

HEARING BEFORE THE NATIONAL COMMISSION ON VA NURSING

TRANSCRIPT OF PROCEEDINGS

Long Beach, California

April 30, 2003

Reported by:

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CSR No. 2852

JOB No. 113478

HEARING BEFORE THE NATIONAL COMMISSION ON VA NURSING

Transcript of Proceedings, taken at the Long Beach Hilton at 2 World Trade Center, Long Beach, California, beginning at 8:30 a.m. 4:10 p.m. on Wednesday, April 30, 2003, before SHERYL HILTON MEYER, Certified Shorthand Reporter No. 2852.

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- 3 NATIONAL COMMISSION ON V.A. NURSING:
LINDA BURNES BOLTON - Commissioner
MR. DAVID COX – Commissioner
OYWEDA MOORER - Staff Director
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Long Beach, California - Wednesday, April 30, 2003 8:30 a.m. - 4:10 p.m.

MS. BOLTON:

Good morning. My name is Dr. Linda Burnes Bolton. I'm one of the commissioners for the National Commission on V.A. Nursing, and I'm pleased to welcome you to our final hearing. We held four hearings across the United States, and both David and I have had the opportunity to be at two of them together. With me is David Cox who a lot of people in the audience actually know, and he's also a commissioner. We also have Oyweda Morrer who is commission staff director. We also have Stephanie Williams, who was out in the registration, and she is a program analyst with the commission. Our court reporter this morning is Sheryl Hilton Meyer. And we don't have any other members of the commission with us, but we are very happy to have you with us. I'd like to go over this morning some of the background relative to the commission and then go over the sort of rules of the day in terms of the commission hearing. The commission was established by the Congress and appointed by the Secretary of the Department of Veterans Affairs and our duties are as follows: We are charged with conducting assessments, and we have been doing this in a variety of ways, both in terms of receiving testimony at these hearings. In addition people have had the opportunity to submit things to our Web site, and they can also send information via the snail mail, and they can also fax things to us. We are conducting the assessment concerning both the legislative and organizational policy changes to enhance the recruitment and retention of nurses and other nurses personnel by the Department of Veterans Affairs. We are also charged with looking at the future of the profession in the department and to make recommendations about how we will sustain a qualified nursing workforce to meet the needs—how to sustain a qualified nursing workforce to meet the needs of the veterans. We will be making recommendations on legislative and organizational policy changes to enhance the recruitment and retention of nurses and other personnel in the department. Our commission consists of 12 members of both V.A. and non-V.A. as designated by Congress to carry out this charge. We held our first meeting on May 8, 2002 and since that meeting have a lot of feedback. David and I were just speaking about the fact that we must have heard from over a thousand people since we started back in May. We are going to be submitting an interim report to the Secretary in July of this year, and our final report will be submitted to Secretary of the Veterans Affairs in May 2004. This Secretary will then have 60 days to submit a report to Congress, and that report will provide the Secretary's view of the commission's findings, things that we have discovered during our assessment phase. In addition it will explain what actions, if any, the Secretary intends to take to implement the recommendations of the commission and the Secretary's reasons for doing so. Today's hearing is to obtain input from V.A. staff as well as in terms of professionals organizations relative to the commission's high priority of what things should we do to retain and recruit a qualified nursing workforce. We value very much the information you'll be providing us today, and over the next few months you'll have the opportunity besides today to submit information at our Web site which is at www.va.gov/ncvan or you can mail e-mail the Commission on Veteran Affairs at

vhaconcvan@hq.med.va.gov. I'm sure we'll have that out in the foyer if you didn't get that from me. Having given that background, we're going to move the agenda forward by laying out these ground rules in terms of the hearing. Scheduled testimony, and we require—we received written testimony for all of those individuals who are scheduled to present which will take no longer than 10 minutes. David will be responsible for the timekeeping, and he will issue a yellow card warning when you have three minutes left and a red card warning when you must cease. When the red card goes up, you must stop speaking, and if you don't stop speaking, we will continue to tell you to stop speaking. The commissioners, David and I, may pose questions to those—to the individual that's presenting. However, you're not allowed to question us. If issues in the witness testimony have been expressed in a previous testimony, the witness may give an introduction and verbalize agreement to the previous testimony, add things to it but not—we request that you don't repeat. So if you have something to add in addition to what someone has said, get up, and say "I support the testimony that was previously given, and I wish to add the following." We will have a 20-minute opening forum in the morning and in the afternoon as indicated on your agenda. That first open forum will occur at 11:35 a.m. this morning. If you registered outside for the open forum, we will call your names, and as time permits we will go through the list. At the time of the open forum I will give the names of individuals who have registered and call them forward. Each of those individuals will have an opportunity to speak for three minutes only, so you won't get a yellow card. You'll all just get a red card when the time is up. Are there any questions about our process this morning?

MR. VAGGDES:

Can we use common acronyms CPRS and BCMA and use those standard acronyms or do we have to explain them?

MS. BOLTON:

You have to explain them to me. I'm not a member of the Veterans Affairs. I neglected to tell you a little bit about who I am. I'll do that and have David also do that. As I said, my name is Dr. Linda Burnes Bolton, and I'm vice president and chief nursing officer of the Cedars-Sinai Medical Center in Los Angeles. I hold a variety of national roles including as a member of the National Advisory Council, Nursing Education Practice for the Division of Nursing in the United States Health Services. My expertise is in those things in relationship to recruiting and retaining a qualified workforce and in addition to looking at the workforce, organizational change efforts across the United States.

MR. COX:

I'm J. David Cox. I'm from Salisbury, North Carolina. I'm the first vice president of the American Federation of Government Employees National V.A. Council most of

the time known as AFGE. I've worked for the V.A. for about 20 years. I am a registered nurse. I got there by way of being a food service worker to a nursing assistant to an LPN and moving on to become an RN, and so I've held various roles in nursing and been involved with a lot of various things.

MS. BOLTON:

Okay. If a presenter does not use the allotted time to speak, they may not yield it to anyone else. Okay? So if you only use eight minutes you can't give two minutes to anybody. We will have breaks during the course of the hearings today. Our first break will occur at 10:00 a.m. If there are not any other questions from the audience, we will begin with our first presenter. No, we're not. Oyweda Moorer has some housekeeping.

MS. MOORER:

Just a couple little housekeeping chores. The bathrooms are right outside this door if you go out the back door and look over to your left. There is a bank of pay telephones. If you are going down the hallway toward the escalators, before you get to the escalators there's a little alcove there which has about eight pay telephones there. There is a parking ticket validation machine in the back on the table where the water is. If you parked here, you can get a discount on your parking. Instead of paying \$9 all day, it will be \$5 all day. So all you have to do is put your ticket in there and validate it. Also we ask that you turn off all of your cell phones because that's very distracting, especially when people are testifying. And if you have not registered, please do so. Anyone who wishes to speak in the open forum must register and must complete one of the forms, the form that looks like this. So please register if you've come in since we started this. That's it. Thank you.

MS. BOLTON:

Very well. Then let us begin, and our first speaker to give testimony is Cynthia Nieves. Please as you come to the mike, introduce yourself, your role, your title and what facility or organization you are representing.

MS. NIEVES:

Good morning. My name is Cynthia Nieves. I am proud to have worked as a registered nurse at the Long Beach facility for more than two decades. Presently I care for veterans who have sustained spinal cord injuries. I am proud to care for these heroes. We owe them much. The very least we can give them is compassionate and high quality nursing care. Unfortunately, staffing on the spinal cord unit is not adequate. Most senior nurses are retiring, and I see no replacements being hired. The pressures of caring for too many patients leaves us with no time to even hold a patient's hand or to offer words of comfort and encouragement. To try to address this dire problem, V.A. management has

contracted with traveling nurses. They come on to the unit for 13 weeks. While these may seem like a solution, it creates problems. Permanent staff like myself must orient these contracted nurses. When you are short-staffed, it is frustrating to have to train a new nurse over and over again. I would much rather train a new nurse who would become a permanent member of our nursing team. Even after we train them, these contracted nurses are not full members of the veterans' care team. If a contracted nurse makes a mistake, they are not held accountable in the same way that permanent nursing staff are held responsible. The real solution is to recruit and retain permanent nursing staff for the spinal cord injury unit. The real solution is to allow nurses to have a say in staffing levels. In the short term if the V.A. is to continue to use temporary nursing staff, we should have a designated nurse as a clinical instructor to orient these nurses. The nurse clinical instructor should receive additional pay. The V.A. can improve retention and recruitment of nurses by fully using its existing pay options. For example, my facility provides all the direct care staff in the spinal cord injury unit at a 10 percent retention bonus base pay, but we still need to recruit and retain additional SCI nurses. Why isn't my facility offering nurses the full 25 percent bonus allowed under the law? Even with a retention bonus some nurses are transferring to the Palo Alto veterans facility because the difference in locality pay is substantial. The difference in locality pay is \$25,000. The locality pay at the Long Beach facility is lower than the locality pay in Loma Linda, West L.A. and Sepulveda, all facilities in VISN 22. Under the current law our facility director has much discretion over our pay. The director can decide whether or not to conduct a locality pay survey. The director can decide whether or not to pay us an increase. I urge the commission to recommend that the directors must conduct annual pay surveys. Directors should be held accountable for not retaining and recruiting adequate staff. This should be part of the performance evaluation. The V.A. needs to do more to promote and advance nurses. This is key to retaining nursing staff. I feel the promotion process is not objective and does not support the professionalism of nursing. To many it seems a promotion to the next grade is impossible unless one belongs to the circle of cliques/friends of the nurse professional standard boards. It also seems that the promotion process is linked to "magic words," not how you care for veterans. The boards cannot be true peer review if there are no term limits. The boards never explain what a nurse needs to do to improve her performance to get promoted. I have a BSN and two decades of experience. I have published two articles, but this is still not sufficient enough for a promotion. Some of my colleagues are still a Nurse I, Step 12 level with experience of over 15 to 30 years. They run the ward smoothly as charge nurses but are still denied a promotion. What is wrong with their performance? Why aren't the boards telling them how to advance? I urge the commission to recommend that Congress empower nurses to improve the frustrating and unprofessional process. I urge you to support a change in the law so that nurses through their union can sit down with the V.A.'s nurse leadership and agree to a fair, more objective and simpler promotion process. If we can make decisions that affect a patient's life or death, we should help decide how to improve the promotion process for nurses. V.A. support for nurse education is really a mixed message. On the one hand the V.A. says it is encouraging nurses to continue their education preparation for practice. I enrolled

for my MSN last January 2003. I had to pay for my credit out of my pocket. I was told no funds are available. I cancelled my next class due to unavailability of the NNEI, the Nurses National Educational Initiative, funds to June 2003. I requested my own days off for my class and will work most weekends. If the V.A. is serious about education, it must have the funds and distribute them in advance. Also the V.A. must support nurses returning to school by offering them better schedules. If the V.A. won't help you get an advanced degree, then it should not be able to deny you your promotion. I thank the commission for the opportunity to speak on issues of great concern to V.A. nurses and our patients.

MS. BOLTON:

Thank you very much. David, do you have questions?

MR. COX:

No questions.

MS. BOLTON:

In relation to your question about the spinal cord injury unit itself, from your testimony you indicated that they have contracted staff assigned to the unit, but your utmost concern is that the patients do receive nursing care; is that correct?

MS. NIEVES:

Yes.

MS. BOLTON:

And so your primary recommendation relative to not using contracted staff is to find a way to increase the number of nurses within the V.A. who receive some type of an additional education and preparation to be SCI nurses?

MS. NIEVES:

Correct.

MS. BOLTON:

I just need some clarification. I didn't hear that clearly from your testimony.

MS. NIEVES:

Okay.

MS. BOLTON:

Is that your primary recommendation?

MS. NIEVES:

Uh-huh.

MS. BOLTON:

Okay.

MS. NIEVES:

We need to hire more nurses, you know, and not contracted nurses. They're only there for 13 weeks, and they go home, and, you know, they're just there for the money.

MS. BOLTON:

My question was more in trying to clarify. I believe your overall recommendation is that the V.A. should try to hire more nurses specifically to take care of the spinal cord area which is a specialty area, and my question primarily is do you see the solution then if they were not to hire contractors?

MS. NIEVES:

Yes.

MS. BOLTON:

Do you see the solution as an educational intervention to other nurses in say acute med/surge that would then be prepared to work in the spinal cord area?

MS. NIEVES:

Sure. Right now I think that \$5,000 for those entering the spinal cord injury area, that's a good incentive bonus.

MS. BOLTON:

Thank you. Our next presenter is Patricia LaSala.

MS. LaSALA:

Before I start, I'd like to apologize to the commission and my colleagues for having to leave soon after my testimony. I have to catch a plane to get back to

San Francisco to make a meeting, and, by the way, it's my birthday, and I'm anxious to get home. Good morning. My name is Patricia LaSala, and I'm a registered nurse at the San Francisco V.A. Medical Center Fort Myer. I'm also president of the Federal Local 1, National Federation of Federal Employees, International Association of Machinists and Aerospace Workers. My union represents the professional employees at the San Francisco V.A. It's a privilege for me to have been selected to appear before you today for the second time. I had the honor to address you in New Orleans as well, and I thank you again for your attention to issues that affect V.A. nurses and ultimately those we care for, the American veteran. I have the good fortune to enjoy a very rich nursing career, and I'm honored to work for the V.A. I have been a nurse for 33 years. I worked 10 years in the private sector and have dedicated the remaining 23 years of service to the V.A. in San Francisco where most of my career has been in nursing administration. I am now president of the professional union. My focus, however, remains the same, first patient care and then staff concerns and the supporting of optimum working conditions. My testimony is quite lengthy, and so I will share some parts of it that I did not address in New Orleans. Let me again share my V.A. nursing background. I started at the San Francisco V.A. 23 years ago as a staff nurse in psychiatry. I became the head nurse, then the psychiatric nursing coordinator and finally the assistant chief nurse for psychiatry, medicine, surgery and patient transportation previously known as Escort. I changed that name after my mother begged me not to say that I moved to California to run an escort service. Today I will focus briefly on the per review process as I did in New Orleans, and then I will share with you my own personal experience with the boarding process when I applied for a position at the San Francisco V.A. 23 years ago. I believe the Nurse Professional Standards Board was originally a laudable process that has outlived its relevance in today's world of nursing. All too often I hear from my colleagues at my station, as well as colleagues throughout the V.A., how unfair and unreasonable the process has become. The process varies from V.A. to V.A. If the board was to work as it should, anyone could share it, and the outcome would be fair. How often do we hear "Oh, I don't want to go to her board" or better yet "I hope I go to his board. He promotes." If you think these comments are stretching a point, trust me they are not. Also it is common dialogue between nursing staff, which chief of nursing service is, for or against a Nurse IV in a clinical role. Something is wrong here. Please spare us another task force or commission or whatever you think will fix it. I don't think anything will. I think it's time to adopt a pay system that recognizes excellence in practice without the caveat that make advancement all but impossible. I suggest we look at a model in the private sector. As I mentioned in New Orleans, the Kaiser system might be a good one to look at. This is a healthcare organization that we lose many of our new and recent graduates to. Be bold. Recognize the system has outlived its usefulness and move into the 21st century. If you do, I promise you many of us will move with you. If not, you will lose a national treasure second only to the American veterans, that being those dedicated V.A. nurses who care for them. Grade levels. My comments will be relevant to the above topic, but I would, however, like to share with you how arbitrary and

capricious I found this system when I first met an acquaintance of the V.A. nursing service. I am a diploma graduate with advanced degrees in psychology and public health. When I applied for a position in San Francisco in 1980, the association chief nurse interviewed me. She explained that because I did not have a BSN, she could only offer me full grade Step 1 appointment. Never having worked in the V.A., I wasn't quite sure what that meant, but my previous experience just before coming to San Francisco was that I was the assistant director of nursing for the adult and child community mental health centers at the Jersey City Medical Center in New Jersey. I had helped write, and we received at the time the largest single grant awarded by the National Institute for Mental Health. I was the assistant director of nursing for six years also assuming responsibilities in the department of pediatrics. My interview with the assistant chief nurse was followed a few weeks later with an interview with the chief nurse Mary Anderson. Ms. Anderson was very complimentary of my experience and voiced her wish I consider to work at San Francisco, but I remember her surprise when she saw the recommended grade and step. Still being a novice in the world of the V.A. system, I paid it no attention at the time. Having just relocated from New York, I continued my scheduled interviews at local hospitals, and one evening in June or July of 1980 I received a call at home from Ms. Anderson. She asked if I accepted the position yet, and I replied "Nothing firm." I was offered a director of nursing position, but I hesitated because my plan was to stay in San Francisco no more than one or two years—well, 23 years later—anyway, she proceeded to tell me that she was retiring from the V.A. and accepting a position with Joint Commission. I wished her luck, but I wondered "Woman, why are you calling me?" She then got to the point. Ms. Anderson told me that I should call back the associate chief nurse and request something called preboarding for intermediate grade with a waiver for education. She explained what she meant, and again she was very kind about me being the kind of nurse that the V.A. was hoping to find. I did as she instructed. My application and letters of reference were submitted to the local board. They recommended a waiver and consideration—a waiver for consideration and intermediate grade Step 1. Dr. Laurence Foye, the Medical Center concurred, and off my OPF went to D.C. to the board in central office. I still have a copy—I still have a copy of the telex that came back. The board recommended intermediate grade Step 5, four steps above the local board. By the way, Ms. Vernice Ferguson, nursing service VACO, chaired my board. Some of you may remember her. You may ask what have I done with this honor, and I do consider it an honor. I am proud of my V.A. career, and please forgive my lack of humility at this time, but I'd like to share some of the things I've accomplished just to prove my point. The V.A. has acknowledged me with contributions, advancements for both performance and achievement. I have two director's commendations. I have several service organizations awards. I was nominated for the President's Point of Light award. I was named Federal Employee of the Year two years in a row in San Francisco, one for administration and for community service. I won the latter at the VISN level. I've been nominated for numerous local nursing awards, one nomination for the Administrators Award for Excellence in Nursing Practice. The latter is the

one I am most proud of as they come from my peers. So again forgive my flurry of self-serving rhetoric. My point is to demonstrate what was needed by me to be employed as a V.A. nurse 23 years ago, and at that time the performance standards were much more liberal than they are now. Yet two experienced, seasoned, career nurses with years of federal service to their credit had interviewed me and had very different views about what my grade should be. I doubt that I would be here today if it wasn't for nursing leaders like Ms. Ferguson and Ms. Anderson, and I certainly don't believe that I would be here today if I was applying as a new V.A. employee. There is another important point. Baby boomers like myself are at the end of our career. New graduates stay a very short time at V.A. hospitals because they see it's too difficult to advance with our system. We are slowly losing the cadre of nurses who are the clinical experts, the educators and the leaders. They were the professionals who inspired us. What are we to do when they are gone? I think we need not worry. The halls and clinic and wards of V.A. facilities all over this country are filled with the pride of our profession. They are out there. They are caring for our veterans with grace, dignity and elegance. It is time we recognize these nurses and change this outdated, unfair, elitist system that fails to recognize them. Lastly, I would like to say again I love being a V.A. nurse. I am proud and humbled by the nurses I have worked with and now represent. I know that you will do what you can to help. Thank you for affording me this opportunity, and I wish you and your families' peace.

