degree in nursing." I'm here to say that if I had the money to give her today, I'd buy her a Mercedes E Class for that information, because after going to the VA, I wouldn't recommend an animal to go into nursing, and let me explain to you why. First of all, the VA on Tenth Street, we need what I call confirmative action. We need to confirm that each nurse is represented fairly. We need to confirm that each one have an opportunity to be educated properly and for proper training. Let me give you one very good example. We have what we call the loom pump; and those of you that are in critical care nursing knows what that is. That's a very tedious piece of equipment. In our unit, we only get one every six months, so the opportunity for training is not great. Well, on one particular occasion I had not been trained and the other minority nurse had not been trained, and a person came in that was on balloon pump. And our question was, "Okay. We have got this now. Can one of us be trained?" The answer was, "No. You know, Jim and Bob are close friends. Bob is going to days tomorrow, so Bob and Jim wants them to be on balloon pump." Therefore, we were denied the training based on the fact that Jim and Bob wanted to be together. It had nothing to do with patient load or us being more viable nurses or knowing our job; just that Jim and Bob wanted to be together. To me that's not confirmative action. And let me also say that we are living in a day and time where minority representation transcends almost all professions, including nurses, yet we have great issues on not only the training, but we even have great issues on the salary. Let me give you an example that can be proven. There's two nurses on our unit -- and I love them both very much. One have eight years of critical care experience; one have seven. One have a double Master's in the health care field. One of them have an Associate's. Guess who is making more money? How does that go ahead and encourage education, for instance? And think of how she felt when the nurse said to her, "That's why I won't go back to school. I don't need to." Just by the color of her skin she doesn't need to do anything more. I personally came in with a Bachelor's Degree, 27 credit hours short of having another Bachelor's Degree in supervision and management; but yet still they will take new nurses coming in straight out of school with no experience and without their

Bachelor's Degree and I guarantee you that that nurse will make more money than I'm making. Another thing I want to bring up, too, is that I was really appalled because everybody is saying a shortage of nurses, et cetera, et cetera, and my thinking is how can you be so short and really want to do something about the problem, but yet and still you constantly do things that actually discourage minority participation in nursing, because the worse we're treated, the more we decide to get out. For instance, I've cut down to part-time only because I can't continue dealing with the situation as it is, and, yes, I do plan on going to school and, no, it won't be in anything connected with nursing, not unless I lose my sanity on the way to sign up. For instance, we are on what we call -- I don't know if you all are familiar with this -- compressed work week where we are supposed to work 12 hours and then 8 and that's your work week. I have actually had to come in six days in one week just to make up my 40 hours because some prima donna decided she wanted the shifts that I was working, so they scheduled me for four here, four here, eight here. I asked my husband one time -- I said, "Why don't you plan a vacation?" And he was like, "Who in the hell knows what your schedule is?" So in order to get some semblance of fairness, I had to cut down to a part-time employee; and as this other lady said, now I'm out in part-time employee, but I had to choose between the open as far as protection is concerned because you have no rights as a protection and sanity. And let me say, too -- and then I'm going to close with this because I really could go on and on with examples that could be proven. We need to confirm that each individual in the health care field is extremely important. There is nothing that can replace a bedside nurse. By the same token, you cannot elicit loyalty, you cannot elicit trust, et cetera, et cetera, if you keep treating your nurses the way you do, particularly the minority population. The only thing -- and I've talked to several nurses before I make this statement. The only thing that's keeping a lot of them in the VA system is their five-week vacation. If any facilities located around us can ever come up with a six-week vacation, you would definitely see a mass exodus of minority population from the VA system, because what I'm telling you has happened to me is very, very, very representative of what happens to all the minority nurses and unfortunately we have no recourse. And I listened to the people talking about their education, a Bachelor Degree, et cetera, et cetera. Come to the VA on Tenth Street. You won't have to have anything. If you're not minority and you're breathing, you got it.

MR. GORMAN:

Thank you, Lucinda. We now enter what is scheduled on the agenda for 2:00. We are going to open the microphone up again, and next on the list is Mr. Bruce Detty for three minutes.

MR. DETTY:

Good afternoon. My name is Bruce Detty. I'm an NA at the Chillicothe VA Medical Center. I've been a nursing assistant at the Chillicothe VA Medical Center for the past 23 years as a psychiatric nurse. I'm also a disabled veteran. I feel and see the quality of patient care decrease in last few years. This is due in part to the staffing

levels of the Chillicothe VAMC because it is working at a minimal staffing level throughout the whole VA. The staffing are burned out due to being overworked to ensure the staffing levels that we need so our patients can have better care and treatment. As a disabled veteran, I feel that we don't care because when I go to the VA hospital for an appointment or treatment, I have to wait at least two to three hours to even be seen for my appointment due to the lack of staffing. So this is only part one of many of the ongoing problems. This means our patients are not getting the proper care to assist them in their daily living at a group home, nursing home, VAMCs, or even their own home. This is why our patients stay so long or return to the VAs, you know, because of not proper care. When we have the job opportunities for new employees, once they see how it is, they leave. There's no incentives in pay. Promotions are not there. This is why our patient care seems to be dropping. As a veteran, I have felt the decrease because the government has promised all of us veterans care and health. All of our veterans never get it because they are told they are not entitled to it. If a promise is given, stand by it. Don't steal from Peter to pay Paul. Help all veterans by having better care, more materials to work with, cleaner and more up-to-date facilities, and by all means hire more staff. So give us veterans what we were promised. And then also, as said previously about LPNs going to RN levels, it's just as costly for NAs to go to LPN level. And, as a matter of fact, it's probably more so because we are going to lose bigger pay and it's hard to do in the VA system. And I thank you very much for letting me talk. You all have a good day.

MR. GORMAN:

Thank you, sir. Joann Page?

MS. PAGE:

My name is Joann Page, and I'm from the Iowa City VA. I am currently in the role of infection control and patient safety. I'm also an Air Force veteran and a VA nurse. I've been at the VA for almost ten years now. All total, I probably have close to 30 years of nurse experience. I do have a B.S.N. It was required to get into the Air Force, but that didn't make me a better nurse. I'm here today to talk to remind us all of the need to maintain a safety net we have in the health care industry -- nurses. We must endeavor to retain the seasoned skilled nurse who knows the compassion, the labor, the focus of this profession. Today the average nurse is in their mid-40s. We have heard that already. We average probably 20 to 30 years of nursing experience in the health care profession. These experienced nurses respond by staying at their posts when supported with a safe staff-to-patient ratio, a realistic work environment, and compensation that is comparable to their value. Safe staffing requirements ensure a work environment that has proven to decrease staff injury of all types -- the back strain or back injury from trying to lift a patient when there is nobody there to help you, the needle stick because you rushed and stuck yourself, the medication errors because you were tired because you had to stay over and work extra because somebody called in sick or staffing was just short to begin with, the dangerous fantasy of multi-tasking. Med errors, staff and patient injury primarily from strains

and falls, and hospital-acquired infections have all have been steadily on an increase because there's not enough staff to do the task. Hospitals are not the healthiest places to work, but we can try and make them as safe as possible by adequate staffing. I'm kind of like the fly on the wall. I go around and look for infections and safety issues, and I hear the experienced nurses and how discouraged they are. They don't want to stay in a system that their hard-earned experience has taught them if you start cutting costs and cutting staffing, you also cut your safety net. You see the increase in infections. This can produce about a 2.5 percent increase in accelerated death rate from reversible things. The telemetry patient on a unit where the only experienced telemetry nurse is busy orienting a new staff member, the patient suffers because they don't respond in a timely fashion to his chest pain, the new nurse suffers because her orientation is cut short, and the seasoned staff nurse suffers because she is bearing the brunt of the whole unit. So we need to concentrate on safety, and I thank you for listening to me.

MR. GORMAN:

Thank you. Bryce Henson? Good afternoon.

MR. HENSON:

Good afternoon. My name is Bryce Henson. I'm a registered nurse, and I work in an intensive care unit in the Iowa City, Iowa VA hospital. I'm also a veteran of the U.S. Navy and a current member of the U.S. Army Reserves. The current nurse qualification standards make it extremely difficult for the clinical staff nurse -- i.e., the 24/7 bedside nurse -- to be promoted. The current standards do not reflect the skills and competencies that VA nurses bring to their positions. The steps that are required to be promoted are awkward and time-consuming at a time when the bedside nurse is short-staffed and the VA population is increasingly sicker and requires more care. VA clinical nurses are proud to work in direct bedside care and should not be punished or be biased against for being a bedside nurse. The current standards are skewed against clinical bedside nurses and can be used in a very subjective manner. The board that views these for promotion may interpret these in a subjective manner. Also they can be used differently from facility and facility and from year to year. The morale level of these nurses can be greatly increased if they feel that there's more real chance of being promoted without the feeling that they're jumping through hoops. The board that oversees promotions are not comprised of staff nurses who know the day-to-day work and professional competencies that are required. The VA is not only facing a nurse shortage which is here now, but also an aging work force. Out of the 27 nurses that I work with, only two are under 30. The VA needs to be the leader in recruitment and retention. We need to give nurses a reason to stay with the VA. They will leave if they feel they are not valued. The veterans that we work with and care for deserve to have competent and motivated nurses, and they have paid the price for it. Some possible solutions? Target the standards towards a truer reflections of the skills and competencies that are needed and used by VA clinical bedside nurses, and also allow staff nurses to sit on promotion boards and also allow for review of the

boards by mutually agreed upon, neutral third party. And I also want to say one more thing. I got my B.S.N. courtesy of the U.S. Army, but I was a Diploma grad before that. 1994 was the first year of NCLEX boards and I can assure you that we weren't taught the NCLEX and thank you for your time.

MR. GORMAN:

Thank you, Bryce.

MR. GORMAN:

Jeff Puttkammer? Jeff Puttkammer? Cynthia Pendell?

MS. PENDELL:

That's me.

MR. GORMAN:

That's you.