MR. COX:

And I heard very loud and clear that you have concerns with the professional standards boards and things like that. When somebody says that, tell me what to replace it with.

MS. LaSALA:

Well, there are ladder systems in the private sector that reward nurses much quicker than we do. We're losing a lot of nurses in San Francisco to the Kaiser system, to UCSF and to the University of California. They don't—the starting salaries interesting enough are not usually as high as ours, but after one or two years the nurses top out, and this is after we have given them two wonderful years of education and experience, and they move out into these systems where they can advance much more quickly. Kaiser in particular. We're losing a lot of nurses in San Francisco to the case ladder system.

MR. COX:

I'm not really familiar with that system, but I'm sure you are.

MS. LaSALA:

You said that last time too.

MS. BOLTON:

Can you tell me—I didn't hear in your testimony which we heard in New Orleans, but I still didn't hear the issue of do you or do you not support peer review as a part of that process?

MS. LaSALA:

I support per review, but something's wrong with the system of peer review that we have in the V.A. I am sure I am not the only nurse in the last four hearings that hasn't echoed great concern.

MS. BOLTON:

I heard concerns about the board, but I'm trying to get clear because our charge is given the current state and the concerns expressed when we do have Kaiser being a model, that's just one model. And I'm trying to hear from you based on your years of experience whether or not maintaining some type of a peer review system is essential?

MS. LaSALA:

Absolutely. Absolutely.

MS. BOLTON:

Thank you very much. John Royce. Sarah Atkins.

MS. ATKINS:

Good morning. I'm Sarah Atkins. I have been a staff nurse at the Portland, Oregon V.A. Medical Center for 13 years which is my entire career as an RN. I work in medical surgical, medical short stay and inpatient and outpatient oncology. I have an associates degree, a bachelor's degree and a master's degree in nursing and a national certification in oncology nursing. I'm a professional unit vice president for AFGE Local 2157. First I'd like to speak to you about the emphasis on the BSN degree and the associated problems. A nurse's initial educational preparation is meant to prepare the nurse for safe entry into practice. It's not meant to be the most significant factor that defines the nurse for the rest of his or her career to the exclusion of expertise that's gained on the job. I consider that both the associate's degree and the BSN prepared me to take the same license exam and in 2002 that earned me the exact same score. Research does not show that BSN-prepared

nurses perform better at the bedside than any unprepared nurses. Only for initial licensure is education what makes someone eligible to be licensed as an RN, but for subsequent licensure practice as a nurse is required in all states. One cannot continue to be licensed as an RN based on educational attainment alone. When a nurse with an ADN or one with a BSN doesn't get a different license, he or she continues with the same license as before. The literature reveals that basic nursing education becomes obsolete in a few years. In the state of Oregon a nurse who hasn't been practicing nursing for 15 years can never be relicensed. He or she has to start from the beginning of their basic program. Weighing the BSN so heavily causes the V.A. to undervalue the experience and practice and by extension underreward it. It makes no sense to value a BSN degree more than years of experience or worse as to penalize the experienced RN for the lack of a BSN degree. We know that older nurses are less likely to have a BSN, and yet these may be the experienced nurses who are providing the excellent expert care and valuable mentoring to our nurses. We also know that nurses of color are less likely to have a BSN. Privileging nurses with a BSN and disadvantaging those without it impacts recruitment and retention of excellent nurses. One of the best nurses I ever worked with who had an ADN left the V.A. after 15 years of service. Nonpromotion, not having a BSN was a major factor in her decision. She told me it was wonderful to be valued for her expertise in her new job in the private sector. My suggestion for change to this practice is a policy change that rewards but does not confirm an automatic preference for the BSN degree. We can get an educational differential of either an amount per hour or percent above base pay. This is a widespread practice in the private sector. This can be an incentive to get to obtain master's or doctorate degrees. It would be consistent with V.A. emphasis on its supportive education but would separate education from performance, and this would allow the nursing qualifications standards to emphasize a measure of performance and remove the automatic BSN preference that takes the process. What that amounts to is preselection for promotion. Now I will address the nursing qualification standards and the standards boards. At the Portland V.A. there's a lack of understanding and quite a bit of mythology surrounding the qual standards of the boards and what one has to do to be promoted. The agency takes great pains to keep the identity of board members a secret. It's rather like the "Wizard of Oz" where the wizard is behind the curtain manipulating circumstances in secret. No one, neither managers or staff, has clear, consistent, accurate information about what to do to get promoted. Information given to staff nurses by their managers varies widely, not only through the medical center but within the nursing units. Similar managers give widely varying amounts of assistance to their support giving some lots of mentoring and giving some none, and this has caused a widespread belief that the process is tainted with favoritism. In attempting to address these issues with the chief nurse executive, I was dismissed and told "The proficiency process belongs to management." Even though the standards require that the nurse be given reasons for nonpromotion, usually the nurses are just told "You didn't meet the standards" with no clue at what they need to do to meet them. This information, believe it or not, is either delivered by a little strip of paper which is the comments section cut from the official form that reports board results or via e-mail. Here is the e-mail I got

from my supervisor last month. “Hi Sarah. I wanted to let you know that you were not promoted to Nurse III and your request for a two-step increase for your request for an MS degree was denied as well. Sorry for the bad news.” What was I supposed to do with that? Nurses put their hearts and souls into excellent practice, and they believe they are meeting the standard only to be told in this unprofessional and disrespectful way they are not, with no mention in regard to how to meet the standards. Recently an RN preparing to write her narrative told me “I’m going to talk to so-and-so who’s been on the board because I feel that there’s magic words that you have to put in your proficiency if you want to get promoted.” Staff nurse in Portland exchange like a black market of successful proficiency language. Although what’s worked for one year doesn’t work for others. There is a widespread belief in Portland that verbiage, not the accomplishments of the nurse, is what gets you promoted. Last week a nurse manager told me “I just called up so-and-so on the board to find out how to write it.” Education waivers are unheard of. The process is perceived as being so arbitrary if you dare to challenge your denial of promotion that you will make somebody mad, and then you’ll never be promoted. This is not only frustrating and hurtful and outrageously unprofessional, it stifles one’s initiative. Also, as I testified earlier, it can cost us our best nurses. There seems to be a misperception in Portland that only nurses who hold assigned leadership positions as managers can obtain Nurse III. This is inconsistent with the qual standards as written, and it does not make sense in any case. How many chiefs does one hospital need. It also completely overlooks the informal leadership of excellent, experienced nurses who lead and teach by example every day as they deliver care and mentor their peers. As part of the project in my master’s program I looked at the literature related to performance evaluation and peer review. The V.A. calls its nurse promotion process peer review, but it isn’t peer review because it lacks the necessary feature of peer review as described in the literature. By arbitrary and inconsistent application it actually violates the essential attributes of peer review. In short, the lack of reliability and validity of qual standards both initially and in ongoing evaluations which is absent and the evaluation to administer them renders the whole process invalid and inappropriate for use in promotion and evaluating our RNs. My recommendation for change are as follows:

First modify the qual standards to create a career track that is clearly clinical in nature and in addition the existing track that is interpreted as requiring a management role for advancement. This will reward excellent nurses who chose patient care rather than the current system that emphasizes a formal leadership role. Second, currently Title 38, 7422 of the U.S. code, blocks V.A. management from collaborating with staff nurses over the qual standards and their interpretation and application. I urge the commission to recommend a legislative change that would allow management and staff nurses to come together at the table to resolve these issues. This would be a win-win situation for everybody because it would add the vast experience of the staff nurses, the real experts on those jobs and who do the jobs to be added to expertise of the nurses and V.A. management. I also recommend a legislative change to 38, 7422 so a nurse who is denied a promotion or educational waiver can appeal that denial or other board decision to a mutually

selected independent third party. I recommended a legislative change to 38, 7422 to allow input by unions that represent staff nurses into the selection of board members of standards boards. Currently unions have no input in such selection which taints the legitimacy and neutrality of the boards. Modify the qual standards to specify that when an RN is denied a promotion that the RN or, pardon me, the board will provide the RN with a specific plan that describes with clear measured detail the specifics of what the RN needs to do to obtain the clinical competencies. In addition, nurse managers would be required to mentor all RNs under their supervision in equal manner to ensure that the RN is enabled and empowered to meet the plan and be promoted when reviewed the next year. Modify the qual standard to ensure that the evaluation tool is reliable and valid. Require joint labor-management training of standards boards on the process and standards to ensure consistent interpretation and application of the standards. Finally, modify the qual standards to require an automatic education waiver when the RN has met the performance standards. Thank you for letting my voice be heard.

MS. BOLTON:

Thank you.

MR. COX:

You talked some about a clinical track versus a management track.

MS. ATKINS:

Right.

MR. COX:

Tell me what you mean by that.

MS. ATKINS:

Often nurses who feel they can get an explanation are told you didn't manage a program, you didn't manage people, and they talk about specific behaviors that are not needed by every nurse in practice. They are the kind of behaviors that are only needed by a few in administration, but the things they do that are other kinds of leadership in the clinical area are completely ignored. And the community has clinical tracks, as the previous speaker has said, that reward both kind of nursing, and we need to do that as well.

MS. BOLTON:

Can you give me an example of leadership in a clinical track.

MS. ATKINS:

People who are—possibly a charge nurse which is not a normal management or maybe they're not even a charge nurse. They have such expertise they are seen by their peers as informal leaders, and we need to learn how to do procedures and that's who you go to if you have a different clinical situation, and that's who you go to. That's leadership, and the literature describes that, but we have no way to capture it and, therefore, no way to reward it.

MS. BOLTON:

Are you talking about individuals who take on preceptorships?

MS. ATKINS:

They could be, yes.

MS. BOLTON:

Okay. Any other questions? Thank you very much.

MS. ATKINS:

Thank you.

MS. BOLTON:

John Royce. Okay. Linda Stringfellow.

MS. STRINGFELLOW:

My name is Linda Stringfellow, and I'm an operating room nurse from Salt Lake City. I was advised to talk about nursing issues for all nurses and not make it personal. However, this is a personal issue to me. It affects me and my family, my coworkers, the most important people who are dedicated to caregiving. Recruiting is a difficult issue because there are not many nurses to recruit. Nursing programs are underfunded in Utah, and there is a lack of master's prepared nurses to teach the VISN program. So there are few nurses to recruit from.

MS. BOLTON:

I'm having difficulty hearing you.

MR. COX:

You may need to pull the mike closer to you.

MS. STRINGFELLOW:

Is that better? To get these few nurses to consider the V.A. is simple. It's simple because we are there and can see it. It's not simple for administrators because they want to solve the problem without spending any new monies. The solution goes back to the old rule of supply and demand. If the supply is abundant, the price goes down. If the supply is inadequate, the price goes up. The major incentive for a new nurse would be pay and benefits. Given this, and I know that the V.A. hospital would not have a problem recruiting new nurses. The retention problem is more complex. Pay nurses above the standard rate for your area and this will help get nurses in your system. Paying nurses more is a difficult issue because it directly relates to the promotion process at the V.A. This system is antiquated, difficult to express and biasly administered. The Salt Lake V.A. hospital has a major problem related to promotion. It is a dictatorship. I have over 10 years OR nursing experience, but I have worked in the V.A. only six months. I have been told almost from day one that I would not ever be promoted because that was the way the V.A. did things. The main complaint I heard after it was known that I was going to testify was the hiring and promotion process at our V.A. It is under the control of one person. Our nurse recruiter hires and sits on the promotion board and on almost every major committee of the hospital including the V.A. credit union loan committee. She has the most power and influence on all employees. This is a major conflict of interest and an abuse of power. We need to revamp this promotion process. Long-term, intelligent, hard working, experienced nurses are a rare breed, but they are discriminated against. We are told no promotion if you don't have a BSN. The V.A. handbook dated 1-12-03 states that to get a Nurse II you need a B.S. and/or an associate degree plus years of experience. Many nurses I work with have all these requirements including many more years of experience than anyone but are refused promotion. Most nurses don't have a BSN. A BSN is not necessary to be an excellent nurse. To be a supervisor or an administrator, yes, but don't punish the nurse who wants to be a direct patient care nurse. Reward him or her for doing one of the hardest but most rewarding jobs around, taking care of the patient. There is a major conflict in my V.A. hospital as to how they handle promotions. In some hospitals OR nurses are automatically a Nurse II or even a III. This rewards them for their expertise. In Salt Lake you're a Nurse I. I was told that you cannot go any higher. Why this discrepancy? I feel it's important to reward a nurse for their specialty expertise, but it needs to be consistently at all V.A.s. If a nurse goes through the time and effort to get an advanced degree, he or she will probably get out of direct patient care and into an administration or specialty nursing. Most nurses with advanced degrees will not stay in direct patient care. It's not cost-effective. Reward the direct patient care nurse who loves his or her job. Pay and promote for excellent patient care, not just for administrative work. There is a certified registered nurse anesthetist, a CNRA, at our hospital who is 42 years old

and has reached the maximum step he can for a Level III nurse, Step 12. He's been there for three years. He cannot go any further. He told me that he would have to go back to school, which the V.A. would pay for, get another degree and then leave patient care to be an administrator. He does not want to leave patient care but does not know what else to do. Another nurse I work with got his BSN and is still waiting for his promotion. Arbitrary time limits are given as the reason, but no one is able to document this requirement. Another nurse applied for her nurse II and has been a nurse since 1978 and is in charge of the specialty in the OR functions just the way a charge nurse does and has gone above and beyond her duties but was told when she applied for Nurse II that she probably won't get it because she was not hired before a certain date. Again no documentation provided for this requirement. However, other nurses with less experience and new BSN hires are given a Nurse II automatically. Also the V.A. will pay for a BSN, but not pay for those to be educated in his or her specialty, and this is an expensive process. The V.A. encourages us to become certified, but they will not pay for it. Please pay for classes that make us better nurses and in turn give our patients better care. To retain the valued nurses within the V.A. for many years and to decrease burnout, please consider the following needs: More ancillary support staff. The V.A. operating room in Salt Lake City is an excellent place to work. We have a great ancillary support staff, and I can spend more of my time doing nurse's duties. However, I know this is not true for the floor nurse. Nursing is a very physical job. And without adequate ancillary support staff, this will physically and emotionally wear out any nurse. The more flexible shift option is another retention solution. We have been told in our OR that we cannot have part-time people. Why? Other units have them. What about job sharing, two nurses sharing one shift? This sort of flexibility would give a lot of nurses who have left nursing due to burnout from poor conditions and long shifts the option of getting back into nursing. This would also help keep nurses in the profession longer. This would appeal to nurses who have families and do not want to work 40 hours a week, older nurses who do not need to work 40 hours a week and who cannot physically work 40 hours a week but could work 20. This would bring more nurses back into the profession. Less on-call mandatory shifts. Many nurses with 40 hours have had to be on call for further shifts and often on the weekends. This is a major factor in nurse burnout. No other industry requires this of their employees. Why are nurses expected to do this without question? Many, many are also required to work over their shift when staffing is low or just to complete their workload. How about a no-call policy for older nurses, say 55 or 60. This would help keep older nurses in the system longer. In closing I would like to explain why this is such a personal matter for me beyond just being a nurse. My dad was a veteran. He was a patient for many years at the V.A. in Salt Lake City. He died at the V.A. They took very, very good care of him and were so kind to me during this time, and this is a major reason I wanted to work at the V.A. I want all veterans who served our country to get the very best care. Many veterans have no one else to care for them, no family, no friends. The V.A. nurses take care of them and become their family. They depend on us for medical care, emotional support and someone to just be there. They deserve it, and I feel honored to give them this care. Thank you.