MS. PENDELL:

Hello. My name is Cynthia Pendell. I'm an RN at the Dayton VA Hospital. I have been there for over 31 years. I would like to add to some of the things that have been said about the Nurse Professional Standards Board and the inconsistency. I have written several -- many proficiencies that I have wanted my nurses to go from Level II to Level III. It was easy when the nurse qualifications first came out. The nurses were very deserving. It has become increasingly difficult because they say the interpretation of these criteria or dimensions have been changed. In fact, one nurse that I recommended for promotion and educational waiver was boarded by one board and then the chief executive looked at it and didn't agree with it and it was taken to a second board and denied. There are nurses that take jobs that the job requirement or the expectation is that they will be promoted to Level III nurses and then within a year or two they want to go back to a bedside or staff nurse position and they do that and they do not lose their Level III, so they are working side-by-side with staff nurses and getting quite a bit more money for the same job. So I do agree that the whole system has to be looked at. I also want to talk about some recruitment and retention problems or issues. We have to reshift our mission from looking at promoting and developing administrators. The clinical nurse has to be more valued within our system. It seems like the clinical nurse is less valued within the system that we have. We have to examine a clinical ladder for promotion of the bedside nurse. Increasing the steps within Level II would help to defray some of this discontent. We already are losing qualified RNs with 15 years or more experience because they can come in -- I interviewed three people for the OR and three people turned me down because they

are Associate Degree nurses and they would only be coming in at a Level I and they couldn't afford the salary and they were seasoned nurses. Thank you.

MR. GORMAN:

Thank you. Thelma Boyd?

MS. BOYD:

Good afternoon. My name is Thelma Boyd. I'm a registered nurse at the Dayton VA Medical Center. Currently I am in the position of nurse manager on our surgical unit. I've been at the Dayton VA for 34 years, 9 years as an NA and 25 years as an RN and many different capacities from staff nurse, nurse manager, coordinator, so forth. On my unit I'm extremely proud of the care that we give to our veterans. Our veterans, a lot of them request to return to our unit when they are readmitted. It is apparent that there are problems VA wide in the qual standards that we have talked about so much today. My example concerns the bedside nurse. The bedside nurse is not afforded the opportunity to be promoted to Nurse III even after meeting the educational requirements. Some of these nurses have no desire to be in a management position. Our current pay scale makes it very difficult to recruit nurses from our local community college at the AD level, so they go to the private sector so they can get a higher pay for the entry level. Our technology is great. However, at our center we are using the BCMA delivery system, which has doubled the medication administration time. However, hopefully in the future with updated equipment, it would get better. We hope that all 24-hour nursing staff members will be able to receive yearly bonuses, and we hope the clerical duties, housekeeping duties, dietary and lab tech duties will be returned to the departments in which they belong.

MR. GORMAN:

Thank you. Richard Ade?

MR. ADE:

Thank you. I've got 52 years -- my name is Richard Ades. I'm from the Louis Stokes VA Medical Center in Cleveland, Ohio. I've got 52 years of federal service. 27 of those years were with the United States Air Force as a retired colonel, 25 years with the Louis Stokes VA Medical Center as a clinical nurse specialist. There are several issues I'd like to talk about, but I'm only going to give you two very specific. Staffing levels, as you've already heard, are at a very critical low, and it's dangerous and unsafe to take care of patients and to meet their needs, and it also endangers the license of the RN. Mandatory overtime is used as a tool against the nursing personnel because of the shortage of nurses to care for these patients. Many of these nurses are working long and hard hours to meet the needs of these patients, but are being burned out on mandatory overtime. Nurses are asked to do more for less, get no reward, so why would a nurse come to the VA knowing that he or she is going to be abused and

make less money? And this is a fact, and it's not a myth. The two situations I want to give to you that I've not heard of yet is the levels in the locked psychiatric ward are inadequate. How can one nursing assistant on a special watch in a hallway watch two patients in full leather restraints for an 8-hour shift? Impossible. Okay? This patient - - one of these patients had died and management wants to hold the nurse and the nursing assistant accountable for this and I don't think so. This is a management problem that needs to be addressed, and it's never addressed under those circumstances. The second issue is another veteran died at 5:50 a.m. because there was no midnight shift operator on duty. The nurse tried to do CPR on the patient. She runs the methadone clinic. She is there early for the vets so they can come in and get their urine tested and do the methadone treatment and go back to work. At 5:50 a.m. she called a code because one of the patients said, "Please come and look at this patient. Something is wrong." She came out there, and the man was in full cardiac arrest. She picked up the phone to call the code. There was no operator on duty. If there is no operator, it's supposed to ring over to the AA person at night. There was nobody at that desk. That patient and the other patient died needlessly. They gave her nurse of the month, \$200 cash. Nobody wants that kind of reward. Management, take care of the problem, because this is happening. I've only given you two instances, and I can give you five or six that patients are dying. I'm a veteran and I don't want to be treated this way and I don't want anybody else to be treated this way. We deserve that care. We deserve the staff for that. The other aspect is that the RN bed ratio and acuity levels are not correct to truly represent the hours needed to care for critically ill patients, and I'm speaking about the spinal cord issue or the spinal cord patients. This is an important factor in predicting the differences among the hospitals and the success rates in saving patients who experience serious adverse events. This unit started with 50 people. It's down to 25 because the chief of that service has fired 25 of those individuals in three years. Thank you very much.

MR. GORMAN:

Thank you, sir. Appreciate it. Let's return to the agenda as far as testimony. The next witness is Patrick Kearns.

MR. KEARNS:

I think you guys have a copy of my testimony. My name is Patrick Kearns. I'm an RN at the VA Medical Center in Iowa City, Iowa, working in the intensive care unit. I've been with the VA since 1994, first as a student nurse technician and then as a registered nurse. I began my VA career at Jamaica Plains VA Medical Center in Boston and transferred to Iowa City in 1997. I received my A.D.N. from Laboure' College in Boston, and I'm finishing my last class for my B.S.N. at the University of Iowa. I'm presently a Nurse III. I would like to thank the Commission for the opportunity to testify. My experience at the VA has brought me into contact with many excellent nurses. These nurses have acted as mentors to others and myself and provided leadership and vision to the VA. These nurses acted as role models guiding my development as a nurse by showing me how to be both technically proficient and

caring. They shepherded me through the years of development that it takes to become a good nurse. The majority of nurses were A.D.N.s. I'm concerned that these nurses if entering the profession today would not consider the VA as an option. By limiting the promotion potential of A.D.N. and Diploma nurses, we negate the impact that they make at the bedside. The education requirements now in place make it more difficult for RNs who are doing the exact same work and functioning at or above the level of their colleagues with B.S.N.s from obtaining the same chance for promotion. Education has value, but performance should be the ultimate determining factor in evaluating an RN's practice. I work in the ICU at the Iowa City VA. The majority of nurses I work with are not B.S.N.s. To say to these nurses that their practice has less value than a nurse with a B.S.N. is not only wrong; it is insulting. Many of my colleagues are angered by the implication that their practice somehow has less worth because they do not have a B.S.N. When we elevate degrees received by an individual above their performance, we demean the practice of nursing. How can we tolerate a system where individuals can perform, contribute, and be leaders among their peers and still be denied promotion based on whether they possess a B.S.N.? There is no evidence to suggest that a B.S.N. provides any measurable effect on patient outcomes. In fact, there is no data to base the educational requirements that exist at this time on. The only data available suggests that the practices of A.D.N.s and B.S.N.s are identical. Nursing is not a club or a social circle. It is a profession based in science. We should change the practice based on evidence. We should not place restrictions on the advancement of nurses when there is no evidence to do so. I work with dedicated nurses who are excellent practitioners of their profession. They constantly work to make themselves better nurses. They take continuing education or in many cases teach continuing education. They mentor new staff and precept nursing students. They work diligently to update and hone our facility's policies and procedures. They work to ensure the practice of nursing is held to the highest possible standards. The majority of these nurses are A.D.N.s. Why would we want to limit the promotion potential of these dedicated nurses and provide an incentive for them to leave VA service? How can we say to them do the work, contribute to the mission, improve our practice, but we won't promote you because you lack a B.S.N.? Waivers are routinely granted at my facility at this time. Every nurse knows that this policy could change at any time with no notice and no explanation. Nurses live with uncertainty in that their contributions can be arbitrarily devalued at any time and their ability to be promoted can be stifled. As I stated earlier, I'm now completing my B.S.N. I received my Nurse III while I was enrolled in the RN to B.S.N. program. I enrolled in the program, to be frank, because it was available and convenient. My B.S.N. classes have not made me a better bedside nurse. They have not made me of more value to the VA. My experience in the RN to B.S.N. program, in fact, has had very little to do with the practice of nursing. Has the RN to B.S.N. program made me a better and more rounded person socially? Perhaps. Has the program made me a better bedside nurse and of more value to the VA? No. I believe in the value of education for education's sake. I also believe that knowledge has value even if it is not immediately useful or applicable. I believe, however, that advancement should be based on performance and practice, not degrees received. Patients are impacted by care provided to them by nurses, not by the degrees that they possess. We must retain

qualified, excellent nurses at the bedside to deal with our ever more complex patient populations. Frequently in order to advance either through the ranks of Nurse I, II, and III or in order to go back to school, the most qualified and best nurses are taken from patient care. This is not in my experience because these nurses want to leave bedside practice. The reason they leave is because the VA does not place the same value on exceptional clinical practice that it places on other elements in the qualification standards. The core mission of the VA is supposed to be the provision of care to our nation's veterans. That mission is being undermined by the removal of our best and brightest from the ranks of those who care for our veterans. What is to be done to address this problem? First, performance should be the only criteria for promotion. If a nurse is doing the work of a Nurse II or Nurse III, they should get a promotion. Education and degrees possessed can inform the process; but if individuals are performing and practicing at the Nurse II or Nurse III level, they should be promoted. Second, the qualification standards must reflect the duties and responsibilities of practicing nurses. The nurses practicing at the bedside must be allowed the same opportunity to work on projects and create improvements for the VA that nonbedside nurses are given. We must retain these valuable nurses to practice and lead our profession while maintaining care for our veterans. Nurses must be allowed to advance their education if they desire to do so. Funding must be made available to allow nurse assistants, LPNs, and RNs the opportunity to continue their education. Funding for education benefits the VA, creating loyalty to the organization. Direct patient care staff must be allowed every opportunity to attend classes and further their education. Employees should not have to choose between educational goals and remaining in direct patient care positions. Fourth, there must be a process in place to have objective oversight of the boarding process. Nurses should be able to appeal the board's decision through an independent, mutually agreed upon third party. Fifth, nurses should be able to negotiate the standards by which we are measured. Our elected representatives in the form of our unions should be able to negotiate the conditions under which we are promoted and practice. Thank you.

MR. GORMAN:

Thank you. John Mills?

MR. MILLS:

My name is John Mills. I'm from the Sioux Falls VA Hospital. I have a four-year degree in nursing, six years of experience as a nurse. I'm a veteran with eight years experience in the Navy, and I hate talking in front of people, so --

MS. CONVERSO:

You'll do fine.

MR. MILLS:

The central issue of concern in VA pay advancement is that the board that decides advancement and pay is a hundred percent subjective. A more comprehensive and fair way should be used. Advancements in pay grade should have some basis in objective data, such as time as a nurse, education, and performance marks. A nurse could have many years of experience, high levels of education, and outstanding evaluations and still not be advanced if the write-up for their advancement did not include key words. A combination of subjective and objective data should be used for advancement. If a person is able to excel more in one area than others, he or she should get recognition for that. A point-based system would help to ensure equality from person to person and facility to facility. I want to deviate from what I've written. We had an incident where we had two nurses hired at the same time. One nurse had - they both had Associate Degrees in nursing. One had 21 years of critical care experience. The other one had one year of experience as a nurse. That person with one year experience as a nurse was hired three steps higher than the other nurse, and I do not understand why. When this nurse found out, she quit. She went across town for a \$10,000 a year increase in pay. How can we hold on to good nurses like that when we have such inequalities in how we onboard people. I have gotten very little to no support from my supervisor for advancement. I have turned in self-evaluations where I have stated things I have done for advancements; and when I get my evaluation, I get no credit for it. I have been very frustrated and have talked to management. The only results I seem to get are more resentment and less help. I almost met also all the requirements for Nurse II. One year I missed like two of them. I tried to appeal it. I was turned down again, and the next year they took away all the requirements I had made the year before with no explanation. I felt like I was being punished for appealing the advancement to the board. Nurses at the staff level of care have minor input to decisions related to nursing practice. The only input staff nurses have on these decisions are whether a committee is formed to address this area. Most committees are made up of nonstaff nursing. The majority of nurses can only participate in decision-making by voicing their opinions to their immediate supervisor, or nurses can go through their local union for contract issues. Staff nurses should have more input into decisions, more two-way discussions in unit meetings, greater numbers of staff nurses on committees, and less management. We have an ICU committee, and they have one staff ICU nurse on that committee. Does that seem wise? Trust can be established and maintained by nursing staff and nurse administration by opening lines of communication. Frequent and open dialogue in ward staff meetings would improve communication. A more progressive model of management is needed where communication is bottom to top as well as top to bottom. When staff feels their voice is heard and cared about, then trust will be established. Staff can participate more in decision-making and problem-solving at the unit level by frequent staff meetings where discussion is open for ideas. Having more staff involved in facility level meetings about decision-making and problem-solving will help at the organizational level. The VA can better support nursing staff education by more funds to pay for job-related training. Nurse staff is able to go to training at times and not able to go sometimes because of inadequate cover of absenteeism. A quality work force is attracted and retained by having a good overall reputation. The strongest way to bring in nurses is by word of mouth. If good things

are being said about nursing at a facility, nurses will be attracted. With a good work environment, these nurses will stay. I have been listening to what other people have said, and I'd like to go over some points they have brought up. I think they're important. On the professional standards board, I don't understand why you can't be present for it. I mean, it's a group of people, your peers, talking about how you perform as a nurse. I think this would be an incredible way to get positive feedback on how to improve yourself as a nurse. Instead it's some secret society that you can't hear nothing about or what was discussed; just whether you got approved or not approved. Also, I think there should be minimum nursing staff levels. California state law passed an enactment that I thought was very good limiting the amount of patients a nurse can have and making it illegal for mandatory overtime. Like for critical care nurses, it's mandatory to have one nurse to two patients. I find myself sometimes taking three patients, and the person that suffers is always the patient on the end. When I have families where they are grieving the passing of a loved one where I just got another admission roll through the door, what do I do? I have to treat this guy with chest pain and ignore the family that's sitting there crying over their father who has just died, and this stuff shouldn't happen. Also our work load has increased a lot from all the new computers. You know, we have to do BMCA now. All our charting is done on computer. This has increased our workload quite a bit, and we haven't got any more staffing. In fact, we had staffing cut with increased work load with these computers. And also that California law, too, was good because it made nursing managers liable for going over your prescribed ratio of patient to nurse. It's no longer your license that's on the line. I've been put in these situations and called my manager and said, "This is an impossible situation you've put me in," and I'll get, you know, I have to manage my time better or just a shrug of the shoulders and they walked away, because it's no concern to them because it's my license that's on the line, not theirs. Also I think LPNs are a very valuable asset to nursing and they should be paid more. A GS-7 should be obtainable, and they should get an across-the-board step increase. If they're a GS-6, they should automatically go to a 7. They're very valuable. They're cost-effective. They help nurses get their job done, and I don't see any reason why they shouldn't do that. I also think nursing assistants should get premium weekend pay and all other staff involved in patient care or indirect patient care. I find myself emptying linen closets out, mopping floors. You know, I'm getting paid \$30 an hour to do a janitor's work, and I just don't think that's cost-effective either. And I think education is very important as a nurse; but also experience as a nurse is just as important, and both should be weighed equally. That's about all I have to say.

MR. GORMAN:

John, thank you. Connie Shiverdecker?

MS. SHIVERDECKER:

My name is Connie Shiverdecker. I'm a nurse manager at the Dayton VAMC, and I work on the hospice unit. I am also a member of NOVA and address you today in both capacities. I applaud the work of the National Commission on VA Nursing and

am privileged to be able to share with you issues of concern to nurse managers throughout the VA health care system. Also I want to say that I know we are here for the same purpose because we have talked about quality patient care, and my unit was awarded the national honor last year for its practice, so I do appreciate quality. I am here to discuss issues and concerns from my colleagues and staff members about how nurses are able to participate in decision-making at the Dayton VA Medical Center. Nurses currently sit on many of the committees that make decisions at the medical center. However, the general consensus is that it is usually management level nurses serving on the committees and not staff level nurses. It is believed committee membership should be shared with a broad range of nurses involved. Additionally, rotation of these positions should occur more frequently to allow more participation on these committees. In the past the schedule of all meetings were published in order to notify the entire staff of when and where these meetings were being held. This was terminated several years ago and staff no longer know when these meetings are being held. They also do not know how to bring issues to these committees when concerns do arise. A former practice that was valued by the staff was quarterly visits made by the triad and chief of nursing to each unit. At these times staff could voice their concerns and know that they were being heard. These unit visits ceased, and staff feel that no one is listening to them. This has contributed to a decrease in morale and the feeling that no one cares what they have to say. This has a lot to do with the creation of care lines and the nursing staff not knowing to whom they need to take their concerns, what concerns are addressed by this care line, and what concerns go to the medical center still. It was heard from many nursing personnel whether or not management cared what they want or what they think because they feel like no one is asking. It is imperative if we want staff to feel valued and continue to help with improving clinical practice that we must rebuild these lines of communication and allow staff to have one-on-one dialogue with hospital administration. The second issue I want to address is how the VA can attract and retain a quality work force. Number one is to have a satisfied work force so that they share positive aspects of work at the Department of Veterans Affairs with potential employees. This is essential in recruiting a qualified work force that will provide quality care to our veterans. It is imperative that nurses feel good about where we work in order to encourage others to join us to take care of our nation's heroes. We need good benefit packages, educational opportunities, encouragement to grow, flexible schedules, and promotion opportunities. The current benefit packages in place provide insurance, vacation, sick time, and retirement and is very competitive with the private sector. Educational opportunities must be improved with adequate funding provided as well as the incentive to pay off educational loans. These need to be used as recruitment tools. The work environment has changed dramatically in the past several years. It is much more complex. Our patients are sicker, and they stay a shorter period of time. In the past, staff could float more freely between the units; but with specialties and changing technology, staff is more fearful of working in unfamiliar surroundings. The increase in litigation also plays a factor in why staff are reluctant to float and work outside their specialties. It is imperative that staff be allowed more training and educational opportunities to keep abreast of practice issues. Mentoring and leadership training need to be in place for nurse managers. I have mentored many of my nurses

to become involved in projects and have allowed them to train other staff at the medical center. They also are involved in data collection for research projects, and they have presented their data at national conferences as well as locally. Many managers have not had an opportunity to do this with staff and would not know how to even start. It is also not feasible with the present levels of staffing to promote these projects and still provide excellent patient care, so the projects get put on hold and staff gets discouraged and soon do not look for projects since they are not supported in their efforts. Nurse managers must also be allowed to offer flexible scheduling to meet the needs of those who are attending classes and meeting deadlines with their assignments. We must also offer flexible schedules to match what is being offered in the community. The largest deterrent within the VA system is rotation of shifts. Our counterparts in the community hire to shifts; so when that employee is hired on, they can work evenings or night shift, but they know that this is time limited. When they get a day shift position, they can remain there for the remainder of their career. With our current system, we are never guaranteed a permanent day tour of duty unless you go into management and work in a clinic type job, and some of the nurses really like bedside nursing. I have a nurse like that who is 71 years old and she still has to rotate, so longevity isn't really encouraged here. Day tour of duty should be an option for nurses who stay at the bedside. Changing shifts frequently has been shown to affect health and productivity and is a drawback to hiring as well as retaining. It would be in the VA's best interest to make the VA more competitive with the private sector to hire to shifts. It would also help to cover these shifts without so much rotation of present staff if the shift premium were raised. I believe the evening differential should be higher to attract nurses to these shifts, and night tour at least 5 cents higher because these are much harder to cover with regular staff. Ever-changing staff and staff who are having a hard time adjusting to the rotation are more likely to make mistakes on the job and have decreased productivity through no fault of their own. It also would increase staff morale and satisfaction. Also an issue that we'd like to raise is one of possible direct hire. Right now with nursing assistants being under Title 5, it is a complicated issue to try to hire. This past summer in July we posted a whole lot of positions to cover our extended care unit and acute care; and when we got the list back last month from Richmond, there weren't even enough names on the list to fill the positions. So we are using a lot of overtime and a lot of MRTs, which is a mobile resource unit. The last issue on this section is promotion opportunities. Many nurses do not understand and feel devalued by the present qualification standards and grade level. Most nurses only have the opportunity to advance to Nurse II level because they want to remain at the bedside or the number of positions available at the management level limits opportunities for advancement. The current system with only two levels available for staff nurses and one for management has many nurses in our situation in pay retention for many years and does not promote longevity for new employees. I feel a more career-oriented approach would enhance satisfaction and motivate staff to achieve more satisfaction in their job and offer more input into changes and improvement for clinical practice. More steps in Nurse II would help pay retention and the ability of management to recognize employees who work above and beyond their current level, but do not qualify for promotion to the next level. I feel a lot of this thing is a pay issue more than a promotion issue. That pay retention