MS. BOLTON:

Thank you.

MR. COX:

You worked at the V.A. for six months. Is that what you said?

MS. STRINGFELLOW:

Yes.

MR. COX:

What did you do before you came to the V.A. Did you work in the operating room?

MS. STRINGFELLOW:

Yes, I worked in the operating room for off and on 10 years at two other hospitals in Salt Lake City.

MR. COX:

When you came—where I'm trying to go and get in my head is that you were probably specifically hired to work OR because you had OR experience—

MS. STRINGFELLOW:

Yes.

MR. COX:

-- In those types of things. There is no special pay or bonuses or anything at your facility that you're aware of—

MS. STRINGFELLOW:

No.

MR. COX:

-- for operating room nurses?

MS. STRINGFELLOW:

I think the only thing they considered was my years of experience.

MR. COX:

Do you hire OR nurses without OR experience at Salt Lake?

MS. STRINGFELLOW:

At our V.A. we have not.

MR. COX:

But there is—

MS. STRINGFELLOW:

There is no training program for a brand-new nurse or a nurse without experience to teach them to be that. Other hospitals have an internship program that takes at least six months to get your basics, and it takes approximately two years for an OR nurse to be competent, and that's why it is hard to get them and why they need the extra pay for their expertise because it's so hard to get.

MR. COX: Okay.

Thank you.

MS. STRINGFELLOW:

Thank you.

MS. BOLTON:

Cannon.

MR. MICHAEL CANNON:

I'm Michael Lee Cannon. I'm an LPN with the eastern Colorado healthcare system. One of the things that—one of the questions you all asked on the thing was trust. In our area trust is something that has gone away for a long time. Back in the mid-'90s they started closing down units telling our people that Fort Lyon—that if they went to a nursing home that they would still have

a job. So they went to the nursing home so they wouldn't close down the facility. And then in 2001 they closed Fort Lyon and turned it into a state prison. Since they closed Fort Lyon they were told that they're going to be in a nursing home in Pueblo and five CBOX (phonetic) community-based clinics. In the last few weeks the people of the nursing home have been told that they do not—they're not good nurses, they do not know nursing care, they don't—that they're going to close. They will go ahead and close the nursing home because of the lack of nursing care that they're able to get. These people that are there survived a rift most of them with at least 15 years' experience in working in a nursing home with psych patients most the time and working with geriatric care, and yet they're demeaned, and they're accused of doing things that they have no proof of that are criminal actions, and they have no proof that people even have knowledge of those actions. How can you build trust when your management from the director and the associate directors down accuse, demean and intimidate the staff at your facilities? By the intimidation, the people of the nursing home and most of the oldies of the southern Colorado healthcare system are afraid to speak up. They're afraid to tell their administrators, their supervisors something that they see wrong or something that they think they might be able to change. They are afraid to even put in written testimony for this hearing because they're afraid that it will go back to their supervisors and they will lose their jobs because they spoke out or if they started raising—making waves, that they would fire them. This is true intimidation, and we can't deal with that. It also goes on. To build trust has to do with also the pay in our area. LPNs recently have been hired on at 6-5 levels that have never been in the V.A. before. It has taken a lot of us like myself which I have 25 years in the federal system and 29 years as an LPN, many years, and in 1992 I got my GS6. I'm now a 6-9. These people were hired on straight off the street with four years' experience at a 6-5, and the reason they said that they did it was because they couldn't meet what the civilian sector was paying. When I first went into the V.A., the civilian sector was paying less than what the V.A. was paying. Since that time the civilian sector has caught up and passed the V.A. in eastern Colorado. An LPN now starting from the school in the civilian sector gets 35- to \$40,000 a year. A person, an LPN with about 20 or more years is making anywhere between 50-to 55,000 a year. That's an LPN. RNs are above that. NAs, they're getting just about \$2,000 more than our top GS5-10 NAs. They're getting about \$2,000 more a year. Our system needs to be able to hire on, and you want to get more nurses, but we can't hire a nurse without making the rest of the staff that have been there for years very upset that they bring them on. You have given us the 7 now for the LPNs which is just a drop in the bucket, but it does not really match with what we have to deal with. LPNs are licensed like an RN. We are a hybrid Title 38. We're hired like an RN. We are boarded for advancements like an RN, all the other activities that there are of Title 5, but we also have to maintain a license. We did go to school for it. I myself have an associate's degree, but I am an LPN. The LPNs also have

to take continuing education credits, and so we have to pay for those to, like I said, maintain the license. We have the same wages as a nursing assistant. Nursing assistants do not have to maintain those continuing education credits. Nursing assistants don't have to pay for license fees. If it's going to cost us so much to hire on new LPNs at the GS6 level so we can get an LPN to come in and work for us, we need to look at revamping the grade system for the LPNs. I suggest that we start out LPN out at the GS6 level and we go to a GS9 level. That's just a suggestion on my part. You would equal the amount of pay that the civilian sector is paying plus you would be able to show a better advancement for the LPNs. The other thing we have is a locality problem. In my area I work in a rural community-based clinic. Our cost of living is only about 3 percent less than what it is in Denver. Denver gets a very high locality pay. Colorado Springs and Pueblo are out of the Denver locality pay system, but yet their cost of living is the exact same as what it costs in Denver. Denver, the only difference in the cost of living is the cost of housing. In the urban areas we have a lot of rural community-based clinics. In the rural areas the cost of food is higher. The cost of gasoline is higher and the cost of clothing is higher because they have to transport it in. Housing is a little cheaper because nobody is out there, and to be able to buy a house, they have to bring the cost down. That's the only reason it's 3 percent cheaper than it is in Denver. The only way I can see this is we need to equal out locality pay. Either do away with that system completely or take a look and wherever the entire system is under one jurisdiction, that entire system should be allowed to have the higher locality pay.

MS. BOLTON:

Thank you.

MR. CANNON:

Thank you.

MS. BOLTON:

Before we adjourn for our break, I want to go back over some ground rules for those that came in after our initial start. First I will remind you that if you hear testimony on a topic that you were going to address, we request that you come to the mike and say I support reexamining the promotional board or I would support relooking at whatever and then just give your additions to that. Just give your additions to that. Secondly, when you first come in, please give your name, your title, and that includes both whether you're an RN, LPN or CNA, and we have your written testimony about what your degrees are and the location and what you do at that facility. So we will come back at 10:15 a.m., and we will begin with Dr. Maurice McKennon.

(Recess.)

MS. BOLTON:

Please take your seats. Thank you.

DR. McKENNON:

Members of the commission, good morning. My name is Dr. Maurice McKennon. I'm the dean for family studies at Portland Community College in Portland, Oregon, and I'm here this morning representing Dr. Jess Carreon, the president of Portland Community College. On behalf of Dr. Carreon, who is also the chair elect for the American Association of Community Colleges Board of Directors, I wish to thank you the members of the commission for the opportunity to provide testimony on this very important agenda. Before I read Dr. Carreon's testimony, let me share a few points about myself. I am a registered nurse with more than 25 years of experience. I have also taught various levels of nursing ranging from the certified nursing assistants to those pursuing a bachelor's of science degree and nursing. While teaching in our associate degree program at college, I took my second-year students to the Veterans hospital at Portland for their clinical experiences where they worked with a very special population, veterans and their families. I must tell you that our students were well loved by veteran patients and their families. The staff was also extremely kind to our faculty and loved the students as well. Today we have no students doing clinical experiences at the V.A. I was also the director of the nursing program at Portland Community College prior to assuming my current role. Finally as a nurse of 25 years plus nursing educator and educational leader, I fully support Dr. Carreon's statement. And I will quote it. "I have been directly involved in the debate over the education of nurses in this country for more than 20 years as community college administrator and president. Moreover, I am here today as a community college president and Chair-Elect of the American Association of Community Colleges Board of Directors. My interest, and that of my colleagues, in this issue stemmed from two primary concerns: One, meeting the needs of the students and two, addressing shortages in the workforce that will continue well into the future. "We at Portland Community College want our graduates to be able to get jobs and fill the needs of the workforce. We also want ADN graduates to be able to go on to get their bachelor's and master's degrees if they are able and want to advance their education. Toward that end we support lifelong and continuing education for nurses and always have and will continue to do so: "Our ADN nurses are well qualified. They pass the NCLEX-RN exams at the same rates as BSN nurses. They have the same kind of clinical experiences as the bachelor prepared nurses and may be

even more clinically competent than their BSN colleagues in providing quality patient care. Community College Associate Degree graduates also have several other attributes. They tend to be older, more stable and reliable, and many already have degrees in other fields and are making nursing a second career. "Further, community college graduates represent a large percentage of the nurses of color in the profession and bring a breadth of experience and dedication to the field of nursing. Compared to Bachelor of Science nursing programs associate degree programs allow students to move into the workplace faster and at a reduced cost. "We all know that we have a critical shortage of healthcare workers in this country. We also know that the majority of nurses currently in the workforce have their initial educational experience in an associate degree nursing program. With this point in mind we at Portland Community College find it very disappointing that the VHA's hiring and salary promotion policies do not value the associate degree nurse, and this is of concern given the shortages in the field, the high quality of educational preparation of the associate degree graduates and the diversity they bring to the profession. "The VHA's current policies are based on the unvalidated premise that more formal education automatically equates to better performance. And in that case we encourage the VHA to base employment and advancement policies on the quality of the job performance and continuing education of its nurses rather than solely on the attainment of advanced degrees. And in fact there are no data in our research indicating that associate degree nurses perform less competently on the job than do BSNs. The requirement that V.A. hospital nurses have the Bachelor of Science degree clearly prevents associate degree graduates from seeking employment opportunities and ultimately deprives the V.A. hospitals and its patients and families of well-educated and highly qualified nurses. "Portland Community College placed many of our nursing students at the local V.A. hospital for their clinical experiences until 1994. However, because of the initiation of educational discriminating hiring practices, we stopped sending our students there for clinical experiences. "With the current hiring policies the V.A. cannot hire our graduates and so is deprived again of many well-qualified, experienced nurses who are capable of providing outstanding high quality patient care. We believe that for almost a decade none of our graduates have gone to the V.A. hospitals because of this change of policy. How shortsighted on the part of the VHA. "In summary, my recommendations are number 1, employ new associate degree graduates at the same level, Nurse I, Level I, as baccalaureate nurses. 2, provide pay raise and promotional opportunities for all nurses based on skills and job performance and standardized continuing education criteria. 3, develop a policy for advancement of associate degree nurses and opportunities for continuing education for all nursing employees. 4, make training shifts equally accessible to both two- and four-year graduates." Just recently I was talking with one of the nursing faculty who shared a little story relating to number 4. One of our second-year students went to the V.A. HR's office to inquire about trainingships and

was basically told they were not available. However, after further discussion the employee at the hospital found out that this young lady was a veteran and then all of a sudden a trainingship was available. Finally the VHA current employment and salary advancement policies and practices smack of discrimination as evidenced by the example that I just shared. I would like to thank the committee for the opportunity to participate in this hearing.

MS. BOLTON:

Thank you. David.

MR. COX:

You currently have no affiliation clinical affiliation with the V.A.?

MS. McKENNON:

No, we do not.

MR. COX:

You have not done that for a period of time?

MS. McKENNON:

That is correct.

MR. COX:

Are you aware of what other nursing programs are affiliated with the V.A. Medical Center?

MS. McKENNON:

Our four-year schools.

MR. COX:

Four years?

MS. McKENNON:

Yes. They get primary clinical placements at the V.A.

MR. COX:

Where do you find most of your graduates go to work at?

MS. McKENNON:

Most of them are currently—most of our graduates currently stay within the Portland area and are employed at local hospitals. We have a large conglomerate called Legacy that has four hospitals as well as the Kaiser system is located there, and there are some other smaller local community hospitals where your graduates are employed.

MR. COX:

Do you have a clinical affiliation with those hospitals?

MS. McKENNON:

Yes, we do, with all of the other affiliates in the area.

MR. COX:

Okay. Thank you.

MS. BOLTON:

You say that 30 percent of your current enrollment if I heard you correctly—

MS. McKENNON:

30.

MS. BOLTON:

-- have advanced degrees. Did you mean advanced degrees or have bachelor's degrees in another field?

MS. McKENNON:

Bachelor's and above. So some of them do have the advanced degree above the bachelor's degree.

MS. BOLTON:

And in relationship to your recommendation number 2, you're suggesting that in terms of promotional opportunities besides job performance you used the term "continuing education."

MS. McKENNON:

Right.

MS. BOLTON:

That has different meanings. Could you be more explicit?

MS. McKENNON:

Right. A lot of the nurses have to maintain special certifications like CCRM, like oncology or the OR. Those are some examples of continuing education.

MS. BOLTON:

So you're not talking about general continuing education, but you're talking about certification?

MS. McKENNON:

Certification.

MS. BOLTON:

In a specialty area?

MS. McKENNON:

Certification.

MR. BOLTON:

In specialty areas?

MS. McKENNON:

Yes.

MS. BOLTON:

Thank you very much. Ahnnya Slaughter. For those of you who are going to be seeking to speak during the open forum, if you came in and you did not complete this form which requires you to give us some demographic as well as address what specific question you will be speaking to during the open forum, you need to complete this form and hand it to Stephanie. And we only have about 11, but we have over 30, the prior number of people who were seeking to speak during the open forum, and so we do need this completed.

MS. SLAUGHTER:

My name is Ahnnya Slaughter. I'm from the greater Los Angeles V.A. healthcare system. I'm a registered nurse, and I work with the critical care unit. I just want to thank you for the opportunity to come here today and represent my colleagues at the hospital taking care of patients. I have worked at the V.A. for almost 12 years, and I believe the V.A. is a good place to work. And there's some wonderful opportunities for nurses, but we have to propel our system into the new millennium. Being a child of a navy soldier, veterans have a special place in my heart. I believe these men and women who unselfishly served our country deserve to be provided the utmost care through our healthcare system. The V.A. ought to be a safe haven for these veterans. Those who we trusted to serve us now entrust their lives to us nurses and healthcare professionals. When we give them substandard care, we're betraying that trust. And what can we do to fix that? Well, there are civil issues that contribute to the problem and some have been addressed already today, and so I won't repeat them. One of them is a competitive salary issue, but another angle of the salary is that even if we're not the highest paid system, I believe that the nurses feel supported and able to grow even though we're a few dollars less, and I think we could retain and recruit the nurses. The second issue is a supportive work environment. The third is a system breakdown. The supportive work environment, let me address that first. This has to start at the point of entry. We have to streamline with the hiring process and the HR or the human resources process. We sometimes refer to our HR as a black hole because things go in there, and we're not quite sure what happens once it gets there. And I have examples of friends that have applied for jobs, and they haven't heard from anybody for months and so they take positions elsewhere. Now in this day and age of a nursing shortage, there are hospitals where they have same day interviews and they start the hiring process the same day. If the V.A. wants to compete with these hospitals that are just a few blocks away, we have to take notice of their practice. Let's see here. And the other issue that we have to look at is supporting the nurses that are here already. We have to look at providing manpower support as well

as physical layout support for the nurses that are practicing. Let me give you an example of a system breakdown. Nurses spending their time looking for wheelchairs, gurneys, I.V. poles and supplies that they need to practice ought not be and also ancillary services must be available to support the nurses. Otherwise the nurses are there picking up the slack for the ancillary services. Over the last 11-plus years I've seen nurses forced to play the role of the janitor, the clerk, engineer, dietitian, baggage clerk, staffing coordinator, pharmacist, about every other service that you can think of. And this really takes away from the nurses being able to be a nurse. This is what we want. We want nurses to be able to be nurses, and that's what nurses are looking for, somewhere they can be what they trained to be and what they love to be. Many of the things that we get seem to come from headquarters, and I appreciate the fact that headquarters is doing this so we can give feedback, and hopefully they will listen. Things such as the BCMA, and that's the Bar Code Medication Administration System, that came down from headquarters, and it seemed as though the nurses really had no say in what happened with that. Now conceptually it's a great tool, but when you practically try to implement the system, it can be quite dangerous, I believe. It jeopardizes the patients, and it jeopardizes the nurses, especially when the glitches have not been worked out yet. The nurses are forced to become innovative in trying to continue to practice while working with the system that has flaws; but when something goes wrong, it's still the nurse that gets blamed for the problem. And it's clear that trying to pass medication with this new system takes longer. I mean there is no doubt you try to do something through the computer versus a piece of paper, it naturally is going to take longer. We haven't adjusted our staffing for that, and as a matter of fact we probably have fewer staff to work with because of the shortage. And that's just one system. The nurse today has to deal with Vista, the Vista system, the BCMA system. When I say Vista for you, that's our old, and I believe it's a DOS-based system we have had for years and years. CPR is our computerized record system, and we still have to deal with hard copy records. I don't think anybody has looked at how much longer it takes to provide patient care because of these overlapping systems. It is though we keep—one of the questions that was asked was how can we better implement technology at the V.A. system. I think we're good at implementing them, but we keep putting one on top of the other without looking at how things work together. And it's like an old TV where people just keep piling the newer ones on top, and that's what we've got. We've got sort of a chaotic system. And as far as physical layout, we need to look at the way our physical structure is, the old POD system. They may have worked years ago in the way nursing was practiced back then, but I don't see it really serves nursing now. So my recommendations again, salary, staying competitive with local hospitals, a supportive work environment, and an example beefing up the ancillary services. I don't quite understand this process all the

ancillary service. I'm just going to give an example of housekeeping that comes to mind. The majority of the staff come in at 7:30 to 4:00, but patient care is a 24-hour process and trash comes all the time. Why we don't support the nurses by having ancillary service during the busiest times which is during the midday to early evening from 11:00 to 8:00, for example. That would greatly help the nurses, and as far as environmental, I'm not picking on them, but it's just one example. Escorting is another example we need support, pharmacy, all the support services. Another issue is when we do have staff that aren't doing their work, we need to have that be responded to quickly. I've seen behaviors tolerated at the V.A. that would be immediate dismissal anywhere else. I understand that some of the people that we hire are veterans, but that shouldn't alleviate them from being professional to our fellow veterans. They should know better because being veterans, they are likely to be the patients soon. So I think that we need to look at how we keep good people and how we deal with the people that aren't doing their jobs. Let's see. One other thing I say when I'm doing classes on pain management to the nurses are you being the nurse you want to be—you'd want to have if you were in pain, and for the system I challenge them to ask are we being the healthcare facility that you'd want to be in if you were needing healthcare. Thank you.