is demoralizing. Also with our current practice, the two steps for nurse managers is a good incentive and has made these positions attractive to candidates who qualify for these positions. It is, however, a deterrent when these candidates are encouraged to move up the ladder with their experience and have to take a pay cut to get promoted to the next level. Coordinators can make less for accepting a higher position if they have equal education and length of employment. Nurse coordinators also should have some kind of reward for accepting more responsibility and accountability for a larger population. And I can speak from experience because right now I'm a nurse manager. May 5th I will be taking a coordinator position, and I will be losing \$3,000 a year. So it doesn't hardly feel like a promotion when they ask you to move up and you accept and there's no way to make the same money even. Also something we use at our institution a lot is what we call root cause analysis, and it's currently the way we look at many events in our institution. The process is meant to be for improving clinical practice and decrease negative outcomes for patients. It feels to the staff that it is just another way to tell them what they are doing wrong. The process is viewed very negatively by staff and highly valued by management. RCAs have generated many new forms over the last two years and increased paperwork for nurses with no adjustment to staffing levels. Many of the old forms are changed frequently now, and it's very hard even for a good nurse manager to make sure the forms that are on his or her unit is the latest edition. It is also a chore to keep units with forms because there's no central place to order forms now, so forms get reproduced by many different people and many different machines and some of the copies being used are not very legible. Many of the copies -- we need more clerical staff. Thank you.

MR. GORMAN:

Thank you, Connie. Larry Debuhr.

MR. DEBUHR:

Good afternoon. My name is Larry Debuhr, and I am an RN at Sioux Falls VA; also a B.S.N. and have been in the nursing profession for 25 years. I've worked on an acute medical ward, which included acute respiratory and oncology patients. I've worked in urgent care, ambulatory care, and I'm now in outpatient primary care for the past several years. I'm responsible for three providers and their panels, which consist of approximately 900-plus patients per provider. We have six similar teams throughout the facility that have these types of numbers, and we have no contingency plan at this time to cover any illness or leave for both the staff and providers. We provide care sometimes by crisis it seems. The patients I currently work with are those who come to the VA for scheduled appointments and those who just walk in and have multiple questions that we deal with that deal with anything from health issues, appointment changes, medication issues. Duties include I locate and check in the patients; do the vital signs; health care summary; a preventative health screen, which may include vaccinations for tetanus, pneumonia, or flu. I'm also responsible for multiple treatments, such as catheterization placements, irrigations, dressing changes, ear irrigations, IV antibiotic therapy, blood administration, therapeutic

phlebotomies, preparation for hospital admission, and transportation to the admitting floors. Between these duties, we also, like I said, are checking in our patients. I also take care of incoming calls from patients in addition to the 15 to 20 daily calls concerning health and scheduling concerns. It seems at times that I play the role of mother, father, and confessor to both the patient and the provider. I have served for three years as a medic in the United States Air Force in the mid-'70s, and I am currently serving as a registered nurse in the Army Reserves. I have a deep and personal interest in those who I serve. I believed when I came to the VA in Sioux Falls that I would be helping in taking care of veterans. I'm not sure if my job is taking care of the veteran or seeing just how many numbers can be generated to fill a daily or a yearly quota. Up until just recently, I was proud to work at the Sioux Falls VA and I felt that I delivered competent, consistent, and quality nursing care. And at day's end, I would go home feeling that I had made a difference in the veteran's life. The bottom line for today's VA seems to be quantity instead of quality and money instead of caring. Our staffing on a regular basis is working in the red zone versus being in the green zone. I never feel like I can get my job done. We are tasked to get today's work done today, and we have to be satisfied with hopefully getting yesterday's work done tomorrow. Because of time, the question is how complete are jobs being done. I rarely get to spend enough time with my patients. If I need vacation time or, heaven forbid, any sick leave, I feel guilty about leaving the staff short-handed. For the past few years, the nursing staff has been working on edge every day. Patient care ultimately suffers because of this. The answer to these problems is more patient care staff. We need to have more representation who can meet with the management and negotiate over the numbers, types of, and grades of employees needed to provide safe quality health care to our veterans. This means more clerks, more nursing assistants, more LPNs, RNs, and providers in that order. It is counterproductive to hire more providers without hiring the necessary support staff. Clinical staff cannot provide quality patient care if they are kept busy emptying trash, mopping the floors, and scheduling patients. We need the necessary support staff. Haste, fatigue, and frustration are the key elements to a potentially fatal or near fatal incident. Retention of staff has been a problem at this VA and others, which you all have heard. The practice of advancement through peer review is very inconsistent and unfair. The process appears to be whom you know and not what you have accomplished and is totally subjective. I have personally been a member of the Nurse Professional Standards Board and have never received any training for that task, and for the most part the attitude of the members seems to be whether or not anyone knew the person being boarded and not whether the individual was functioning at a higher level. During the years that I was on the board, no one ever advanced from a Nurse I to a Nurse II. This year was the first year that a step increase was given since 1997 to one of our RNs. And I know that not every nurse proficiency before the board should be advanced to a higher level, but we should be able to give these highly efficient nurses a step increase for performance, if nothing else. We need nursing representation to meet with management and negotiate over the membership of the board. Our VA has reduced also the number education hours from 60 hours yearly to a total of 20, and this is ridiculous. We need to add more education hours, not less. Health care technology is changing virtually every day. If we do not keep up with the

changes, we will be left behind. Without mandatory state requirements for education, it's easy for a facility to use that money for other issue. We seem to always be short of money, and what better place to find a potful than in the education fund. We also need to have enough staff so that the employees can attend training programs that are provided. It does no good to offer educational programs if no one can attend because they're taking care of patients. We do love our veterans, and our veterans love us; but we can't live on love alone. We need to be fully staffed and full funded to provide those who served the health care they deserve. Thank you.

MR. GORMAN:

Thank you. We will now revert back to the open mike part of the program, and next up will be Ruby Malone.

MS. MALONE:

Good afternoon. My name is Ruby Malone. I'm a staff nurse at the Louis Stokes Cleveland VA on the spinal cord unit. My main concern for this hearing is this staffing levels. I work on a unit that is not considered a specialty unit, but to the staff we consider it a specialty unit. My main concern is the night shift. I'm a night shift nurse, and the staffing is maybe one nurse to about 25 to 32 patients. We may have two NAs, a health tech, and maybe one LPN, sometimes two. But the concern is when they leave us one RN, we have to do the charting, which is on the BCMA for the meds, and the charting also in the computer and then we also have to review the charts. That does not leave the RN time to go to the bedside to give the proper care or the proper time to the patients. Our biggest concern is the patients, and that leaves us very limited. We would like to see more staffing, not only RNs, but LPNs, NAs, health techs, because our patients deserve it. And like many have said, when they fight for our country, fight for us, why can't we give them the quality care that they need? That's my concern, the staffing levels, and I have nothing else to say. Thank you.

MS. CONVERSO:

Ruby, I'm sorry. I just missed what kind of floor you worked on. I apologize.

MS. MALONE:

Spinal cord unit.

MS. CONVERSO:

I thought that's what you said. Thanks.

MR. GORMAN:

Thank you. Karen Anderson?

MS. ANDERSON:

My name is Karen Anderson. I have worked in the VA for about 30 years, and I am the lone representative from the VA in Madison, Wisconsin. I have a few comments on the NPSB. I've been on and off the boards many times in the past ten years. I'm currently on them. I'm very familiar with the qualification standards and the current regulations. I have listened with interest at the testimony of my colleagues today and have been totally impressed with how much how the board operates will depend on your nurse exec and your director. Those of you that have been with the VA long will understand it when I say I have survived many nurse execs and directors. We are fortunate in our area right now to have a pair that has worked very hard to have a fair system and find ways to make the system work for us. We have many staff nurses on the boards. Our LPNs do come in at a higher rate of pay than RNs. We do recommend waivers and they are approved. I totally agree with my colleagues concerning the qualification standards. The Nurse III scope as written is generally beyond what a staff nurse is going to be able to accomplish. The Nurse IV scope dictates that no more than one or two nurses in administration would ever meet them. At my facility we have used the locality pay system to keep our salaries on track. Unlike many VAs, the system did work for us. The rules changed this last year; and instead of surveying only hospitals in our area, we now have to use published Wisconsin Hospital Association rates for Southwestern Wisconsin. Within less than four months we have suddenly become non-competitive at many levels. We need to be competitive in the Madison area, not with communities a hundred miles away. We have tried bonusing, and that has not helped. We spent a year trying to extend our Nurse II and Nurse III steps. We spent almost a year negotiating with headquarters and HR and wrote and rewrote programs. We were turned down because we had not lost enough staff yet. It is disheartening to be in a system that requires total collapse of staffing before it can be fixed. I am asking this Commission to strongly consider allowing hospitals to determine their own survey areas for locality pay and to allow institutions to be proactive in extending their step ranges. Thank you.

MR. GORMAN:

Thank you. Deborah Smith? Bear with us for a second. I think we have some additional names. Why don't we take a break. (WHEREUPON, a recess was had.)

MR. GORMAN:

I'd like to be able to get started again if we can. The next testimony is not scheduled until 3:15, so I'd like to take these 15 minutes or 12 minutes and try to get back onto the open Mike. Is Rebecca Spears here? Rebecca Spears? We will come back to her.

How about Carol Dwyer? Beverly Jackson? Diane Clines? You've got 12 minutes -- only kidding.

MS. CLINES:

Good afternoon. I must say that I agree with a lot of the information that has been shared by some of my colleagues, but there is one topic that I haven't really heard a lot of discussion about, but it does impact recruitment and that is the recruitment process itself. We lose a lot of our employees just in the initial phase of the recruitment process. And what it is is that they sent a lot of letters out to former employees and they're requesting information about their level of performance because they use that information compared to the standards and then decide at what point to bring that person in money-wise. But what's going on, because we are such a litigious society, the only thing we get back from HR is dates and times of employment, so that doesn't help very much when you're looking at the standards to see if that person provided leadership skills or was a charge nurse or the different kinds of components that you need when you look at the standards. So that kind of delays the process. Then another part of that is the nurses are brought in at a temporary salary, and that salary will change maybe once they're boarded; so what you recommend the nurses do is perhaps wait until they're boarded, which actually when you look at the physical exams that they have to take, they're waiting for the license certification, they're waiting for license verification, they're waiting for the letters to return -- that can take anywhere from about six weeks or so. So in the process of all of that, nurses that came to the facility that were interested in VA employment by the time that process is completed have taken jobs elsewhere. And another part of that component is for those who have decided to come in before being boarded, once they find out the boarding salary, they're not satisfied because a lot of times it's \$10,000 or more less, from what I'm being told. They may work a short period of time, but within a year, two years maximum, that nurse is gone. And it's mainly because of the problems they are having with the boarding process. I talked with a nurse right before coming here who has 17 years of experience. She wasn't happy with the salary that they brought here in at, which was at Nurse I level. She had a B.A. in health systems administration. She was told that of all those 17 years of experience, they would only accept 10, and they would not waive her B.A. degree. So she was brought in at a Nurse I, Step 6. If she doesn't get the increase after she asked to be reboarded, because that's the process -- if you're not happy, instead of being able to grieve your proficiency or have a third mutual party take a look at it, you have to be reboarded. So you send all that information back before the very same people who denied you the first time hoping that somewhere along the line they will change their mind. If they don't change their mind on her, I'm sure she will probably leave within the next few months. Thank you.

MR. GORMAN:

Thank you, Diane.

MS. CLINES:

Oh, I forgot to tell you. I'm from the St. Louis VA Medical Center. I forgot to tell you that.

MR. GORMAN:

KC Smith?

MR. KC SMITH:

Good afternoon. I'm KC Smith. I'm an RN at the Saginaw VA Medical Center in Michigan. I do agree with all the discussion that's been ongoing about boarding, but I think there's other issues that also have to be addressed. One of the major issues is staffing at our facility. In the mid-'90s we had a combined 519 employees at the entire medical center. Since that time, we have dropped down to 498 employees at the medical center. However, our patient load has gone from 43,000 visits per year to exceed 150,000 patients that will be seen by the end of this fiscal year. One of the other issues deals with the LPNs at our facility. The last time there was any study done in reference to their wage was in the 1987/'88 fiscal year. We also look at health insurance benefits. If you have an employee that's a single parent at our facility and has to carry health insurance, if they carry it on themselves alone, it's \$30 to \$40 a month depending on the policy. If they carry a family plan, it's five times that per month. There have been no bonuses nor promotions to any nurse staff that I'm aware of in the last few years. Over the past eight months, I've had two letters by providers submitted to my supervisor recommending a step increase because of my performance at my job, and I am told by the supervisor those will remain in my personnel file for two years when I'm eligible for promotion again and won't be acted on until that time. Another thing that was brought up as far as education by our two education individuals who were here, what they didn't bother to tell the board was on-line courses are not reimbursed by the Veterans facilities at this time. So regardless of all the education that is available on-line or correspondence, it is not reimbursable education to the employees at the VA. They also spoke about the NCLEX. NCLEX, to my knowledge, has never been taught at any school. However, whether you have an A.D.N. or a B.S.N., until you pass your licensure boards for the state that you're affiliated with, you're not an RN. So whether you go to four years of college or five years of college, until you pass your boards, you're still not an RN. At our facility, we tried to submit some forms to management about staffing shortages. We asked the supervisors to sign those forms to identify the fact that there were shortages on the units. After our night supervisors signed the second form, they were told by management not to sign any more. Period.

MR. GORMAN:

Thank you. One more. Dana France?

MS. FRANCE:

My name is Dana France. I'm an RN at the John Cochran VA in St. Louis, Missouri. I'm in the ICU, and one of my concerns is the qual standards being able to be a Nurse III. I was told by my head nurse that I had to walk on water to become a Nurse III. I can't do that. And then staffing, I have concerns about the level of staffing that we do. Sometimes you get two patients, three patients and occasionally you do get four patients and I do work in the ICU. The floors are very understaffed, so the nurse ratio to the staffing -- I'm very nervous -- on the floor is, you know, ridiculous. And I think that staffing needs to be addressed and also the nursing qual standards. That's it.

MR. GORMAN:

Thank you. Thank you, Dana. Let's get back to the agenda as far as testimony is concerned, and next up is Jeri Burn.

MS. BURN:

Hi, I'm Jeri Burn, and I'm from Ann Arbor, Michigan. I worked until midnight last night and drove all day to get here.

MR. GORMAN:

We appreciate that.

MS. BURN:

I appreciate the opportunity to speak. I want to address the question how can the VA best attract and retain a quality work force, and what I want to say is this: Quality health care relies on the expertise of nursing professionals and a continuous supply of nurses must be available as the current population of nurses approaches retirement age. However, the unfortunate reality is that many of us are dissatisfied with our careers and feel unappreciated and unrecognized by our employers. We are educated professionals who are treated by our managers as blue collar laborers. Many of us would not recommend the nursing profession to friends or family members, myself included. This is a situation that must be changed. Nurses are vital to the provision of quality health care, and nursing must be promoted in order to both survive and advance as a profession. National Nurses Week is an opportunity for employers of nurses to express genuine and sincere thanks to their nurse employees. Unfortunately, there are times when the ways in which the celebration takes place causes further resentment among nurses who already feel unappreciated. I authored an article on this very subject, and it was published in the December issue of the Federal Practitioner. Since the country is currently experiencing a nursing shortage that is predicted by the Bureau of Labor Statistics to become much more severe over the next several years, National Nurses Week celebrations warrant careful consideration and planning by VA administrators. The profession of nursing is chosen

by individuals who seek not only the extrinsic rewards of pay and benefits, and but the intrinsic satisfaction of serving in the health care profession and making a difference in the lives of patients and family. What means a great deal to a nurse are expressions of gratitude received from the patients and family the nurse cares for. VA nursing also provides an opportunity for another kind of service -- providing health care to our nation's veterans. We are at a time in our history when patriotic pride and service is of utmost important. The opportunity to serve the health care needs of veterans and thereby serve our country must be emphasized through all VA recruitment efforts. This message must be brought to current VA nurses and potential VA nurses on college campuses. Staffing and scheduling issues also must be addressed. Adequate staffing must be provided to ensure that quality patient care is provided in a safe environment as well as increasing nurse satisfaction in providing that care. Mandatory overtime must be minimized, if not eliminated, for the same reasons. Scheduling needs to be flexible to accommodate nurse needs. My recommendations are: Like anyone in any profession, a nurse wants to be appreciated. Genuine, sincere expressions of thanks should come from top VA administrators and especially so during National Nurses Week. This could be as simple as a personal encounter with a non-nurse administrator who comes to the unit, looks each nurse in the eye, shakes hands, and expresses genuine appreciation for the work that nurse does. Such gestures would go a long way towards recognizing that nursing is a special profession, that nurses are appreciated by administrators, and nurses have every reason to feel good about themselves and the care they provide. Nurses who feel good about themselves and the work they do will recruit new nurses into the profession. VA nurse managers must also realize the importance of professional pride and make efforts to raise the morale of staff nurses. Promotion to a higher grade should not be an unattainable goal and should be facilitated with the aid of the unit nurse manager. I myself am a Nurse I. I have been in the four years that I've been employed there. I'm almost done with my Master's degree and still have not been promoted. In the words of the popular book, *The One Minute Manager*, people who feel good about themselves produce good results. People are more productive of quality work when they feel good about themselves. Nurse managers would do well to read this text and abide by the valuable advice the authors provide. A copy of this book should be provided to every VA nurse manager. Nurses are professionals and must have a voice in staffing and scheduling issues. Forums must be created on individual units to give nurses an opportunity to speak and problem-solve issues. Float pools should be created to help cover staff shortages. I go to work. I work 3:30 to midnight. Every day I don't know if I'm going to get out or if I'm going to have to be up all night long. As the largest health care system in the United States, the VA must be the leader in nurse recruitment and retention efforts. It is the responsibility of VA nurse leaders and VA administration to help instill a sense of professional pride into the nursing profession. Nurses who enjoy their work, are proud of the nursing profession, and feel appreciated by hospital administration will remain in the profession and will encourage others to consider nursing as a professional career. Thank you.

MS. CONVERSO:

Do we have a copy of that article?

MS. BURN:

You can have as many copies as you'd like.

MR. GORMAN:

Thank you, Jeri.

MS. BURN:

You're welcome.

MR. GORMAN:

Monica Moore?

MS. MOORE:

Good afternoon. I'm a VA staff nurse at the Central Iowa Health Care System, which consists of Des Moines and Knoxville, Iowa, two facilities. I am the president of our union of nurses at the Des Moines facility, and I work in the ER. I've been a nurse for 22 years there. As chair of our unit of RNs, I have had many discussions with nurses and management regarding the process of the Nurse Professional Standards Board and the nurse qual standards, and I would like to offer my observations. The general discussion of the nurses, all the nurses, at our VA is that at our facility, Central Iowa Health Care System, that the national VA standards have been set, but we are abiding by a different set of standards, a different set of rules, that have been made up by our top management. A good example of this is Patrick Kearns from Iowa City has just talked about they have waivers there and Karen Anderson was talking about how they have waivers in Madison. Iowa City is a hundred miles from us. We don't have any waivers at our hospitals. We have, for an example, a nurse that has been working for 26 years; left for a year and ten days; was a Nurse II when she left, came back as a Nurse I because she didn't have her B.S.N. and she cannot get a waiver to be a Nurse II. And there is no way she is going to go back and get her B.S.N. She is older, and she's got the experience. She's got the knowledge, and she doesn't have the need really to be a B.S.N. except the fact that she cannot get promoted. And it is also very difficult for any nurse at our hospital who works at the bedside or in a clinic position to be promoted beyond the Nurse II level even with a B.S.N. These are highly important nursing positions. I think they're the most important positions in the VA organization, and they are not being recognized for their worth. Nurses are being told by nursing upper management that they need to be in positions that are global, that affect network programs and which involve multi-disciplinary programs. The nine