MS. BOLTON:

Thank you very much. David.

MR. COX:

With the ancillary staff do you think there is a need for additional staff or is there a distribution in how they're scheduled?

MS. SLAUGHTER:

I think it could be possibly both. Without having a knowledge of the numbers and so forth, I can't answer that 100 percent, but I have a feeling that it's both. I think part of it is distribution, and part of it is that they are also lacking in the number of people that they have working for those departments and they keep coming back. For example, pharmacy, I believe, is down to one pharmacist in our hospital at night, and that really puts a strain on the nurses.

MR. COX:

Can you give me a percentage or some measurable number how much of your time or the average nurse's time is spent with ancillary duties that if there was other staff to do those?

MS. SLAUGHTER:

That's tough to answer because it's different in the different areas. Med/surge may have one issue with one area, and critical care may have problems with another area. So that would be difficult to answer, but it's not uncommon to see nurses staying an hour, two hours, three hours after their shift is over without claiming overtime just to finish their charting. And I wonder if that's because they're doing things that other support services could have been doing, and a lot of times they don't claim the overtime because they're afraid for their manager, that they are going to get in trouble if they claim overtime.

MR. COX:

Thank you.

MS. BOLTON:

Can you tell me in your facility if staff nurses are part of a technology assessment committee and examples of the impact of work that the technology might have had prior to the deployment of that technology?

MS. SLAUGHTER:

To my knowledge I haven't heard of anything like that, but the problem with getting staff nurses involved in committees and meetings away from patient care is they don't have time to take care of the patients as it is. When you're taking them away for meeting for an hour, two hours at a time, they get behind, and so don't want to participate. And I think one of the speakers before mentioned creative staffing, and I think we can use that concept to bring in people for two hours to bring in people for a four-hour shift to cover nurses that have to go to staff meetings, for example, for nurses to go to committee meetings and educational programs.

MS. BOLTON:

Thank you very much.

THE WITNESS:

Thank you.

MS. BOLTON:

Okay. Next we have Holly Martin.

MS. MARTIN:

Hello, good morning. I'm Holly Martin. I am a nurse practitioner at the V.A. Medical Center in Salt Lake City. I'm going to address the promotion problems at our facility. I've worked in the system two years now and recently got a step increase. It was great. It came to my attention though that I would get this increase whether my proficiency was filled out or not and that it had nothing to do with merit. This got me wondering what must be done for a merit increase or raise of any kind for that matter. I really sweat blood over filling out my proficiency. I asked questions regarding the proper wording because I've heard there are magic words. I work extra to meet the criteria. I've written articles. I've joined committees. I fulfill all of the requirements that indicates my staff and level and then some, but I never get any feedback related to this document other than the standard line "declined for level increase at this time." As a master-prepared nurse I'm a Level II. I'm told that I cannot have a level increase because I do not do research, and I'm not participating in programs which are beneficial hospital and VISN-wide. Nothing in my job description says that I'm required to do research. I am a clinician. I see patients every single day of the week in a business as a primary care clinic, and I find this quite a beneficial hospital because I take care of 800 men. Why is my ability to form and participate in groups being measured when my profession is about preventing and treating illness and disease? The measuring stick is either all wrong or intentionally worded to prevent clinical people from ever getting advancement. Indeed, the less likely you are to have patient contact, the more likely you are to have time to work on the requirements for promotions and accolades. There is nothing at all in the nursing proficiency tool that measures time spent with patients, patient satisfaction, number of patients seen, effectiveness of treatments, efficiency in a clinical setting, a well written note, anything of that sort, all of the things we value as clinicians. An administrative nurse that sits on the board told me to my face in a meeting about proficiencies "You can be the best clinician in the world and never get a promotion here." It would seem this is precisely what the goal of nursing administration is. There are no factions out there lifting nurses up and assisting them in getting promotions. It feels like the opposite. The intention is to keep the front line clinicians down and make it impossible for them to get out of that area or get out of a full-time routine. There is no reward at all for being a good clinician. There is no reward at all for seeing large numbers of patients. There is no reward at all for doing most of the requirements for a promotion, and there is no reward at all for being efficient and timely in a clinical setting. I can see two major problems with nurse practitioner evaluation in particular. The first is the proficiency tool. It's made to help administrators and researchers get advancement and to keep clinical

people right where they are it seems and nowhere else. The second problem is that practitioners practice primary care, and our supervisors are often MDs. A medical director has no idea what this tool is trying to measure, and they're not likely to be able to wade through the layers of the nursing jargon and ennui associated with this ineffective tool. It's as if there is a secret language that must be used to get promotions, but no one is allowed to know the code. The result is a pile of proficiencies that are often late and poorly filled out. I would suggest that nurse practitioners, PAs and primary care physicians all be measured with the same tools and that we be measured with tools that actually reflect what we do all day. I would also suggest that incentives be initiated related to patient load, clinical hours and patient satisfaction. I have two testimonies here from colleagues that are MPs that I work with. Both of them sit on or attend the Nurse Professional Standard Boards, and they work in primary care with me. The first one is a nurse and has been one since 1969 as an LPN, an ADN, a BSN and a staff Ph.D. She's taught at two universities, and she's written textbooks, and she sits on the board, the Nurse Professional Standard Board, and I quote her in saying that the evaluation is inappropriate and subjective. She is completely frustrated with the whole thing. She summarizes her thoughts by saying she is an advocate of advanced education, but degrees are not the only yardstick by which to measure success or ability. And she goes on to say the promotion criteria should blend educational preparation as well as clinical expertise. She proposes that—especially in Salt Lake—that we undergo a complete revision of the process and change it from being not so subjective to more specific. And then she also says that if the members of the Nurse Professional Standard Board have to attend a workshop as to learn the correct interpretation of the evaluation criteria, then the wording of the tool needs to be changed to attain clarity. The second letter is from my supervisor. We finally got a nurse practitioner supervisor, and she's been an employee since 1991 filling out proficiencies for herself in a nursing role and employees on the floors and now as a nurse practitioner for herself and for us. And she takes exception to the fact that she's been there 12 years and she can write up a proficiency, and nobody ever gets promoted no matter what she does. She thinks the tool is ambiguous and full of busy work, and especially now the concern is we have demands for experienced, qualified nurses, and it's just too hard to get them in there and keep them in there with the requirements. Her specific recommendations are that we establish guidelines and criteria for the front line nurse which are separate and different from the criteria for nurses in a supervisor role. The second was that the criteria should be simple, readily applicable, written in a universal language where there is no room for misinterpretation. She also suggests the local Nurse Professional Standard Boards should be required to get out of there after a certain amount of time and that 16 years is clearly too many for some people. She also recommends that

proficiencies should be anonymous, that you either meet the criteria or you do not. And she suggests that we reevaluate the extent and power given to the local Nurse Professional Standard Boards. Thank you very much for your attention.

MR. COX:

I'm familiar with advanced practice nurses and the PAs and the evaluation tools. At your facility are the pay scales comparable for nurse practitioners and physician assistants?

MS. MARTIN:

We have—not really. The PAs come in a little bit less. As you know, they are on a different pay scale. And then the nurse practitioners have their own step and level locality scales which is their argument for not giving us Level IIIs because they say we have already adjusted your salary up, and so what do you need a Level III for. My ego just screams and cries and says because I want one, you know, but yes, there is a little bit of difference, and the PAs are lobbying to make it a little more reasonable and fair.

MS. BOLTON:

In relationship to the recommendation about having a different set of criteria from which to evaluate nurse practitioners and physician assistants, could you be a little bit more explicit just in terms of criteria?

MS. MARTIN:

Yes. We function as primary care providers. What we do all day is we're essentially paid for our opinion. What we do all day is no different than what a physician does all day. So in your mind if you can try to evaluate a physician with this proficiency tool, that's what we're up against. So I think we need to be measured not just on workload but on our ability to use current research to provide effective care to the veterans and improve health and outcome and be able to measure it.

MS. BOLTON:

Are you familiar with the Dartmouth-Hitchcock of quality which looks at outcomes in relationship to the both quality defined specifically for patient populations along the lines of clinical outcome, cost efficiencies and then satisfaction?

MS. MARTIN:

Not—no.

MS. BOLTON:

That's a model in relationship to evaluating both independent and dependent licensed practitioners and primary care physicians, and I would recommend it to you as you go forward with this. And finally in the relationship to your work, do you believe that you should as a group start moving away totally from having a review through the professional standards board and set up a separate per review process for advanced practice nurses?

MS. MARTIN:

I think advanced practice nurses definitely need a separate evaluation tool. There is no question about that. What we do is entirely different than what a floor nurse does or a supervisory nurse.

MS. BOLTON:

Would you see having though a peer review process as a part of that?

THE WITNESS:

Peer review is important in any profession. Feedback is essential. You need to know what your colleagues are doing. They're a measuring stick other than your patients and what your patients say to you, but they're the only measuring stick.

MS. BOLTON:

So you are supportive of a separate peer review?

MS. MARTIN:

I think so, yes.

MS. BOLTON:

Thank you. Collette Ferreira.

MS. FERREIRA:

Good morning. My name is Collette Ferreira, and I work at the Long Beach V.A.

MS. BOLTON:

You need to speak directly into the mike.

MS. FERREIRA:

Good morning. My name is Collette Ferreira, and I work at the Long Beach V.A. I'd like to thank you for coming to our area and inviting us to be heard. I responded to the e-mail, and I'd like to address how can the V.A. best attract and retain quality workforce. Within the Long Beach V.A. facility it's extremely difficult to advance or to promote, especially to the nurse Level III, without being in an administrative position. The quality standards are written so the nurses who remain in the clinical setting are not rewarded for their expertise. The Long Beach V.A. does not have adequate staffing for clinical nurses to leave their stations to devote time to projects, committees or workshops that might help them meet the standards for promotion. I know a nurse who left the Long Beach V.A. six to seven years ago to work in a private facility. She was a nurse Level II when she left. At the other hospital she quickly advanced to Level IV. This nurse recently considered returning to the V.A. but was told that she would have to go through the boarding process and would be fortunate to return as a Nurse II. It appears as though nurses leave seeking better pay elsewhere and upon proving themselves at a private facility, it is still questionable if they can be recognized and paid at least in a same monetary ballpark as a private sector. Our facility does not seem willing to pay for quality clinical nurses. In the surgical outpatient clinics there are four to five RN vacancies. Throughout the hospital there are many vacancies mainly due to attrition. Typically registry nurses are being used to meet needs on a daily basis or if they aren't, the area simply suffers. Nurses who leave are not replaced. Those who are left are expected to make up the slack. These nurses are already overwhelmed, and extra workload is unreasonable. I have some recommendations that I would like to suggest such as separate quality standards for administrative and clinical nurse positions. The quality standards to my knowledge are currently the same for both the clinical and administrative nurses. The reality is that it is very difficult to achieve promotion as a clinical nurse without leaving the patient care area for an administrative position. I believe this would inspire nurses who feel the calling to remain in the clinical setting and also I believe this will help in the retention and recruitment of quality nurses. Currently for many there is not much incentive to stay in the V.A. system when the hope of higher pay is

minimal. We lose nurses to the community where their chances for advancements are greater. It's not uncommon to see our nurses who have retired from the V.A. to return to work at the V.A. but via the registry service for higher pay. We need adequate staffing to care for our patients. Our veterans deserve quality-nursing care, and to attract and retain a quality workforce I believe nurses would value greater opportunities for advancement and pay that is comparable to the community. Thank you.

MS. BOLTON:

Thank you. Thank you very much. Michelle Olguin. Would you provide written testimony?

MS. OLGUIN:

I do have six more copies just in case.

MS. BOLTON:

We have one.

MR. COX:

Thank you.

MS. BOLTON:

Just let us have copies. We would appreciate it.

MS. OLGUIN:

Sure.

MS. BOLTON:

Thank you.

MS. OLGUIN:

Good morning. My name is Michelle Olguin. I'm a registered nurse at the West Los Angeles Veterans Hospital. I want to first thank the National Commission of V.A. Nursing for allowing me to speak on behalf of my fellow nurses and myself. Although I have many concerns regarding our V.A. nurses, I would like to take this opportunity to address one, how can trust be better established and maintained between nursing staff and

administration, how the V.A. can better support nursing staff education and training, how can nursing administration better support staff in obtaining additional education training focusing on the NNEI which is the National Nursing Educational Initiative in the retention of our current V.A. nurses. I'm a recent BSN degreed nurse as of October 2002, and in December 2002 I received my Public Health Certificate from the California Board of Registered Nurses. I have worked at the Veterans Hospital in West Los Angeles for almost 10 years as a diploma nurse. I initially hired at the Veterans Hospital as a Nurse II. I have over 25 years' experience as a registered nurse. I'm certified by the American Nurses Credentialing Center as a psychiatric and mental health nurse in addition to being a graduate of the Army Nurse Corps Officer's Academy which I served as first lieutenant eight years in the Army Nurse Reserve Corps. I'm currently working in the mental health client as an RN case manager. Although I'm grateful for having the opportunity to return to school through the National Education Initiative, I feel that there are serious concerns that need to be addressed. After reviewing the NNEI VHA handbook, which I was only recently able to obtain, I would like to make recommendations that would help other RNs trying to obtain their BSN without the struggles I had to endure while pursuing my BSN degree. Statement from Secretary of Veterans Affairs, Anthony J. Principi addressing the nurse shortage. "VA nurses are essential to maintaining the high quality care veterans receive through the V.A. Through a systemwide multidisciplinary approach to healthcare, we are addressing the need to keep valued nurses and add new ones to your clinics, hospitals and medical centers. "The NNEI helps V.A. registered nurses expand their formal education. The program prepares nurses for a new and evolving role as a V.A. continue to transform from a hospital base to one that focuses on primary care management and outpatient home and community settings. VAs Educational Department program is a tuition reimbursement program in which the V.A. will help pay for nurse schooling up to a total of \$44,000." This is to include tuition books and supplies. According to the NNEI VHA Handbook 1020.2 "The primary intent of an NNEI is to award scholarships for completion of BSN degrees or advanced degrees in nursing or related field. Exploring the potential for enhancing the flexibility to provide innovative educational assistance to the V.A. nurses." The facility responsibility. According to the NNEI the facility of your place of employment is responsible for identifying accessible, reasonably priced education and training programs to meet local requirements. During the initial phase of selecting a school to complete my BSN, the veterans hospital where I'm employed through their educational department had several different BSN nursing programs come to meet with the V.A. nurses. We were able to sit down and talk to the different nursing program advisors and discuss their particular curriculum. After reviewing each of the nursing schools that the V.A. educational department had invited, I decided that the University of

Phoenix in Woodland Hills would be the most appropriate to meet my profession and personal needs. The University of Phoenix was willing to hold classes on my day off which wouldn't interfere with my V.A. job responsibilities. I was never at any time informed that the V.A. would pay only a selected amount of monies per unit course and the fact that I would be personally responsible to pay thousands of dollars that I had to borrow to complete this nursing program. I feel that nurses should be given the opportunity to make the decision if they were financially prepared to extend this money before starting. Some of our nurses due to their financial situations were unable to meet the financial obligations the university demanded were sent to collections and were unable to continue to pursue the BSN degree. I met only twice with a V.A. educational advisor, and that was only to turn in my NNEI application before starting the BSN nursing program and two years later when I completed the program. I was forced to use my accrued annual leave in order to satisfy the majority of the nursing clinical hours required to complete the BSN. I was not able to complete these nursing clinical hours during my off hours at work due to the fact that I work in an outpatient clinic Monday through Friday from 8:00 a.m. to 4:30 p.m. The majority of my clinical needs out in the community had to be done during weekdays, when community, public, and private health facilities were open. After completing the BSN program and receiving my BSN degree and receiving a public health certificate by the California board of Registered nursing, I was informed that I was not eligible for any kind of promotion or step increase. I know that there have been other V.A. nurses that were recognized and awarded for their educational achievements. When my outstanding performance evaluation, BSN degree and Public Health Certificate was submitted to the Nurse Professional Standards Boards, I was denied any kind of promotion or step increase although my nurse leader had submitted a special advancement for achievement, SAA, I was initially informed by the Nurses Standards Professional Board that this request from my nurse leader in addition to a copy of my Public Health Certificate was never given to the Nurse Professional Standards Board. I was instructed to submit a copy of the SAA recommendation from my nurse leader. A few days later I received a phone call from the Nurse Standards Professional Board, and I was told I did not need to resubmit these items. I was informed that my public health certificate and recommendation from SSA was given to the ambulatory nurse administrator who happens to be the chairperson of the NSPB. I was also informed that the request my nurse leader wrote for special advancement had been written incorrectly, and that was the reason that it was never submitted to the NPSB. In essence the NPSB was never given the complete packet for special advancement consideration. According to the Nurse Practitioner Standard Board, June 2001, the Nurse Standard Board and alternate chairperson are responsible for assuring the official personal folders are complete for

board review and for convening and conducting board and reviewing board actions and employees letters. In essence I was informed not to bother to submit any recommendation because the board does not recognize receiving a degree as an achievement—for special advancement for achievement. Therefore, I'm convinced that there are double standards being practiced at West L.A. Veterans Hospital. The NSPB is only one of many faulty processes that are practiced at West L.A. hospital that affect our nurses and that will continue to affect the retention of good nurses. I respectfully submit this letter in hopes that other nurses will be given all the information needed to determine if they wish to pursue a BSN degree or higher degree to NNEI. NSPB members should be replaced every two years in order that other nurses are given the opportunity to participate. Currently practice at the NPSB is a faulty and unfair means in promoting or giving well-deserved step increases to our dedicated nurses. The West Los Angeles Veterans Hospital is willing to spend thousands of dollars to hire traveling nurses to fill the shortages we are currently experiencing but unwilling to acknowledge and reward the attributes of the dedicated and hard working V.A. nurses we currently have who are serving and caring for our veterans with respect, dignity, and the compassion as they well deserve. All nursing committees should be composed of the nurses who work directly in that particular nursing specialty to determine the needs of our veterans and the nurses that provide their care. Thank you.