dimensions of the nurse qual standards require an extensive write-up at our facility. Nurses are having difficulty addressing these nurse qual standards, and I request that an educational program that would go through each of the nine dimensions and assist the nurses in contributing to their proficiencies and developing their career and potential be offered to the nurses. I attended one of the programs last summer that was offered, and the nurse exec and the associate nurse exec provided it. What happened at that session was not what I had envisioned. Instead of the nurses being given advice and support, they were told that they would never be qualified to attain Nurse III. They were told that we are a flat organization and there are not positions for nurses to advance, and we do not believe this is the intention of the nurse qual standards. Needless to say, this was very demoralizing to the nurses. These are professional staff members who have devoted themselves to improving the care of veteran patients. They have worked on committees, work groups, individual task initiatives, et cetera, in order to constantly evaluate and improve the quality of patient care in this changing environment. They are daily involved in life and death situations and all the responsibilities that come with that. They are expected to be more than a nurse. They are covering for a lack of staff in pharmacy, respiratory therapy, social work, psychology, administrative support, and environmental management to name a few. And to be told that they are not doing enough for the organization is a gross understatement. Second, another confusing aspect of the standards and the NPSB is that at one boarding the nurse will be denied promotion to the next grade because certain dimensions were not met, so the nurse will work on those dimensions and be boarded the next time, but then another set of dimensions is determined not to be met by the board. It is a lose-lose situation for the nurses. They cannot get ahead. Third, I have seen qual standard requirements from different VA facilities around the country. Some facilities keep the requirements very basic. Others get very complicated and involved. Some facilities allow promotion of RNs on a more reasonable basis than others which are tight. We recently had an RN appeal her denial of a Nurse III promotion. It went all the way to headquarters and it was approved. This demonstrated to us that we have qualified nurses who are not receiving deserving promotions. A fourth concern is that the nurses are being given lower ratings on their proficiencies than they have received for years. They are being told that previous ratings were inflated. Their documented achievements and accomplishments clearly meet the nurse qual standards, but subjective ratings are leading to unrealistic expectations. For some reason this has been getting worse at our facility. And, fifth, we have an APN who is a clinical nurse specialist in acute psychiatric mental health. She is an independent practitioner, has prescribing authority, has a panel of patients. She is an advanced practice nurse. In the State of Iowa, this is just the same as an NP, a nurse practitioner. She is on a separate pay scale from the NPs. We have been working for three years to try to get her equal pay for her equal work and have not been able to succeed because our facility would not allow it. However, it is being done in other facilities, and they are being paid the same as nurse practitioners. So this is very -- it's like certain people can decide. If this is a VA directive, it should be across the county. It shouldn't be just that our facility doesn't allow this to happen. And the last point I'd like to address is personal. As the chair of our UAN unit, I am very involved in hospital committees, work groups, and counsel work from the local

to the network level. These are done in partnership with management. I would like these responsibilities to be recognized in my proficiency. They should not be brushed off as union business. We all know how important it is to value and recognize nursing staff, but what we in Central Iowa feel is needed is that it just not be words that come from headquarters, but actions to be taken seriously all the way down to the local facility and nursing management. Thank you.

MS. CONVERSO:

Monica, one question: Do you have any idea -- I have heard what you said about the ratings being inflated and coming down. I've heard that not only from you, but from other people. Do you have any idea why that is or why they're decreasing those other than them saying they were inflated before?

MS. MOORE:

I don't know if there is some other agenda. I don't know what it is. I've also heard that there is -- across the nation there is this whole idea of taking a Nurse III, a person who is a Nurse III, and going back to the bedside position and then taking them down a grade to Nurse II. Why would you want to do that? That's, again, against the qual standards. It's looking at the position and not looking at what the nurse is doing. So I don't know if it has something to do with that, too, showing that Nurse IIs maybe can't be promoted to Nurse IIIs. I haven't talked to the nurse exec about that, but that's what the nurses were coming to me about.

MS. CONVERSO:

I appreciate it.

MR. GORMAN:

Thank you, Monica. Karen Mays?

MS. MAYS:

Good afternoon. I am Karen Mays from St. Louis Community College. I'm the director of nursing education for our three campuses. St. Louis Community College has a 40-year history of Associate Degree nursing education. We excel in the preparation of our graduates, and our graduates excel in the community and beyond. Our graduates as well as Associate Degree nurse graduates nationwide have consistently performed at or above their Baccalaureate counterparts for initial licensure examination. No evidence exists to demonstrate that the quality of patient care provided by registered nurses differs depending on where the RN is educated, whether in the Associate or Baccalaureate nursing degree program. The majority of nurses begin their education with an Associate Degree. The Associate Degree in nursing prepares nurses to practice in a profession that has endless opportunities. We

as Associate Degree nursing educators believe these opportunities need to be expanded by the provision of career advancement in the Veterans Health Administration based not only on continuing education, but also on job performance. Through the national nurse education initiative, the Veterans Health Administration is spending an average \$11,000 to educate Associate Degree registered nurses to the Baccalaureate level. This same funding could provide an Associate Degree education for two generic nursing students, thereby providing a relatively quick work force of very high quality. The nursing qualification standard that requires a Bachelor of Science in nursing, a B.S.N., for promotion up the career ladder within the VHA system is a disincentive for experienced, dedicated A.D.N.s to join the VHA. Although many of our graduates do eventually continue their education for an advanced degree, many need time to recover their lives, having sacrifice much time away from their family, from their community, from their jobs in order to be successful in their nursing program. In my 20-year tenure at St. Louis Community College, I have known only a handful of our graduates to seek employment at the VA. I trust that the B.S.N. requirement for advancement will further disenchant future graduates from seeking the VHA for employment in spite of the many very positive qualities of the VHA. Furthermore, A.D.N.s with many years of valuable experience practicing nursing have no incentive to join the VHA as the system will not customarily recognize or reward experienced RNs under the guidance of its new nursing qualification standards. The American Association of Community Colleges strongly supports continuing education for all community college graduates. Community colleges work closely with the communities they serve to meet their health care needs. Community colleges are currently supporting a nursing initiative through the American Association of Community Colleges to expand opportunities for the Associate Degree nurses and enable community colleges to expand nursing program enrollments. The nation and VHA cannot meet the critical need for registered nurses without the contributions of the community colleges in educating the nation's nurse work force. The nation's health care system recognizes the value of the Associate-degreed nurse and employs them alongside their four-year colleagues. The VHA should do the same. Nurses provide service to their patients during the happiest of times, during the saddest of times, and during the most challenging of times. We are asking for the same opportunities so our Associate Degree nurses can provide this service to those who have served our country, our veterans. My recommendations to improve the VHA are these. Number one, promote RNs within the VHA system based on job performance and continuing education. Two, support continuing education for all RNs. Three, develop a policy for advancement of Associate Degree nurses utilizing educational opportunities. Four, implement an RN to M.S.N. program to address the nursing faculty shortage. Five, encourage experienced RNs to work for the work VHA. Six, provide a career path for RNs that encourages them to continue to practice within the VHA system. I thank you. Questions?

MS. CONVERSO:

Yes, actually. I thought I heard -- and I'm watching the clock, so I'm doing like -- I don't multi-task that great, but I thought I heard a recommendation in here for some of the NNEI money to go not only to B.S.N., and I didn't see that in your formal recommendations.

MS. MAYS:

That is part of the -- let's see. It's not a formal recommendation, you're very correct; but it is supporting continuing education for all RNs, if you consider LPN as the actual first ladder in the RN.

MS. CONVERSO:

Right, because I kind of thought that was interesting.

MS. MAYS:

That would be money well spent.

MS. CONVERSO:

So I saw that, but I didn't see it in the recommendations.

MS. MAYS:

You listened well.

MS. CONVERSO:

See, I can multi-task, I guess, but my other question is I was distressed to hear that most of your students do not go to the VA for employment, being a long-term employee of the VA. Do you take them there for a rotation or anything?

MS. MAYS:

Currently we do not. One of our campuses is quite close to the facilities that we have and we attend their education fairs, they come out to our career fairs, but we currently do not utilize them.

MS. CONVERSO:

I'd like to see that.

MS. MAYS:

So would we because we are always looking for clinical sites.

MS. CONVERSO:

I have benefitted from students being in my VA, no matter what school they were from. It is really great to have them there when you've been there so long. You sort of feel out of touch, so I'd really like to see that from all the schools.

MS. MAYS:

I will promise you within six months I'll make that attempt.

MS. CONVERSO:

That would be great.

MS. MAYS:

Thank you.

MR. GORMAN:

Gregory Miller?

MR. MILLER:

I'm Gregory Miller. I'm an RN at VA Hines right here in Illinois. I work on the spinal cord unit. Nurses in our facility are allowed a wide latitude in clinical decision-making on a case-by-case basis with the concurrence of the attending physician. The process gets bogged down whenever a clinical decision is forwarded to a committee. For example, I have the latitude to suggest to the attending physicians certain wound care modalities which are then formalized into orders. The patient care gets delayed when I suggest, for example, a vacuum pump for wound closure and I have to justify the need for that to a person in the supply department with no clinical or medical training to obtain the required equipment. The reason I have to do this is because the skin care committee decided that course of action would be appropriate. There is no recourse to appeal the delay in that procedure. Hence, patient care gets delayed. Changes that could be made that would improve meaningful participation in the decision-making process at Hines are, one, acknowledge that the hospital is open 24 hours a day. Services are severely curtailed after 1600 -- for example, escort, housekeeping, secretarial -- and the lack of these circumstances cause nursing staff to spend more time away from the bedside. Two, make committee meetings more accessible to the nursing staff on the p.m. and night shift. Three, have the majority of the clinical decision-making committee members actual bedside nurses instead of the

ancillary nurses who are one, two, or even three levels removed from actual bedside care and only postulating what is best for our veterans. Trust can be better established if all clinical nurse managers did their job by walking around instead of being inaccessible because they all have offices with closed doors or they're in meetings the majority of the time. I have seen my clinical nurse executive once since I've been at Hines in over two years. The only reason I saw her is because we had a group meeting with her during orientation. I have seen my clinical nurse manager's boss only once in over two years. She is the service line supervisor for spinal cord, the blind center, and extended care center. I have never seen the director of the hospital or the chief of staff. These people occupy plush offices in Building 1, which is a very long walk from Building 200 where the actual work of patient care occurs. Trust cannot be established until there is more physical accessibility to the administration. When I was in the Navy for 21 years, I saw my commanding officer at least once a day, knew him or her, and could trust their judgments, especially in combat. Four, the education and training department is very proactive at Hines. They give the most up-to-date clinical education based on well-founded research and the latest and greatest technologies. I'm afraid that the trouble with the dissemination of information is centered on the 0800 to 1600 mindset which is firmly ensconced in the administration's way of doing business. The nursing staff on p.m. has to come in early for training, which makes for a very long shift. The night shift have to go to training at 0800 after they have worked 8 hours and are tired and training could not be as effective because of possible inattentiveness. I'm sure if I was on midnight shift, all I would be doing is watching the clock until I could go home and put my feet up. Getting outside education and training is like pulling teeth. The process for getting authorized absence or even working with your clinical nurse manager to schedule time off for CTEs is like Oliver begging for more gruel. The forms and processes must be more streamlined and more user friendly. The VA can best attract and retain a quality work force by the very simply expedient of internships. I know and I've read that this has been done at some VA hospitals with good success. The trouble with recruiting nurses is that the pool from which available nurses are coming from is shrinking. I have identified the point where we lose candidates for nursing. That point is in the fourth grade when long division and multiplication are taught. When students stumble in math at that grade, it causes a domino effect which unfortunately lasts their entire life. When I started nursing school in college, there were 400 students identified as nursing students. I graduated with 31. What was the major cause of attrition? The math and science prerequisites. 369 students had the interest and the desire to do good, give care, and become nurses, but couldn't join our ever dwindling ranks because I'd wager their math skills were not that strong. The building blocks of math were not sound, so their chosen profession was denied to them. We must be proactive in the community by tutoring and mentoring students to improve their math skills so that our replacements will be available to us. Another good recruiting tool would be to advertise our pay and benefits packages. This would attract more nurses who are looking for a good career. Our benefit packages and pay would compare favorably with any other agency or facility, especially five weeks vacation. The VA has taken quantum leaps in the use of computers to help deliver care to our veterans. The only problem with the use of computers in delivering care

is the excessive time one wastes logging onto a system which takes us away from the bedside. One password should give me accessibility to all the systems I need to deliver, not three. For example, I have timed this over and over; and from the initiation of a call light for relief of pain, it takes me over 17 minutes on the computer to log out one aspirin for a patient in pain. That is unacceptable. If any of us were in pain for 17 minutes and it was a computer's fault -- you put computers in between the patient and us. Some technologies we already have that are used to enhance practice on an aging work force are the Arjo lift, the Hover mat transfer system, and the Sara lift. These devices are real back savers. However, there are not enough of them to cover the amount of lifting and transferring that is done in Hines this day. More should be purchased or pay the price for all the ortho problems that are coming on down the line. Bring back the position of ward men. I don't mean to be sexist, but men do have more upper body strength than women do. We had a morbidly obese patient that I and another nurse who was male could routinely turn and transfer. It took four women to do the same when we were not present. Someone should invent air wedges for turning patients. Say one wedge under the shoulder, one under the buttocks. They inflate. What did Archimedes say? Give me a big enough lever, and I'll lift the world. Same thing as -- same principle with the Hover mat. Just use air to turn the patients, give either bowel care or wound care. Wedge pillows, inflate the things, you turn the patients, and the patients would get better care. It would also protect our backs, necks, and other joints; and patients who are turned regularly will get less pressure ulcers and would save us money and shorter hospital stays. And I thank you for letting me testify today. Any questions? Thank you.

MR. GORMAN:

Thank you. Appreciate it. That concludes all the scheduled testimony. We still have some folks who would like to take the open mike, and next is Alisa Gwynn.

MS. GWYNN:

Very good. Not many get it. I'm from the Danville Illinois VA; and I have a prepared statement, but I think what I'm going to do is just kind of do a hit and miss just kind of touching on a few points that have been brought up. One of the things that we had talked about while we were at lunch break was how everybody is kind of stating where they're having problems getting their Nurse III and Nurse IV. Well, at the Danville VA, it would be nice if we could even get a Nurse II. I have a B.S.N. My background is critical care, and I currently now did a switch from ICU and acute care and what I'm doing is acute psychology, so I get paid basically to go to the zoo. Okay? But what my frame is, because I was raised in a family of veterans, and so my -- I really truly believe in giving back to the veterans. I really do. At one point I was making over twice what I'm making now when I was working for an agency. I did a really wanted to come back to the VA because brief sabbatical from the VA, and I was making up to \$95 an hour. I really, that was my goal. That's where I loved working. Even though I have my Bachelor's and even though I give what I think is fairly good care -- not that I'm trying to polish my halo above my head, but I try to

give care that is with compassion, sympathy, empathy, and respect. But I'm here to tell you that as nurses we don't get that respect back from the nursing administration. One of nurses that is following me has a Bachelor's also from our facility. He's also a Vietnam vet service-connected. He does not have his Nurse II either. I work with a nurse -- work with quite a few nurses there that do not have the Nurse II. One of them has been there for 22-1/2 years and still does not have Nurse II. To me this is a sin. This shows clearly that there is something wrong with the system here. Let's see. What else? Also, too, I think, kind of changing pace here a little bit, are staffing issues. We are cut down so low with staffing at this point that it's a safety issues. I work with acute psychology, and a lot of our veterans that come in are being delusional, they're being homicidal. They have homicidal tendencies or suicidal tendencies, and then we have nursing observation. We are told we have to watch three of them in the day room with one person.

MR. GORMAN:

Thank you. Appreciate it. Daphne Osborne?

MS. OSBORNE:

Hello. My name is Daphne Osborne, and I'm a nursing assistant at the Danville Illiana VA Health Care System. I'm up here to talk about the nursing assistants and how they should receive a uniform allowance. We work under the RNs and the LPNs and we all work together as a team. The LPNs and the RNs are entitled and they do get their uniform allowance, and I think it's only fair and equitable for the NAs to receive the uniform allowance also. Our laundry facility did -- they do offer uniforms; but since we made a switch and we are into the colored uniform now, we are not getting our uniform allowance. We have to go out and buy our uniforms if we want to wear colored uniforms with the LPNs and RNs, where the RNs and LPNs get reimbursed their money back. Like I said, you know, we want to be treated fair and equitable just like the RNs and LPNs. On staffing, our staffing needs and levels in our medical center must correlate with our veterans' specific needs. My recommendations are a uniform allowance for nursing assistants would be an appropriate retention and recruitment tool. Recommendation on staffing levels, they should be changed to allow nursing staff and other VA health care workers to negotiate overstaffing levels. Thank you.

MR. GORMAN:

Thank you, Daphne. George Barnes?

MR. BARNES:

Good afternoon. My name is George Barnes. I'm a registered nurse working at the Danville VA. I've worked there for 8-plus years; hard in with a B.S.N., still at a I. I worked in an acute hospital setting, nursing home care unit. Now I work on a med

psych unit. Those patients are pretty unique because they have got a dual diagnosis of acute or chronic medical problems along with psychiatric problems. Those kinds of patients on a daily basis vary in the type of care that they might need because of not only the medical problems, but also the psychiatric problems that they have. We need some kind of direct input on staffing levels on a daily basis, but what happens is that they will pull our extra staff down to minimum staff no matter what our situation is in these units; take some of our NAs or LPNs or so forth, put them in escort, places like that, put them over on the hospital units to pass water, stuff like that, when we could very well use them. It makes our unit one of the highest assault rate areas because of this situation because of low staff. Patients know when you're low staffed, you've got different staff, and so forth, and they act out quite a bit. The qualification standards board, they have talked all day long but how that is, and it's still the same at our hospital. It's just terrible. Another area of real concern is about the locality pay surveys. I've been a member of the locality pay survey for three years at our hospital. It's an archaic system. It doesn't work. The hospitals that allow you in -- you know, and half the time you can't use the data that you collect there because it doesn't match to the criteria that we have to use to be able to use that; and the ones that would do you some good because of the kind of pay and bonuses that they give won't allow you in the door. So, like I said, it's a system that doesn't work, and it hasn't worked for quite some time. I'd recommend that Congress amend 38 U.S.C. 7422 to allow nursing personal and other health care workers to negotiate overstaffing levels; and really, like I said, we need to be able to do that on a daily basis. The Commission should recommend that Congress require VA to change the highly subjective and cumbersome process for promoting nurses because it just doesn't happen in the VA system. And I've seen this in the pay survey out there, that a lot of them have a stepladder with experience and so forth like that that on the outside they are promoted on a regular basis. It's very subjective in the VA system. And the Commission should recommend to Congress amend 38 U.S.C. 7422 to allow employees and their representatives to negotiate overpay issues and allow objective oversight. Thank you very much.

MR. GORMAN:

Thank you. Rebecca Spears? Carol Dwyer? Beverly Jackson? Is there anybody else that would like to take the mike to say or discuss anything that hasn't been talked about thus far? Sir?

MR. ADE:

Richard Ade from the Cleveland VA Medical Center in Cleveland. One issue is that the nurses do not report to nurses. Myself, I have four degrees. Two of them are Master's. I report to a clinical coordinator of radiology who doesn't have a degree in nursing or any other field. Because he's the signing individual and he has no idea, no professionalism, on how to write a professional evaluation of a nurse, I have to write my own evaluations and I have to submit it to him and tell him I want this to go with the attached documents before you send it off to the board. We have psychologists

that are overseeing nurses. We have PAs that are overseeing NPs, which is against the state law. They have to be governed by physicians as well as the nurse practitioners. We have -- some of the PAs are doing evaluations for the physicians. That's not correct. We are not on the same level playing field. This is a structure that needs to be looked at; and if the Commission could have that impact on doing that, it's making this right, to have nurse report to nurse, psychologist report to psychologist, and so on through the system. I think that we would have a better understanding of one another's proficiencies. Thank you.

MR. GORMAN:

Thank you. Oyweda, do you have anything to share?

MS. MOORER:

No, I don't.

MR. GORMAN:

Ann, do you want to -- oh, I'm sorry.

MS. MARSHALL-DOWDELL:

I have a question that I haven't been able to find the answer to. Who decided once you're in government service and you convert to part-time status that you no longer have any rights as an employee? And is there any way that that could ever be changed? And, if so, what is the process one would go through to try to start effecting a change?