MS. BOLTON:

Thank you. Dr. Janet Rogers. We don't have copies of your testimony.

MS. ROGERS:

You don't? Well, I have one that's all marked up. Can I have someone fax them to you today?

MS. MOORER:

Yes.

MS. ROGERS:

Thank you. Good morning. My name is Janet Rogers, and I'm a past president of the American Association of Colleges of Nursing newly retired as a nursing educator. I am now chair of the Board of Trustees of ScrippsHealth in San Diego. I'm here to offer testimony for the American Association of Colleges of Nursing. The American Association of Colleges of Nursing is the national voice of baccalaureate and graduate

nursing education representing more than 570 senior colleges and universities that educate over 150,000 students each year and employ a 900 nursing faculty. AACN member schools work in collaboration with the VHA to provide the necessary education to develop the VHA nursing workforce. VHA employees are attending 300 different educational institutions at almost 400 locations throughout the United States. Many nursing education programs are offered on-site at VHA facilities, and many of these facilities provide clinical placement opportunities essential to educating new nurses and assisting the transition from academia to clinical settings. The Veterans Health Administration is a recognized leader in adopting the best practices and setting the standard for quality healthcare in the United States. The administration's commitment to improving patient care and reducing medical errors serves a model for other healthcare providers to follow. As the nation's largest healthcare system with almost 36,000 registered nurses, the VHA is the nation's single largest employer of RNs and as such plays a lead role in setting the professional standards for nursing practice. The VHA has a commitment to provide the best possible care to our nation's veterans that extends to preparing a well-educated nurse force. VHA employs nurses in roles consistent with their education preparation and provides them with the education necessary to develop new clinical skills and move forward in their nursing careers. The nurse qualifications standards creates a 15 framework of appointment and advancement of RNs based on education and practice requirements within the veterans healthcare system. They established the baccalaureate degree as a level of educational preparation the V.A. registered nurses must have to move beyond that point. Secondly, the VHA provides significant financial support for academic achievement through the National Nursing Education Initiation, NNEI. This program ensures that the VHA workforce can meet the challenges of an intense complex and changing work environment. The VHA recognizes that a highly educated nursing workforce is good for patient care. The administration understands the role education plays in enhancing patient safety and managing an increasingly complex system of care. Already the standard for nursing practice in the military a bachelor's degree is essential to assume the educational preparation for nurses is commensurate with other health disciplines. The additional education provided by a BSN enhances clinical decision-making and critical thinking skills and includes preparation in community health, patient education and nursing management and leadership. I would like to just take a minute to personally comment on two things that I'm particularly interested in, and one is the career ladder, and the other is ethnic diversity. I have worked in six educational institutions either as a faculty member or as an administrator and in all of them we had tracks for registered nurses who would like to come back to pursue degrees. My most recent assignment for 15 years at the School of Nursing in Health Science at the University

of San Diego, a school that was established in 1974 with an endowment specifically for RN students to come back and get a bachelor's degree. They felt that in the San Diego area there was not adequate opportunity. Since that time of the bachelor's we have turned out master's students, postmaster's and Ph.D. students. We used to, up until last year when we started a new program master entry level for second career students, be the only nursing school in the United States that exclusively offered education to RNs for baccalaureate, master's and doctoral preparation. The other comment I wanted to make has to do with the fact of our increasing interest and concerns and efforts toward diversifying our student body. Currently the USD program has 32 percent ethnic diversity in its program, and interestingly enough every year the university awards a career achievement award to one member of each of the five schools at the university who they think deserve an outstanding award. This year the nursing school is awarding Captain Sandra Bib who is the research coordinator and director of the Southwest Clinical Region Population Office at the Navy Hospital Corporation in the Naval Hospital in Camp Pendleton. Sandra is a black woman who came to us from the South who got her BSN at USD. She then progressed and got her MSN, and then she got her doctorate of nursing science. We are very proud of the fact of wanting to help our students prepare themselves to meet the much more complex health system that we have now, and we at AACN applaud your efforts and join you in working together for creating a workforce with the goal of providing the best patient care to the nation's veterans.

MS. BOLTON:

Thank you, Doctor. In the San Diego area the model that has been put in the literature about the combinations of using both the service facilities in the V.A. and the education facilities together to try to promote the number of individuals who return back to obtain a bachelor's degree, can you tell us a little bit more about that.

MS. ROGERS:

I'm not sure whether you're implying by the question the latest Nurses Now project which has to do with more nurses, yes. One of the things that we have done in San Diego is although we're competitive in many ways the community really works together for needs and the lead school that took advantage was San Diego State University, and they started what is a Nurses Now program. They said the state won't give us any more money to prepare nurses. We don't have faculty to do it. We have to provide additional clinical placements, and so the communities said okay, we'll help. And I think there is now seven different hospitals who each contribute for a period of three years, and I think it's \$3,000 a year. They guarantee San Diego State that amount of money for a clinical

instructor. The Nurses Now program is graduating its first class this May. Other examples exist in San Diego between other hospitals and associate degree programs and others in terms of how can clinical agencies who desperately need nurses and schools who want to turn out nurses but need the money for faculty and clinical facilities, et cetera, work together.

MS. BOLTON:

Thank you. Jeffrey Slack—Sladek.

MR. SLADEK:

Sladek. Good morning. My name is Jeff Sladek, and I work at the Tucson Veterans Administration hospital.

MS. BOLTON:

Mr. Sladek, I'm afraid that we can't hear you.

MR. SLADEK:

Does that sound better? I work at the Tucson Veterans Administration and hospital, and I've worked there for the past 18 years as a staff nurse. I currently work in the utilization review department and also provide emergency hemodialysis service. This is my testimony. Staff nurses at Tucson V.A. have little to no input into the way nursing is practiced at the patient care level. The main hindrance to nurses participating in the decision-making process is that the staff nurse is so occupied with the patient needs at hand that there is not any time to get away from direct patient care responsibilities and participate in the decision process. The end result of nonparticipation in the nursing decision process is that those administrators that are not directly involved in patient care decide by default how care will be delivered and documented. It has been my experience that when you do not include those who do the work in the decision process that you do not arrive at the best conclusion on how to get the work done. In contrast when there is adequate staffing available, the staff is well rested and able to improve the quality of the work they perform. When there is adequate staffing, there is increased patient satisfaction. The nurses can take the time to educate themselves to stay up to date on current practices and research as well as participate in the nursing decision process, you will have a professional staff that will deliver excellent care. Nursing is a profession, and all professionals need the time to participate in professional activities. The key to quality care, patient satisfaction and the development of a satisfied professional staff is adequate staffing. Nurses clearly understand what administrators have yet to endorse. There is a clear link between nurse-patient staffing ratios

and patient outcomes. Research conducted by Linda Atkin and Julie Sokowlsky, advisors to this commission, found that each additional patient over four in a RN's workload the risk of death increases by 7 percent for surgical patients. At the Tucson facility RNs in the medical-surgical unit are responsible for up to ten, not four patients. Veterans, and the nurses who care for them, deserve better. I am deeply concerned that the V.A. staffing is not consistent with community standards and are placing veterans at a greater risk of dying. I know that when we are forced to care for too many patients, we do not have adequate time to provide each veteran with high quality and compassionate care. Private hospitals and nurses who work at those hospitals will soon learn how much time it takes to administer medications using the BCMA system that FDA has mandated that we use. The new technology is constantly intruding in the nurses's daily work life saves lives, but it does not save time. Perhaps one of the hardest truths for nurses to learn is the nursing time requirements due to technology and increased documentation requirements has spawned the need to lower patient-staff ratios. We need to change Section 7422 of Title 38 to give the secretaries the flexibility to empower V.A. staff and bedside nurses to have greater decision-making roles regarding staffing levels. This flexibility is inconsistent with current federal management rights. The V.A. nurses want a real say when the V.A. management sets staffing rights. The staff nurses and the veterans we care for are the ones who must live with the staffing ratios, and they should be able to make those final decisions that so affect our nursing practice. If the V.A. is going to recruit and retain nurses, the V.A. must evaluate nurses based on their job performance first and based on their education second. General Tom Franks who commands the Allied forces in Iraq is a college dropout. In the V.A. system he would not be allowed to be a clinical nurse manager. Those clinical nurses who specialize in med surgery and critical care find it very difficult to advance in the promotional system that evaluates performance in nine general areas. There needs to be a clinical track for advancements. Currently the promotional system favors those in administration and restricts those in clinical areas to Level I and II nurses. As a member of the Professional Standards Board I can tell you the nine dimensional yardsticks used for advancement is subjectively administered with good intention but has inconsistent outcomes. As an example of this inconsistency is when the board demands documentation for each minuscule area of each of the nine dimensions and disregards the clinical nurse manager's evaluation dimensions and accomplishments because the proficiency lacks specific examples. I believe this process frustrates clinical managers. I know this process frustrates the nursing staff who find it difficult to adequately document for the board what they know they are doing every day. We all know that to be an RN you have to take the State Board of Nursing Exam. You may have seen the statistics that show the passing rates for BSN and ADN-prepared nurses is exactly the

same. If the 50 great states in the United States of American do not have a multi-tier exam for different educational levels, then why does the V.A. find it necessary to require different educational levels to achieve advancement. I know General Tommy Franks doesn't believe that, and I know the V.A. nursing staff doesn't believe it either. Someone answered by saying that you can always get an educational waiver and advance. Tell that to those that are on a three-year proficiency board review and marked ineligible for advancements. I suggest that we abolish the educational requirements and evaluate nurses based on their performance. When you institutionalize the educational requirement for advancement beyond the entry level, you take the easy way out to deny advancements based on a nurse's educational level alone. Once an RN passes the exam and is licensed, they begin their real professional education in the practice of nursing. Patients don't always have textbook illnesses or responses to treatment. Clinical judgment, the most important critical skill for nurses, does not come with any nursing degree but is honed with years of keen observation and bedside practice and mentoring from more experienced nurses. In the arena of evaluating an employee's performance many progressive companies now look at the emotional quotient as the key indicator of how capable and valuable an employee is to the employer. Present companies have learned education is not the end all indicator for predicting or evaluating success. Our patients care about our actual nursing practice and our clinical judgment. They do not care whether we came by that experience from bedside learning or through an associate degree program or a baccalaureate program. They do care about the care they receive. They care there's sufficient staff to ensure a positive outcome to their healthcare experience. I urge the commission to recommend the V.A. refocus its priorities for promoting us. We should be evaluated on an individual nursing performance on our bedside or nurses experience, professional, clinical practices, not only on educational credentials. In order to recruit and retain nursing staff the V.A. must do the following: Provide a staffing mix of nurse-patient ratios consistent with the community. Some patients are very aware of community staffing standards, and the V.A. must compete with the community in order to recruit and retain nurses. Nurses equate adequate staffing as a key ingredient necessary to provide the appropriate and safe care for their patients. Nurses that are satisfied with their ability to provide appropriate care on more likely to be retained. The community has come up with creative ways of recruiting and retaining nurses. One such method is to pay full-time benefits and wages for a 72-hour pay period. Additional incentives include cash bonuses for agreeing to work overtime or run unscheduled shifts, time off rewards, paid educational experience and charge nurse pay. It is clear the V.A. must be surveillant as to what the community is offering and meet current trends and incentives or risk falling behind in recruitment retention. The future for nurses training for a primary nursing model the V.A. currently

has staff facilities and a team approach. A decision will have to be made whether to shift to a primary care delivery model or stay with the team approach. The V.A. must remain vigilant and prepared to change in order to meet the challenges facing the healthcare systems in order to ensure and to continue to provide excellent care to the veteran patient. Of that there is little doubt. More important the V.A. must change its promotional practices, staffing patterns and provide incentives that match community hospitals and do it now.

MS. BOLTON:

Thank you.

MR. COX:

One thing before I ask a question. Ms. Moorer was bringing to my attention. Your oral statement was a little bit different from your written statement and if we can get a copy of the oral statement, that would certainly help us with the transcript. With your recommendation of staffing ratios for a better term to use, you're saying to develop those in relationship with what they are in the community or a nationwide standard or what?

MR. SLADEK:

Well, I'd like to see a nationwide standard adopted that was set in California. I think that given the technology and the requirements of nursing today that's almost a necessity if you are going to provide safe care at the bedside.

MS. BOLTON:

How would you adjust for the divisions in the United States Public Health Service in term of division of nursing as well as other research studies of the regional variations in demands for care when you suggest a national ratio model?

MR. SLADEK:

Well, if what you're asking me are there different acuity levels in different needs based on geographic areas?

MS. BOLTON:

The United States Health Service has validated that in terms of demand that means how much nursing care is required. There are regional

variations, regional, in the United States currently. So if it were a national standard, how would you address it in the state of California?

MR. SLADEK:

Right.

MS. BOLTON:

The data from the state of California is different from the data in the states of Louisiana or Montana.

MR. SLADEK:

Well, I can only speak as a nurse. I'm not familiar with what you're bringing to my attention, but I can tell you that in the state of Arizona we have a four-to-one ratio, and I believe in the state of California a four-to-one ratio is appropriate. I don't know what is happening in Louisiana.

MS. BOLTON:

That was to your recommendation that we adopt a national standard.

MR. SLADEK:

Right. I can tell you that I looked at recent Journal of American Medical Association articles talking about the need for four-to-one ratios. I mean JAMA seems to be—

MS. BOLTON:

I'm quite familiar with that research. In relationship to your issues in terms of the education, your recommendations are similar to the other individuals we have heard today relative to removing education as a part of the profession; is that correct?

MR. SLADEK:

Yes, that's correct.

MR. COX:

I want to ask a little further on that. You said to remove educational requirements. Are you saying for the whole gamut of the process or the first couple of levels or what are you saying?

MR. SLADEK:

Well, nursing already has a requirement that is a state licensure. I think after that it's a matter of job performance. Obviously a nurse practitioner is set by the state also. If the state is already setting a concern with the welfare of patients and sets the standard of healthcare based on educational levels, why would the V.A. hold you to a higher standard is my question. I think that is sufficient, and that addresses the needs of the patient.

MR. COX:

Thank you.

MS. BOLTON:

Are you familiar with the research in terms of after the initial education, whether at the two-year or after the four-year program that indeed education affects performance, similar to Dr. Marge Sony's work.

MR. SLADEK:

I'm not familiar with her work, but I have seen other studies that there is no difference.

MS. BOLTON:

I think I want to clarify when you were speaking to the audience of the difference between entry level and initial clinical performance and performance at another level beyond initial competence. Usually competence is defined as that practice within the first two years of graduation regardless of what type of program you have.

MR. SLADEK:

Sure. As I say, I've read other studies that show that the difference between an ADN-and BSN-prepared nurse beyond the two-year period is negligible.