MR. GORMAN:

That was more than one question.

MS. MARSHALL-DOWDELL:

Oh, I'm sorry.

MR. GORMAN:

I don't know the exact -- I'm not sure of the answer, but I would suspect that it's probably the Office of Personnel Management. And I would suspect also that any -- it would probably be government-wide, although I'm not sure of that; but I would suspect also that any change would have to be legislatively initiated.

MS. MARSHALL-DOWDELL:

So I would have to write to my congressman?

MR. GORMAN:

Good luck. Ma'am?

MS. BURN:

Could I say one more thing?

MR. GORMAN:

Absolutely.

MS. BURN:

Jeri Burn, Ann Arbor VA, Michigan. I just want to say that on my evaluation -- well, let back up one minute. I have been known on occasion to go over my nurse manager's head and go to the nursing director about staffing issues, trying to create a safer environment on my ward. On my evaluation, I was reprimanded for going over my nurse manager's head and not following the chain of command, and I felt like I was being told to be a good girl and keep my mouth shut, and trying to promote safe care should not be reprimanded.

MS. CONVERSO:

There was a question back there I think also.

MR. KC SMITH:

Yes, I have two more issues -- KC Smith from the Saginaw VA in Michigan. One of them deals with outsourcing of services. I don't understand how outsourcing of services will be cost-effective. This was -- an example that I was involved with recently was our x-ray department. Their CT scanner went down. They had 12 patients that needed CT scans. Instead of outsourcing them out, they brought somebody in for overtime to work an 8-hour shift on a Saturday to do 12 scans. Because of the cost, each one of the scans if it was outsourced would have been in excess of \$500 per patient. Another thing is the literature that was given to me before I came to this dealt with our veterans using the VA as a secondary source of insurance rather than a primary source. Over the past four years with our large influx of patients, the reasons they have been coming to the VA medical center is they cannot afford insurance, nor can they afford medications on the outside. One example that I have for you is a 76-year-old male came in with prostate cancer. Him and his wife lived on a fixed income of less than \$8,000 a year. The cost of medication to treat his

prostate cancer exceeded \$2,000 a month. He uses the VA as a primary source of insurance and as a primary source of care. So, you know, the cost of -- if we interviewed most of our veterans, I think we would find 70 percent or a larger number the reason they come there is because of cost savings. They can't afford health care on the outside.

MR. GORMAN:

Thank you.

MR. RUSSELL:

Mr. Gorman, may I say something?

MR. GORMAN:

Sure.

MR. RUSSELL:

My name is Patrick Russell. I am president of VA Council 259 representing 12 VAs in a five-state area. I applaud the Commission for the work they're doing in taking the testimony from the nursing staff, but I would also like to advise you that this is a symptom of a disease and the disease is the aging of our VA infrastructure; and that the focus right now is on nursing, but there are so many other areas involved that -- if you look at the entire picture, if you don't have housekeepers to keep your wards clean, you're going to be closed by Jayco. You need housekeepers to keep your wards clean. You need your building maintenance people to keep the physical structures running. You need the transportation people to take your patients between VAs or to appointments on the outside. So the focus here is on nursing, but there is a broader picture, and that's the entire VA system. They have got to focus on the entire picture, not just on one area. You can focus on nursing and make it the best nursing corps in the United States; but if you don't have the structure around it to support the nursing staff, it's still going to fail. Thank you for your time.

MR. GORMAN:

I agree with that, and I would just say that, you know, our charge as a Commission, as we stated earlier, is rather narrow in scope; and that is to look at nursing issues and nursing services and recruitment and retention issues and make recommendations, whether they be administrative or legislative, to try to help cure or at least rectify this problem.

MS. ADAIR:

I just wanted to say simply that I really appreciate everybody's input today. You don't know how valuable it is to us and what we have to write and submit. It's very important. Please pass the word to everybody else.

MR. GORMAN:

I would also thank you all for not only coming, but for giving your testimony, your thoughts, your views, your opinions, your personal experiences. It's especially helpful to someone like me who is not a nurse, not a professional in that sense, to be able to hear firsthand what you and your colleagues have to go through on a day-to-day basis to try to make things work. I work for Disabled American Veterans, and our mission is very simply an advocate for disabled veterans to try to get the services and the benefits that they have earned and they deserve that a grateful nation has said should be provided to them. So that the issues that you bring to the table are not foreign to me certainly, but they are very useful to get on a firsthand basis. And it's gratifying to have heard so many -- I know there's a number of veterans in this work force, but even non-veterans say that the reason they have come to the VA and they stay with the VA and they toil at the VA is because of their patriotic pride, their sense of duty, their patriotism, and giving back to those who have given so much in defense of our country. Veterans have been called heroes. I would suspect that most veterans would say they're not really heroes, but it sure is nice to be thought of in that vein. Veterans I think should be elevated just a little bit above the general populus when it comes to doling out that almighty federal dollar. Who else really deserves it more than someone who has volunteered or has been thrust into harm's way and has served when asked to defend the principles we have and many of whom come home with scars of battle. Many come home with scars that are invisible, but yet are there. So as a veteran and as someone who is an advocate for veterans and for you, I would thank you for coming. I want to mention one thing to you that you may forget as soon as you walk out the door, but I would ask you keep it in mind. A lot of what I heard today and a common thread that goes through all of this is staffing and everything sort of -- not everything, but a lot of the issues and the problems seem to fall from the issue of staffing, which really equates to money, to funding. All the veterans organizations, not only DAV, continue to lobby on an annual basis for increased funds and budget for you. We always get thrown a little bit, really sort of table scraps, when you come right down to it. It's never enough, but the Congress and the administration will always hold up that "we've given you more than was asked for. We have done for you what we need to do," and that's not true. But there's sort of a new thought back in Washington, anyway, that's being pursued, and the DAV and the American Legion and the VFW have joined in a partnership which the three of us have not done before cohesively. town hall meetings, and we are trying to go to the home districts of key Congressional leadership people. And the idea that we have is something we are calling mandatory funding. Right now, the way the process works is the VA -- VHA in our case -- compiles from all their departments and all their services -- everybody gives them a number of what the budget should be for next

year. Somehow it all funnels upstairs and somebody sends it over to the White House every year saying, "This is what we need." The Office of Management and Budget sends it back and saying, "You've got to be kidding. There's no way you're going to get this," and they cut it. The VA always appeals this. They get a little bit more put in. The budget goes to the Hill. The Hill says, "This is dead on arrival," and they take the rest of the year and you well know sometimes beyond a year into the next fiscal year to come up with a budget for you. That doesn't help anybody. It's a laborious process. It frays nerves. It causes a lot of tension and a lot of work on everybody's part. So we think one way to cure that is this scheme of mandatory funding. Right now funding for VHA is discretionary. Congress gives what they have to give, and it doesn't make a bit of difference what your workload is. They can give whatever they want to give, as much or as little. Mandatory funding, on the other hand, would be something that we're trying to put into law that they would have to provide to VHA based on the number of patients that you care for on an annual basis plus an annual kicker or COLA based upon the medical CPI. And there would be a formula. You all know how much it costs to treat a patient. You take the number of patients you treat, you multiply it by the cost per patient, you add the medical CPI index to it, and you get a budget. And each and every year that should work a whole lot better than it works right now, and we think it addresses a number of things. Principal in that is the issue of funding for staff. So it's an idea that we have that's receiving a lot of opposition from members of Congress, but no one else seems to have a solution. We go through the same tedious, inadequate process every year. So I mention it to you only for you to know that there are people back in Washington that are outside of VA who care very, very much about you about, what you do, why you do it, and who you do it for and we are trying to do something. I think sometime in the very near future this issue is going to raise to the level of a very serious issue on somebody's radar. And there are people here from the unions, there are people who we call upon for grass roots support. I know sometimes you can do things as VA employees, sometimes you can't; but you need to know that there is somebody back there trying to look out for you, thinking about you, and trying to do the right thing for you because you certainly do the right thing for us. If there's nothing else --

MS. POUNDS:

I just have one little tidbit that I'd like to pass on to the Commission. I'm Amie Pounds out of Danville. I'm the labor leader out of Local 1963, 7th district. I was a part -- in the audience, rather, of the committee hearing when Principal presented him and Dr. Roswell the budget for '04. And after that committee hearing -- there wasn't even standing room left in that committee hearing whatsoever because there were so many people in there to hear what he had to say, and we met with several legislators and senators in Washington the very next day. Many of those that we spoke to when they found out that we were from VA were actually apologetic for the fact that, once they opened up the Category H, they had not anticipated the number of veterans that would flow into the system at that time. And they were -- I do have to give them at least that much credit. They apologized -- out of Illinois and Indiana, anyway,

apologized for not looking far enough ahead into some of the problems we were facing.

MR. GORMAN:

Well, you know, as constituents, everybody has a congressman. Everybody has two senators. It seems that on Memorial Day and Veteran's Day politicians can't say enough or do enough as far as waving the flag and talking about veterans, but there are 363 more days in the year. And what we try to encourage people to do is make your member of Congress aware of your concerns and then don't accept the fact that they say, "We hear you. We will take care of it. We will do it. We apologize," but look at what they do, not at what they say. That goes throughout. Politicians have so many issues on their plates, that VA -- unless someone really sits down, they are just not educated about VA, what it is and the national treasure that it really represents.

MS. BOLLENBERG:

At my facility, Hines, new patients coming in today needing an appointment with a primary care doctor are getting scheduled for May of '04. That's as soon as we can get them in to see a physician or nurse practitioner.

MR. GORMAN:

That's really an outright denial of care. I'm told we are going to close it out. Thank you again for coming. (WHICH WERE ALL THE PROCEEDINGS HAD IN THE ABOVE-ENTITLED HEARING ON THIS DATE.) STATE OF ILLINOIS)) SS: COUNTY OF DU PAGE) I, SHARYN A. EVERMAN, a Certified Shorthand Reporter of the State of Illinois, do hereby certify that I reported in shorthand the proceedings had at the hearing aforesaid, and that the foregoing is a true, complete and correct transcript of the proceedings of said hearing as appears from my stenographic notes so taken and transcribed under my personal direction. IN WITNESS WHEREOF, I do hereunto set _____ my hand at Chicago, Illinois, this 7th day of May, 2003. Certified Shorthand Reporter C.S.R. Certificate No. 84-2315.

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