MS. BOLTON:

So the audience will know, we are going to address the issue of differentiating practice, and because it is—there is further research that has been done, not so much the initial entry level, as I said, and that's true of all clinicians, okay, whether they be pharmacists, physicians or whatever in terms of that. Thank you. Vilma Divinagracia.

MS. DIVINAGRACIA:

Good morning. My name is Vilma Divinagracia. I am bringing forward to you my issues from the following standpoints. As a registered nurse who completed her Bachelor of Science in nursing degree in the Philippines and as a past member of the Nurse II and Nurse III Professionals Standards Boards in San Diego V.A. and as current chair of the V.A. San Diego Asian Pacific Island committee which is one of the special emphasis programs of the EEO. It is a known practice for the V.A. to hire foreign-educated RNs with a BSN degree obtained from the Philippines. This is something that is known at the time the foreign grad RN applies for a job in the V.A. at the time of hiring and the time of boarding. These foreign-educated nurses like myself had no problems having the foreign school transcripts evaluated by the State Board of Registered Nursing or other state boards to take state board RN licensing examinations. Nursing curricula in the Philippines are often designed after those of the nursing curricula in the U.S. and thus meet the same academic and clinical requirements as required by the state BRNs for RN licensing examination applications. To decide promotions the NPSB, however, does make a distinction if an RN graduated from a BSN program accredited by the Commission on Collegiate Nursing Education or the CCNE. This is the part where I think there is a double standard as far as the promotion process is concerned. This has proved to be a very discouraging factor for many foreign-graduated RNs who aspire for promotion. The fact that the CCNE standards do not extend outside the United States makes it a nonapplicable measure of the qualifications and educational background of a foreign-educated RN. In the January 12, 2003 V.A. handbook addressed the nurse qualification standards. The CCNE requirement was replaced with a requirement of passing the CGFNS and TOEFL exams, that V.A. had to define the CGFNS certification program as follows: Designed to predict an applicant's likelihood of passing the NCLEX-RN examination. As such it does not logically serve its purpose as far as it concerns nurses with a BSN degree from a foreign nursing school who have already successfully passed the NCLEX-RN examination in the United States. Furthermore, the CGFNS examination was designed for nurses in foreign countries who aspire for employment in the United States. To attain a working visa and be allowed to enter the U.S., the INS requires that foreign nurses pass the

CGFNS while they are still in their native country. This way the INS and hospital sponsor are able to predict that the nurse will successfully pass the NCLEX-RN exam and could thus be appropriately and successfully employed in the United States. And on the other hand the CGFNS is not required by many states, especially if the foreign nurse graduate is a U.S. immigrant or a U.S. citizen. Although I have heard these general guidelines are going to be revised, as of this date I have not heard any specifics as to what the changes will be or when they're going to take effect; hence, my decision to bring out my opinions and recommendations at this time anyway with a hope that it might make a positive difference in the decision process if the change process is still in the making. The CGFNS requirement also requires the BSN graduates of the foreign nursing school to demonstrate proficiency in the English language by the test of English as a foreign language or the TOEFL. The TOEFL like the CGFNS is part of the requirements for a working visa to the United States. It was designed to gauge English proficiency of nurses or other foreign workers prior to their immigration and working in the U.S. In addition even for foreign graduate RNs I believe that the TOEFL is not a logical measure of English proficiency for college graduates who have completed their entire education from elementary to their BSN with English as the medium of instruction. Per EEO testing of employees for English proficiency by way of an examination or whatever measure should be done for all groups of employees rather than for just one group in order not to be discriminatory. Thus testing foreign graduates separately for English proficiency via the TOEFL is not a fair measure of English proficiency from the EEO standpoint. For the record being a citizen of the United States or a graduate of a school in the United States does not automatically ensure English proficiency. As co-editor of the V.A. San Diego hospital-wide nursing newsletter as a member of several interdisciplinary hospital committees and as a clinical nurse specialist, my roles and functions have given me several opportunities to edit the poor writing styles of many employees who are neither graduates of foreign schools or naturalized citizens. I am suggesting that having graduated from a CCNE-accredited nursing school should not be made a major factor in NPSB decisions for promotions with a BSN degree from a foreign nursing school. The CCNE requirement should be replaced with more measurable RN proficiency dimension requirements and examples in order to achieve promotion. The CGFNS certificate is not a logical substitute or supplement for the CCNE requirement for promotion. Again I am suggesting that promotion for RNs be primarily based on successfully meeting the nine dimensions of nursing practice. Certainly unfair promotion criteria would deter applicants. In this period of nursing shortage, I don't think hospitals, including the V.A., can afford to exclude highly qualified RN applicants simply because they graduated outside the United States. Unless the V.A. changes its hiring policy so that it no longer hires graduates of foreign nursing schools or makes it clear on

hiring that they cannot be promoted to Nurse II, I would have to say that foreign graduate BSN degree holders who have been previously hired should be evaluated for promotion based on the nine RN proficiency dimensions. Again I would like to stress that this is not an easy way out nor is it seeking preferential treatment for the foreign graduate since the reality is regardless where the nurse graduated from, meeting all nine dimensions for promotion is not an easy task for any V.A. nurse. To test for English proficiency I would suggest the more logical measures: Gauge oral proficiency in English as early as during the different levels of job interviews when the RN first applies for a job in the V.A. Gauge written proficiency in English of the RN applicant through the resume and narrative submitted with the application packet which already addresses the nine dimensions of RN proficiency. Gauge written proficiency in English through the V.A. RN's documentation of patient care and other patient encounters, i.e. progress notes and other patient care records; correct interpretation of doctors' orders and other patient care records through committee reports, written projects, et cetera, during the course of employment. Gauge oral proficiency in English through interactions with patients, families and members of the healthcare team in the course of the patient care and other committee activities. The requirement of the nine RN proficiency dimensions provide abundant opportunities to demonstrate and prove English proficiency as well as proficiency of the nine dimensions. In the past I have completed a research study on job satisfaction. The study results showed that what makes nurses have job satisfaction and resulting positive work performance is not material considerations like pay raises but rather factors like recognition and support from management. I believe that factors like this are what attract and retain a quality workforce. I can proudly say that many foreign-educated RNs did not complete the nursing education in the United States although they are perfectly able to compete and even surpass their U.S. educated RN counterparts. I am addressing this issue to all of you to provide me and other foreign-educated V.A. RNs concerned with answers. I am hoping that this new concern be addressed positively. If I need to address any service or department of the V.A. regarding this, please advise me accordingly. Thank you very much for actively soliciting our feedback in order that you can promulgate and implement logical, rightful, politically correct and nondiscriminatory changes in V.A. practices.

MS. BOLTON:

Thank you. You made a distinction of foreign graduates of nursing schools by country, and in terms of the Philippines, for example, it's recognized by other states, other hospitals systems as being equivalent to the United States but not all countries' educational programs are recognized as equivalent to the United States.

MS. DIVINAGRACIA:

That I'm not aware of but, as far as, you know, as far as what I was refer the V.A. handbook which just came out in January 2003, they did say, you know, to some RNs who they thought would otherwise have already met some of the nine dimensions, they said take the CGFNS because this will be substituted as CCNE requirements. So, you know, as far as we're concerned those were not—it does not pose an advantage just because we graduate from the Philippines.

MS. BOLTON:

Well, I'm trying to get it clear and so that we can clarify this for the record in terms of your recommendations. In your previous testimony you have recommended removing education from promotional board requirement. You're not recommending that. Are you recommending recognizing education and a Bachelor of Science degree from any graduate of a foreign school?

MS. DIVINAGRACIA:

I am not fully aware of removing education altogether as a requirement. As for advancement, like I said before I completed my testimony, members of the NPSB said there were going to be some changes, but there was no document provided as to the specifics. As far as the BSN requirement although some of the others who have testified have tried to establish there should not be any differences between an AD versus a BSN degree, I still believe there are advantages to have a BSN degree, and I believe as per my testimony if the nurses have a BSN degree in addition demonstrates meeting the nine dimensions they should advance like the other U.S. counterparts.

MS. BOLTON:

Okay. From any nursing school in the world?

MS. DIVINAGRACIA:

I cannot speak for the others. As a clinical nurse specialist, I also participate in hiring interviews, and recently we were having some applicants from Africa or some other country. And when we talked to her—you know, there were actually two of them, you know, and they didn't know each other, but they said our program was mainly maternal child. So we said this is not something that we could use in the V.A. They

said they graduated like midwives. So in that sense I would not think all foreign education would be equal.

MS. BOLTON:

Great. That's what I was trying to get at. Thank you very much. We now will start our open forum. During the open forum you've have three minutes to present. Each individual must have completed the document that I identified earlier and have turned those in to Stephanie. Okay. The first individual—we will go as long as to 12:00, and then we'll break at that time. The first individual is Vince Elliott.

MR. ELLIOTT:

My name is Vince Elliott. I'm a registered nurse, a clinical nurse specialist, and I work in the V.A. clinic in San Jose specializing in working with seniors with mental health problems. I'm a front line provider working directly with patients, and my clinic is part of the V.A. Palo Alto healthcare system. I'm also currently the president of the Nova, the professional organization of registered nurses in the V.A. healthcare. There have been dramatic changes to V.A. healthcare during the past 10 years. I'm proud to say that nurses have played a critical role in the improvements that have been made to the U.S.'s largest healthcare system. Ten years ago we were tertiary-hospital oriented essentially driven. I don't think we were very customer-friendly and had probably mediocre quality at best. Now the paradigm has shifted dramatically, and I am proud to say V.A. is a leader in U.S. healthcare, and nurses have been an intimate part of these pages. Nursing staff is the foundation of any healthcare system. We are there for the patients every day, all day. We make or break a healthcare system. V.A. nurses I'm proud to say are making VHA a national leader. I have one big worry, and that's VHA's budget. It is clear money drives quality healthcare. Without an adequate budget, we won't have the very competitive salaries to recruit and retain the brightest and the best registered nurses or be able to buy excellent technology to support them. Also if we don't have an adequate budget, we will end up rationing healthcare from through some mechanism, for example, through long appointment times, and that's actually what is happening with my patients. When the national commission writes its report, I hope you will include all the wonderful things happening in V.A. healthcare and how much nurses are a part of that. Thank you.

MS. BOLTON:

Thank you. Bernice Whittaker.

MS. WHITTAKER:

Good morning. My name is Bernice Whittaker, and I'm a BSN RN working in the acute psychiatric unit at the Tucson V.A. The V.A. system must be competitive with the private sector. Significant changes need to be initiated to recruit and retain RNs, LPNs and CNSs. In the private sector in Tucson nurses have a greater input related to how nursing functions. Nursing operates with greater autonomy as a healthcare profession. At the V.A. nurses have little or no control over the decisions that directly relate to nursing practice and the delivery of patient care including the important areas of staffing and safe patient care. Nursing input is rarely solicited or valued in the clinical decision-making process there. Decisions regarding nursing practice are made by people with no real idea of what nursing does or even worse administrators who have forgotten what nursing really does. For example, nurses there are unable to perform simple tasks like amending a diet order or changing a patient to allow them to eat in a cafeteria without a doctor's order even though those are part of a hospital policy. Nurses are being asked to sacrifice safety for efficiency. They're being timed when taking medicine from the Pixis, which is the system where they actually scan it on the bar code, which is the medication administration system. And while nursing technically is part of the interdisciplinary team approach as advocated by the V.A., rarely is their professional judgment requested or taken. Nurses that are on the front line are in the best position to identify needed changes and care of our veterans as it relates to the nursing profession, not just administrators far removed from the realities of day-to-day patient care. Many of these decisions are made with little regard to the safety of the veterans or nurses. Our opinions are not valued, and we see patients that have died as a result of policies established by other professionals. Frustration and burnout are common outcomes. Nurses leave the V.A. for positions where they are respected and valued as professionals or many simply leave nursing altogether. The V.A. has disempowered nursing by denying them the ability to function as the professional group they are and by not allowing them a voice in how their profession operates. Nurses must have an active, equal voice in the decision-making process. Policies related to nurses must be made by nurses. In summary if the V.A. healthcare system truly desired to recruit and retain nurses, they must begin to treat them as the valued professional they are, and I want to thank you for the opportunity to speak.

MS. BOLTON:

Thank you. Tom Vaggdes.

MR. VAGGDES:

Pardon me, please. Good morning. My voice is low, and so I'll face the reporter. My name is Tom Vaggdes. I'm an RN providing informatics support for CPRS and BCMA at the Southern Arizona V.A. healthcare system in Tucson. I will speak regarding electronic records. I appreciate this opportunity by the way. My experience in V.A. indicates an overall negative impact on nursing and nurses of electronic records. The V.A. continues to widen their scope of these records by mandate and performance measure. The demands placed on nursing have been remarkable. These records are tools, and they capture the workload while they document patient care. CPRS and BCMA are obvious records, and there are others, many others. Currently in my view the tools are too often guiding the nursing process, and the nurses do not. Together these suggest that the model of practice, not just the practice itself, is pressured to change. The V.A. I believe recognizes that, but it is a \$67 billion enterprise as we know, and with the time lines it's under pressure to change as well. Capturing workload documenting the quality care is driven by healthcare economics, aging veterans with multiplying diagnoses and complex treatments need for nurses with broader knowledge bases and skills and the V.A. adapting unevenly to all of it. In this context the nurses have less and less value at the V.A. It's a complicated context. This negative association supported by the finding of Dr. Alderson in the planning group, it could contribute to crisis. This trend can be reversed, however, before irreversible damage is done in my view. Front-line nurses can sit at a table in retrospective review of the impact of electronic expansion as it continues. Basically their job then is to participate in the process, and management's job is to provide support and coverage for those nurses who are front line nurses not doing their tasks in their day, but actually weighing the process of basically evaluating the expansion of these records and the impacts they have on nursing. Second, the trust can be reestablished because there is no trust. Thank you.

MS. BOLTON:

So you can speak to the commission and so the recorder can hear you, please speak directly into the microphone. It might help if you bring the mike forward. If you notice, I have mine angled down so that I'm speaking always directly into it. Okay. We would like to hear your testimony.

MR. COX:

And I would add to that that three minutes is a very short period of time, and so if there is more information that you want the commission to have,

you can certainly e-mail it to the commission at the e-mail address, and every ounce of data that comes in is given full weight. And I'm sure some of your colleagues may be saying I didn't get chosen or I didn't get to go long, but those written testimonies are still looked at and given careful consideration with what has been put into them.

MS. BOLTON:

Bonnie Pierce.

MS. PIERCE:

My name is Bonnie Pierce, and I'm the assistant chief for nursing service for geriatrics and rehabilitative care at the greater Los Angeles V.A. healthcare system. Do I still have time to speak? Trust is a very important issue, and in our agency we have some problems with that. Staff don't trust that they will be supported by administration when serious conflicts arise. Administration has difficulty maintaining consistent practice and boundaries because they are pressured by Congress. Thus manipulation is frequently used to excess to serve the interest of individuals at the expense of the organization. This environment undermines the ability of the agency to establish and maintain the ground rules essential to building trust. Politically expediency is weighted at least equally with financial, clinical and ethical considerations. We recommend that the pervasive influence of political power be reduced as an essential element of creating an environment in which leaders can make unpopular, yet principal centered decisions that are in the best interests of patients, staffs and the agency. Additionally I would like to speak to ways that we can attract and retain a quality workforce. The V.A. does some great things. We have brilliant systems that are cutting edge. Yes, we've got kinks to work out, but we don't do a good job of packaging and marketing ourselves well. We can learn from our sisters and brothers in the private industry about that, and we need to capitalize on them. We can also do a better job of offering refresher courses for nurses who want to reenter the workforce. I reiterate job sharing is important as is providing on-site daycare. How about providing a registry of baby-sitters? What about offering cash out of sick leave every year the first week of December? What about eliminating the mandatory hiring of certain nursing assistants. If the interview panel does not want to select a nursing assistant, then we should not be pressured to select them. I would like to reiterate that it's important that we overcome this stereotype that it's difficult to get hired for the government. Please make our hiring process more efficient. Maybe train staff to help provide one-stop shopping with hiring so that people don't have to—

MS. BOLTON:

Thank you very much. Daniel McTaggart. I need to repeat that we do need copies of these documents, okay, that you were supposed to submit to Stephanie.

MR. McTAGGART:

Good morning, ladies and gentlemen. My name is Darrell McTaggart. I'm a nurse at the V.A. nursing home in Pueblo, Colorado, and what I would like to talk about today is the closure of hospitals and other facilities. I work at Fort Lyon V.A. Hospital which was closed down a year ago and at that time a 40-bed nursing facility was built in Pueblo, Colorado. We were transferred from Fort Lyon to Pueblo and moved from a rural setting to a larger setting, larger city setting, and at that time the cost of living for our people increased dramatically. Now we have integrated with Denver, and although our cost of living has increased, our wages have not. And also our cost of living has not—allowances have not increased to that of Denver. I was wondering if there was not some way that you can make a recommendation to the powers that be that there would be a better way to look at when a transfer of function occurs that the people that are transferred would be given the higher cost of living area allowance, and that way it would make the people that are being transferred not feel as though they are lower class and that they would also be able to move to a larger city instead of staying in a rural area. And it's a lot better for the people. It's a lot better for the V.A., and it's something that needs to be addressed, and I don't think anybody has even thought about this because Fort Lyon is the only facility that's been closed down within the V.A. that I know of, and if you could take time to think about what these people feel when they're forced with closure and having to move someplace else, I would appreciate it. Thank you.

MS. BOLTON:

Thank you. Michael Rains.

MR. RAINS:

Good morning. My name is Michael Rains, and I'm an RN with the Eastern Colorado healthcare system outpatient clinic. My statement concerns the current shortage in nursing and other medical professionals and how that affects access to care, patient safety and the quality of care. Even though official waiting lists don't exist, we currently have about 1,800 veterans waiting to get into our clinic. This is due to budget shortfalls and the inability of the V.A. to pay wages that are comparable to

outside facilities. If the V.A. expects to be the employer of choice, they must raise the range of nurses and other medical professionals to a comparable level of that of competing facilities both to attract new nurses and to be able to retrain nurses with experience. The bottom line is that if the V.A. wants nurses and they need nurses, then they need to pay them. Thank you.

MS. BOLTON:

Gregg Gordon.

MR. GORDON:

Good morning. My name is Gregg Gordon. I'm a master's-prepared nurse in the area of clinical informatics at the Phoenix V.A. Medical Center. Everybody that has computer problems comes to me. I'm the liaison. I also have a different hat. I'm a service connected disabled veteran, and I'm coming here in that perspective today as well as a registered nurse. Veterans like myself are concerned that there will not be enough registered nurses available to take care of us when we are in times of need. That includes today and more so in the future. Currently the average age of a V.A. nurse is 46 years old. The national average for nurses is 45.2. Fewer people are choosing the honorable profession of nursing as a career. This means that the V.A. is really going to have to be competing with the private sector in order to attract and retain nurses to provide care for veterans. Losses of jobs coupled with reductions in healthcare benefits are driving more veterans to seek their healthcare from the VHA. With our recent soiree into Iraq, we will have new veterans with injuries and special needs that will require care from the VHA in the future. The VHA needs to be aggressive in recruiting new registered nurses and retaining many current RNs with experience without losing them to a different career field. There are many things I've listened to people talking about, and I'm going to offer some suggestions instead of continuing going on with repeating other things. One of the things I see the V.A. needs to do is have permanent shifts set up. We still have the day shift nurses that are required to rotate into the evening or night shifts to cover people on vacation or sick leave, and this is not so in the private sector. Patient-nurse ratios need to be deleted in another areas besides the intensive area. Currently you might find one RN taking care of up to 15 patients with assistance from either an LPT or a nursing assistant. Other people talked about some of the different patient-ratio thing, so again this is a concern as a veteran. Change that are happening in hiring nurses, another thing that is involved all of us have a BSN to go to level—you might have a diplomaed nurse coming to work in the V.A., and they can't get paid for where they are at. Some are granted waivers so they can be hired in at Level II. The same process holds true for the progress

to Nurse III. You have to have a master's degree now. Now others have alluded to the fact that if you're a bedside nurse, like I have been most of the time you're—

MS. BOLTON:

Thank you. The last person for this morning will be Jamison Maverick Gabel. Those who did not turn in your testimony, we do need your testimony.

MR. GABEL:

My name is Jamison Gabel, and I'm from the West L.A. V.A. I'm an RN, and I work in mental health. I want to speak about education and training, specifically the NNEI. I'm an AA nurse. I was going to school for the BSN under the NNEI, and I had a lot of trouble with this program as did my classmates. I was in a class of 13 students, 10 of them V.A. students who had qualified for the NNEI, and initially we were paid up front with a check to pay for the first year of the program. The second year was coming around, and we applied for the funding, which was in November, but we did not receive the funding until August. We were in an accelerated program which was full time. I had to pay \$1,200 every five weeks out of my own pocket from November to August waiting for the funding as well as my classmates did. I thought this was very inappropriate for the V.A. to get us into this program where halfway through it now all of a sudden we have to be paying for it out of our own pockets, and then we get letters from the V.A. saying "Warning, warning, warning you're in breach of contract," and I didn't finish going through the program. I'm two classes short of finishing which are electives. I finished the nursing part. And I'm sent "Warning, warning, warning. You're in breach of contract of this nursing program, that you're going to be in arrears, and you're going to be charged three times the cost of the program now." And I'm saying well, what about the breach of contract for the V.A.? Don't they have any breach here? I'm going to school, and I'm doing my part, but they're not giving me the funding. When I did get the funding, it was short of the amount that I needed as it was for my classmates. So I'm thinking how are they going to expect to retain nurses when we get this kind of treatment with our education, and they're the ones that asked us to go to school. So I'm here for myself and for my classmates hoping that maybe you guys can address this problem for us. Thank you.

MS. BOLTON:

Thank you. When we return at 1:30 we will begin—I will go back to those individuals that I called this morning to see if they have arrived, and that would be John Royce. If Mr. Royce is not in the audience, we will begin with Sarah Pullen. Thank you. We will return and begin at 1:30.

(Lunch recess.)

MS. BOLTON:

Are we ready to get back together? Good afternoon. We want to get started again. I notice that we have some individuals who joined us since this morning, so we will reintroduce ourselves. I'm Dr. Linda Burnes Bolton. I'm a member of the V.A. commission, and joining me is David Cox who's a member of the commission. Oyweda Moorer is the commission staff director, and Stephanie Williams is a staff analyst. And Sheryl Hilton Meyer is our recorder for today. We want to thank you for coming back, those of you coming back, and for those of you that just joined us, thank you. We will begin again and just remind you of our rules. When you come forward to the mike for those who are giving testimony, please introduce yourselves, your title, what facility or organization you are representing. You will have ten minutes to speak, and you will receive a three-minute warning in the form of a yellow card. David will hold it up, and when your time is complete, he will hold up a red card. Please stop speaking at that time. For those of you who wish to participate in the open forum, you must have completed the document that was outside about that testimony. Please submit it to Stephanie so that we will have a copy of it, and when you come up to present, please give your name, your title, your facility and what specific question you are addressing relative to the issues of retention and recruitment of nursing personnel. So with that I'm going to call out the name again to see if he has arrived. John Royce. John Royce. Okay. So we will begin with Sara Pullen. MS. PULLEN: Good afternoon. My name is Sara Pullen, and I'm RN case manager at the Anchorage V.A. outpatient clinic. I've been employed by the Anchorage V.A. for the last six years. I've been at my current position for two years, prior to that I was a surgical case manager in the outpatient clinic. I'm a diploma graduate with 27 years of experience, and I recently obtained my BSN in April of 2002. I'm also currently an online student in an MSN program through the NNEI with the V.A. Several of the topics that I was going to discuss this afternoon have already been covered, and they were covered very well. So I decided to address three issues that I felt were important as well this afternoon, some of the hiring practices at the Anchorage V.A., submissions regarding charge nurses that were expressed to me by many of our RN staff that have already been covered but with several other suggestions

and also to the education process for nurses and the NNEI and my personal experiences there. To start with one of the nurses earlier today referred to the human resource department, her facility as a black hole, and I feel that the black hole she referred to extends all the way up to Anchorage. And in some cases many nurses have reported to me and others that they have been boarded at lower levels than their counterparts. An example that I would like to give to you is a coworker of mine. She was hired into the ICU as a Nurse II in 2000, and this is an individual who had 15 years of critical experience at the time. She is a BSN and she is also a veteran. A newer nurse was hired after her six weeks later. This nurse was boarded as a Nurse III. This nurse had 10 years' experience, and she was not a veteran. This second nurse had no previous DOD, Department of Defense, or government experience. So my coworker, who is now a case manager, ended up having to mentor this new hire as well. There are also instances including myself where applications have been lost or nurses have been boarded as long as six months after being interviewed. Now personally I was interviewed in August of 1997, but I was not boarded and notified that I had been hired by the V.A. until December 1 of '97. So there was at least a 90- to 120-day lapse there. Something was going on, but I was boarded at that time. Other nurses have reported to me too that they are not informed or educated as to how the Nursing Professional Standards Boards process works. The knowledge or education is not provided to them upon hire, and that is one area that does need improvement. I'd also like to discuss the charge nursing mentoring issues that have been brought to my attention to report to you today as well. Many of our experienced nurses in various roles in the clinic and case managers feel that they're given no credit for mentoring or taking charge positions. They were just—they reported they would at least like to receive some type of recognition whether it be pay or bonuses or either just given the credit for assuming those extra and outside roles. Then at the present time two of my coworkers are all mentoring at the local universities and are doing it on their own time, their own, you know, without any request from management or anyone else. I'd also like to bring up the personal problems that I have had with the NNEI funding and just some recommendations that I feel would help to make the process simpler and easier for other people who want to continue their education. Several years ago when the recommendation came out that nurses were going to be required to have their BSN by 2004, I took that regulation or that information very seriously. I checked into the local university which is the University of Alaska in Anchorage and their program would not work for me. It would mean I would have to quit my job or take a lesser position and go to school during the daytime. And so I found an online program that worked just fine for me, and online programs are much more expensive than local tuition programs. I filled out my first NNEI application which was a two-page form, and I was told that that was

incorrect, and so I went back and then filled out a second one which was several pages longer, and I was told it was a correct form, but that was subsequently lost. I filled out a third one, and no one seems to know what happened to it or where it ended up. Anyhow I ended up paying for BSN primarily out-of-pocket and also with Alaska state student loans. I am pleased to report that I did apply for and received some reimbursement money for my BSN, and that's to begin in July of this year. But I had applied for a given amount of money last year from the reimbursement, and I did not receive the total amount that, you know, that I spent for my upper graduate education, and then when I—when our administration found out I was going to appear here and testify, magically all of a sudden I received a form that said I would get the full amount that I asked for. I think there is a problem with the NNEI form. The NNEI in general is a very excellent program. I think it provides an opportunity for nurses to go back and continue their education, but I don't feel like our nurse educators at the local level are as well informed about the program as they should be. One of my coworkers and myself are in the MSN programs at the University of Phoenix, and we have been told by other online students in our program that access for them is much easier and simpler than it has been for us. I do believe there is a form and the process itself needs to be simplified and easier for nurses to get into the program. One other comment that I would like to make is that I believe education is important. I'm not underrating the experience of nurses by any degree. I think an experienced nurse that is either an ADN or a diploma graduate is probably valuable or much more valuable for their experience, especially in areas where nurses with degrees are. But my point is I do think that education should be encouraged through the V.A. NNEI program. I will tell you that when I got my degree last spring that I took it to the board and asked, you know, will I be able to obtain a step increase or will this allow me to, you know, get an education waiver for a Nurse III, and I was told no. I was told I would have to wait until I obtained my master's degree before I could be promoted to a Nurse III. Honestly I feel the only—that the BSN did not make me a better nurse or it did not make me a better case manager. I received a lot of education, you know, education in other ways from the degree program, but I don't believe it made me a better nurse. The primary thing I can point to it showed me I have critical thinking skills, but I feel that I had those for 20 years before I started the BSN program. The other issue only to bring up was the inconsistency in the locality pay surveys in our area. Once a year we do have a panel of nurses that go out and do the survey. This year we received an increase of 7 percent. The difficulty that I feel created some problems at our facilities is the LPNs did not receive the same locality survey. This created quite a bit of resentment between the RN staff and the LPN staff because we were asked to keep the amount of locality pay increase we got secret from the LPNs and not to show them our pay scale. I feel that is unfair, and I feel that if they're going to

conduct a locality pay for one group that they should be consistent and do it for both. The other area that I would like to recommend is I feel LPNs in all facilities need to be encouraged to continue their education. Thank you.

MS. BOLTON:

Thank you very much. Ruth Walston.

MS. WALSTON:

Good afternoon. Thank you for letting me speak today. My name is Ruth Walston. I'm a nursing assistant in med/surge with the greater L.A. healthcare system. I have been employed with the government for 19 years. I come today to report on my personal experiences with the Veterans Administration. It does not reflect any particular unit. Staffing and staffing ratio on the unit level has been the major function of the nurse manager in our hospital and the function is delegated to the charge RN for the particular tour of duty. The method used is called staffing by acuity. The major problems of this method is that it was developed through research using a time and motion study of what services were provided and not what services are required. Each RN has their own way of effecting acuity. Therefore, there are two dynamic situations. The RN method of assessing acuity and the time of the day when she assesses the acuity and determines staffing needs. The patient's condition changes rapidly, and, therefore, the RN assessing acuity at the time will not be accurate when the shift ends. The patient acuity does not include the amount of time spent meeting patient's needs through referral to other disciplines such as a doctor, social worker, dietitian, et cetera, due to the fact that the nurse is at the bedside 24 hours a day. Staffing ratio to provide quality care with affordable cost will remain a problem of the nurses working with the patients 24 hours a day. Assessment of needs and immediate provisions of these needs is time-consuming and, therefore, it must be added to the staffing ratio in addition to patient's dynamic condition. One of the issues aside from staffing is there is a dwindling of the nursing assistant ratio on all tours, and the positions are not being filled. The nursing assistants are the backbone of the one-on-one care given to the veteran. The LPNs and the RNs provide the professional care while the nursing assistants provide the basic skilled nursing care. An example is activities of daily living, bathing, dressing, mobility. Also the nursing assistants in the federal sector provide much more skilled nursing care than the private sector nursing assistant. We are trained in the beginning to provide mobility, protect against emotional and physical jeopardy, caring. We are trained to provide fluid management. We do catherizations, Foleys, enemas and irrigations under the supervision of an RN. In the private sector nursing assistants

do not provide such skilled care directly to the patient. This care is given by the professional nurse. My recommendation getting back to the staffing is that number 1, they have structured change of tour where there's walking rounds at the bedside to determine patient care needs with concurrent assignment given with available staff without compromising patient privacy. The advantages would be that the patient will feel a degree of comfort knowing that their needs are being assessed and also meeting the available staff. Number 2, if available staff is not adequate in numbers and skills needed, then an in-house registry should be established to supplement and to meet staffing needs during this tour. Thank you.

MS. BOLTON:

Thank you very much. Your testimony was different from what you submitted in terms of written testimony. Can you make sure that Stephanie receives a copy of that?

MS. WALSTON:

I'll give her this copy.

MS. BOLTON:

Thank you. Melinda Okimoto.

MS. OKIMOTO:

My name is Melinda Okimoto, and I'm a registered nurse. I work at the Long Beach V.A. Medical Center.

MS. BOLTON:

You will need to speak up a little more.

MS. OKIMOTO:

I'm a staff nurse in the HPPC program at the Long Beach V.A. I've worked in this capacity since 1987. I've had 23 years of total experience with the V.A. and I do have a master's degree in gerontology nursing. My question that I'm going to be addressing today is how can V.A. best attract and retain a quality workforce. I'm concerned that there's very little incentive to keep qualified nurses at the bedside of our veteran patients. Fortunately I work with administrators who value clinical and caring for our elderly and fragile veterans at home. I have moved along the clinical career ladder as a front-line staff nurse at the bedside in the home

setting. Many of my colleagues who work in the inpatient setting do not have the same benefit, in other words, little incentive to continue to improve skills, develop patient programs and increase the value of hands-on care. Moving along the clinical career ladder seems to me now that nurses move away from clinical practice in areas such as utilization review, quality improvement, et cetera. These areas are important and well managed by our talented nurses, but this process also depletes the supply of qualified bedside clinicians. As a result also we have fewer nurses working to plan, execute and evaluate care at the bedside. My departmental colleagues and I spend many hours of uncompensated overtime to assure that patient needs are met to the best of our abilities and that documentation is done. We still go home after 12 hours knowing that some things are left undone, but all of us want the best outcomes for our patients. My recommendations: Number 1, please review the qualification standards for a clinical pathway that entices nurses to stay at the bedside. Number 2, consider shared government type of management that allows nurses to support the patients' needs and planning, staffing, education, et cetera. Number 3, develop mentoring programs for the new nurses that will be filling the current and coming nursing shortage in the U.S. The V.A. used to have a refresher program for returning nurses, and perhaps mentoring new nurses could look at some of these guidelines. Thank you for listening.

MS. BOLTON:

Thank you. Okay. Margaret Cotter.

MS. COTTER:

Good afternoon. My name is Margaret Cotter, and I wish to thank you for having us. Can you hear me okay? I come from the Bronx V.A. in VISN 3, a New York section of the VHA. I understand I'm a little out of—I'm in the wrong section, but not really. In the interim between hearings the first speaker and now, I have tailored my testimony to not repeat and not reemphasize issues that have already passed. I came to the V.A. as a baccalaureate degreed nurse more than 20 years ago. My first introduction to professional nursing though was in the private sector. I worked at Memorial Sloane Kettering in the city. I was interviewed by the director of nurses there, and during our interview she reviewed for me the expectations she had of my first year working in her employ. Her words were a constant reminder of where I was going, where I wanted to go and the resources to get there. It was very clear from my first day there what my role would be and would become. I would like to speak today about the culture of nursing and the VHA. We already have a language of our own. Now we need a culture. The culture of nursing has all but disappeared between our VHA, within our facilities, and I will speak as a

VISN 3 Bronx V.A. employee. Our delivery of healthcare system is on the product line delivery system which means that each service center within the hospital that director is accountable for all the employees of that center whether it be building; management; environmental; the doctors, the nurses, the social workers. We do not have a nursing department. As such we have different nursing expectations going on in different centers. What I would like to see and what I recommend is the reorganization of nursing under a nursing department. Professional nursing seen at the Bronx V.A. is very different than what I signed on for. We no longer have escort or messenger service, and so at any given time you will see licensed professional nurses escorting patients, delivering blood, going to radiology and running down to pharmacy for missed meds. Now this is not just the professional nurse you'll see. You'll also see the advanced practice nurse. Nursing at my facility has gone back to the time when nursing did everything. All right? One day I was up on the unit to discuss with the nurse troubleshooting the BCMA, our bar code medicine administration process. While we were at the computer to troubleshoot, her manager called her away. There was a leak in the patient's room. How was this nurse going to address the leak. That is not unusual. Believe me. That is not unusual. So what we see here is professional nurses doing nonprofessional things. We do not see the professional nurse attending rounds like I was used to. We do not see them working with the fellows and the residents that have come to our hospital for teaching. We see them in obscure positions where their talent is not being used. I had occasion to work at MIT at the Einstein School of Medicine in the team approach, a multidisciplinary skilled approach to healthcare, and at that time I was working in an inner city environment. The team approach that has evolved over the years and is now present within our V.A. is not the team approach that it was intended to be. We are not all the same, but we all contribute to patient care, and that has to be acknowledged. It's very conceivable in my hospital to see nurses escorting a patient while the unlicensed professional is catheterizing a patient. This is not the way we want it to be here nor should it be. Skills can be taught, but the value you see before you is that I have the theory behind it. All right. We can measure skill, but we cannot measure theory. My degree and my background supports the knowledge of this theory. The other place you will find the RN is in the bar coding administration. This came about in the late '90s when VHA elected to acknowledge our medication errors within the V.A. system. The bar coding administration system is now in its third generation. It is not a final product. It takes an average of eight hours for a nurse in my facility to administer medication. She has to make the system work for her instead of the other way around. This system is not supporting her role at this time. The safety measures that the system is supposed to put forth in a patient's care do not exist right now. If you were to go on a unit and ask the medication nurse to print out missed medications or missed doses,

she would be unable to do that. On certain units we have dual recording of medication. We have a paper copy and a computer copy. The seriousness of this is like a corporation having two sets of books. It can't be any more serious than that. Without a nursing service we have no culture. We have in our geriatric department, and it's not—let me step back. Service center directors do not need to be nurses, okay? They need to be managers, but they need the resources of a nursing department. Right now we are without nursing as a department—as a profession. I see the yellow card, and so I'm going to quickly summarize some things. Number 1, the nursing culture begins at the time of hire. That's where it begins. The nurse coming into the V.A. system should know the culture that she is working in and our expectations for her, and she should continue on. What was mentioned before, the key to this nursing culture is preboarding. Our nurses should be boarded prior to their coming on as full-time employees. The clarity that comes from the National Professional Standards Board is needed by that nurse as she works on the floor. We need to be at discharge planning meetings. We need to be at meetings where clinical pathways and nursing science are discussed, and right now we are not. We need the nursing culture in the V.A. system in order to recruit nurses and retain them. We have nurses in our area that are retiring from other systems there looking for a second position. This is our framework for hire. When they come to us, they are asked to do nonnursing functions. They're not asked their professional opinion. They do not stay. We are at a critical time in nursing. Nursing is a science. It's a profession. We need a culture in order to recruit, and we need stronger nursing departments. Thank you.

MS. BOLTON:

Thank you.

MR. COX:

You commented on the bar code medication administration and some safety issues. Could you give me an example of the safety issue and recommendation of what would correct that.

MS. COTTER:

In order for the bar code to be truly safe, we need to have pharmacy, the nurse and the computer program right there on-site. Right now at the V.A. the nurse takes two carts to deliver medication, the cart with the actual medication and the computer that works. There are two separate carts, okay. If the computer system goes down, the return time is one-half hour before it comes up. Those medications are not timely. Medication levels are altered by this time. We cannot go on a unit and

ask for different safety such as was the digoxin given in a timely manner. We cannot print that out. The system has not reached that level. In different VISNs there's different practices of BCMA. We have a type of territorial thing going in the VHA. We are not all that eager to share our wealth with other VISNs, and this has kept us back.

MR. COX:

Thank you.

MS. BOLTON:

You indicate that in your facility that there is the lack of a nursing culture, and you seem to be identifying the lack of what you call—when you say official nursing department is a strong and contributing factor to that; is that correct?

MS. COTTER:

Yes, it is.

MS. BOLTON:

Does the chief nursing executive in your institution oversee practice?

MS. COTTER:

The chief nursing executive at my facility is—on the organizational scale she is on a line away from the director. She does not have line authority. She is a resource person. When the board of directors for our facility meet, under the discretion of the director she is invited or not. So we have, let's say, in the nursing home certain practices, nursing practices go on because of that population that might not go on on an acute ward. That shouldn't be because—

MS. BOLTON:

But my question is has the authority for the practice of nursing, is that under the registered nurse, someone who assumes responsibility for assuring promptness across the organization?

MS. COTTER:

I think that that's the intention of the title. All right. The practicality of it it is mostly in the hands of the service centers director who may or may not be of nursing background.

MS. BOLTON:

Okay. Thank you.

MS. COTTER:

I just want to make one comment. I was very delighted when you talk about differentiated practice. Thank you very much.

MS. BOLTON:

Alan Durtschi—Durtschi. I can't pronounce your name.

MR. DURTSCHI:

That's all right. I'm used to it. Good afternoon. My name is Alan Durtschi. I'm a registered nurse at the Salt Lake City Veterans Hospital. I've got a baccalaureate degree in nursing. I am certified in oncology, and I work in the outpatient hematology/oncology clinic. First I'd like to say most of my testimony that you have as written has already been provided, and so I'll give the stenographer a copy of the comments I'm going to make because they are substantially different. First I'd like to concur with the previous testimonies of Sara Atkins and Jeff Sladek concerning the unfairness of making educational degrees a foundation for promotion. I would like to add that each nursing area has specialized needs and skills. The nurses are trained on the job at conferences and seminars and in routine in-services. This provides current up-to-date skills and education, but it is not considered at the time of promotion and it does not count toward advancement. Direct care nurses implement the research. We need more nurses implementing the care than doing the research. Another concern is staffing. An important part of our staff are Title 5 employees. Title 5 employees do not receive weekend premium pay. These employees who directly support the nurses such as nursing assistants, pharmacy technicians, lab technicians and supply employees are not available during the weekend or have a skeletal staff, and in fact the skeleton would be more like a couple of bones. This puts the V.A. at a huge disadvantage at a time when the private sector is utilizing any means to entice the employees to their hospitals because we have a revolving door, not only of nurses who are dismayed by the educational requirements of the qualification standards but also support staff that know they can get paid higher salaries at private hospitals. The law needs to be changed to allow the V.A. to pay our Title 5 employees weekend premium pay so that we have support staff throughout all shifts. Retention of nurses is critical for the V.A. and especially now at the time

we have a national nursing shortage. Under the law 38 USC 7405 part-time registered nurses remain probationary employees indefinitely. This even includes full-time nurses who have met their probationary period and have chosen to decrease their hours. They are converted back to probationary status. Management states that part-time experience does not count towards completion of a probationary period. These employees may be terminated without any access to V.A. appeal procedures afforded full-time permanent Title 38 staff and are Title 5 part-time employees. Why should our registered nurses be treated differently? This antiquated law 38 USC 7405 must be changed to allow these employees the same rights as full-time employees. Once they reach that probationary period, this should help the V.A. to retain experienced nurses who have chosen to continue to practice nursing with decreased hours. I request the commission to review this law. Another concern is that nurses need and deserve a safe working environment. Throughout the Veterans Administration in Salt Lake City, the patient bill of rights is posted, and this protects patients from abuse and negligence. There is no document to protect the nurse from abuse of a patient or their family. Each nurse on my floor reported that they experienced or witnessed physical or verbal abuse by a patient or their family member during the past year. We need a patient list of responsibilities to go along with the patient bill of rights. This must include the treatment of caregivers with dignity and respect. It must also include provisions for punishment for violence against nurses. If we were to have a patient slap a police officer, that person would go to prison. Patients that slap nurses go free. If we were to throw a rock at a politician or other public servant, they go to prison. Yet a patient can crack a nurse's spine with an oxygen canister and go free. Nurse managers seldom support staff and their concerns with the patients' outburst and violence. They excuse it as posttraumatic stress disorder or alcohol withdrawal and other psychological disorders. Inappropriate behavior may be a symptom of some mental illnesses, but that does not make it tolerable or acceptable. We need managers to be trained to assist their staff in recovering from abuse and in reporting it instead of blaming the victim for the situation. Nurses who work with patients who are prone to violence should be awarded premium pay for taking this extra risk. They should be able to have counseling of their choice and time off to recover from physical or emotional damage. This would help to retain nurses in a system that has a large number of posttraumatic stress patients, alcohol and drug abuse patients and other patients with mental illnesses that resulted from serving our country. Retention of nurses is a critical issue that must be addressed by the V.A. We became nurses to provide care for our patients. We did not become nurses to do research, shuffle papers or sit in classrooms. We need more bedside nurses and not more managers or researchers. A course of action would be to provide a safe working environment, eliminate the educational restriction for promotion and to give nurses the opportunity to

create policy for safe staffing and care protocols. We need to retain part-time nurses by giving them permanent and employee status and keep support staff by giving them the same benefits of other employees. Thank you very much for your time.

MS. BOLTON:

I had some questions. Thank you. In relationship to your recommendation about part-time employees and probationary status, are you suggesting that the number of hours required to complete probation be differentiated by what is full time or part time?

MR. DURTSCHI:

I'm suggesting that the number of hours of probation should be constant. If you have so many hours of probation met, then you're then a permanent employee.

MS. BOLTON:

If you were to complete the 480 hours, which is three months of time, no matter how long it took you to complete the 480 hours, then you should be allowed to go on to permanent status; is that correct?

MR. DURTSCHI:

Yes.

MS. BOLTON:

Secondly, in relationship to issues of violence in the workplace, are you saying at your facility you do not have a violence in the workplace policy that adjudicates all the things that you identified including how employees will be treated, their right to counseling, their right to time off, the fact that patients—employees have rights and patients have responsibilities just like when you get on the airlines and they say you have to abide by what the attendant says for the safety of all those concerned. Are you saying that's not available at your facility, and that's your concern?

MR. DURTSCHI:

My concern is not that it isn't in documentation somewhere, but unfortunately we are encouraged not to report violence in the workplace by patients with specific mental disorders because it's a problem with the patient, and we may even be asked to delete notes from the patient's

record which casts them in a bad light or indicates that they have a violent nature.

MS. BOLTON:

So the policies and standards exist, but the application of those policies and standards are discretionary?

MR. DURTSCHI:

That is correct.

MS. BOLTON:

Thank you very much. David Vincent.

MR. VINCENT:

My name is David Vincent. I'm a veteran. I'm a registered nurse, and I'm a charge nurse on the medical/surgery floor at the Veterans Administration Hospital in Rosewood, Oregon, and the questions that I'm going to address today are the decision-making process, trust and a quality workforce. Okay. Decisions related to nursing practicing are done by administrative edict with minimum input from the affected staff. In our last reorganization the nursing service was eliminated and the loss of the institution caused a professional vacuum. A nurse executive position was created, but this has proven to be ineffective. The nurse is realigned onto different teams with many team leaders who are not nurses and who do not have a clear understanding of the nursing standards of care. The result has been nursing practices and the delivery of care declines to the level of team leader's clinical comprehension. Now one result of the administrative's edicts was the creation of what the agency calls a health referral nurse and what the employees call a health denial nurse. The health referral nurse is directed to use the agency's resources to prevent patients who don't have scheduled appointments from being seen. The patient is evaluated by this nurse and then is scheduled for an appointment in the near future and sent home. Those patients that call in are handled in a similar manner with those needing immediate treatment being instructed to go to the nearest hospital. Many patients are reluctant to do that because they have to incur the cost on fixed incomes, and so this is a financial hardship for them. One tragic case I'm familiar with involves a patient who called in saying that he was extremely ill and asked them to transport him because he was about two hours away from our facility. He was instructed to go to the nearest hospital. He said that he was unable to arrange transportation. The same patient calls several

hours later and said that he was getting worse and would we come and get him. We told him again to go to the nearest hospital. It wasn't until the following morning that he was able to arrange transportation. His sister came and got him. On the way over, about an hour out, she said that he became extremely quiet. The medical officer of the day went out and evaluated the patient, and he told the sister that the patient had died. The staff refused to remove the body from the car and instructed the sister to take the corpse to the county mortuary. So this sister with her brother's corpse drove over to the mortuary. She mistakenly thought that the agency had enough compassion to notify the staff there that she was coming, but they did not. She sat there next to her dead brother for over three hours waiting for somebody to come and help her. In another tragic and hurtful situation, a disabled veteran called one of our satellite clinics asking for help. He stated he was also unable to arrange transportation and would we come and get him. We denied him transportation. We told him to go to the nearest hospital, and he died in his home that night. I've known this man for a long time. He was a bilateral lower extremity amputation that was 100 percent service-connected. We could not find in our hearts to reach out to him and transport him. Most recently a veteran was seen by the health referral nurse, and he had some symptoms consistent with a heart attack. All right. We don't have some of the best critical thinking nurses in this position, and he was informed the nurse that he would not be seen that day and that an appointment would be made for him incredibly two weeks from that date, and that he was instructed to return at that time. The veteran could not believe what was happening, and so he left the hospital, went to a civilian hospital where they assessed him and did emergency open heart surgery. With regard to trust those stories go on. With regard to trust how can you—how can trust be better established and retained. I ask you who can trust an institution that treats its employees with contempt, an institution that undermines your peerage and foments disparity. If you are to foster any trust, then you need to put a stop to the prejudice being brought to bear upon employees who are also veterans. In comparison to their nonveteran counterparts, veterans are paid less, passed over for promotion and disrespected. I'd like to share with you some facility administrator quotes. One is a team leader which is like the top dog of one of the groups. The team leader said, "The military bearing and presence of veterans as employees is neither appreciated nor wanted in my clinical setting." A clinic manager stated "We did not send our best and brightest to Vietnam. Why should we hire them? Why should we promote them?" In discussions I've had with human resources I've heard "We only have to hire them. We don't have to promote them." During one of our V.A. meetings where we were discussing the future of the V.A. and the changes being made, how World War vets are dying off and how we were going to change what we were going to do, we brought up the fact that there was 8.3 million Vietnam vets and they were coming to the

age where we expected them to come into the institution, and then we got a whole tirade from these administrative folks that were managing these hearings "Vietnam vets are worthless," and that's a quote. "They're all bums." That's a quote. "They don't contribute to society." These are even nurses making these statements, and this overt bias impacts employees who are Vietnam veterans. My concern is that it will impact the Vietnam veterans that are seeking care. As an example of the bias two employees were competing for an open RN position. One was an honorably discharged veteran with multiple commendations. He graduated from the nursing program with honors, honest, and he had several years of successful V.A. nursing service. The other candidate was a former employee who left the V.A. service under a shadow of suspicion when narcotics came up missing on his ward. At the time the nonvet applied for this position, he had so many restrictions on his nursing license by the board for the state of Oregon that he could not work unsupervised. He did not work off-tours and weekends, and he could not work where you have unsupervised access to controlled substances. The agency did not select the veteran. I've received complaints from veterans who have been harassed for their army reserve training, and they have subsequently retired from those units. I've had complaints about performance evaluations where vets are rated lower and promoted less even when their skills are equal or greater than their civilian counterparts. There are complaints of bias in the selection process. We had a situation where the one person on the board had verbalized an extreme bias against the Vietnam war and touted his civil disobedience during that time frame. So what he did was he refused to rate the veteran at the time they were doing the interviews. He left, went over and accessed their personnel file. When he came back, he rated the veteran as the lowest possible candidate which created enough of a split that it kept the veteran from getting the job. Okay. When you talk about a quality workforce, the current lack of support for nursing is clearly demonstrated with the physical streamlining. We've talked about multidisciplinary, and that's good from 8:00 to 5:00, but after 8:00 to 5:00 we don't have a secretary. We don't have pharmacy. We don't have a lab. Nursing picks all that up. We're hard-pressed to get a CNA. When asked for a CNA, they want to take a registered nurse away. So we need to remove some barriers, and then we need to develop an appropriate acuity process so that we can get an equitable distribution of the workload. We need to respect those that are assisting us. I'm going to speak for the licensed practical nurses and nursing assistants. Their contribution is absolutely essential. We need to embrace them. We need to bring them into the Title 38. They are not getting the recognition they need. Now I'll move on to my summary. It is of the greatest importance that we restore our nursing service networked to each agency with representatives at every level of the V.A. administration. This will provide a forum for policing our profession and provide a venue for participation in

the decision-making process. I'd like to see us expand the affirmative action for the veterans because they have retention rights and they have hiring rates. They need promotion rights and protective status. Appropriate staffing is essential for every aspect of nursing. Our current methods for evaluating acuity are outdated. We need to develop appropriate methods for determining acuity again so we can properly utilize the nursing resource. We need to acknowledge the contribution of the nursing assistants and licensed practical nurses, that they are essential to providing quality care. We need to respect and compensate the contributions, and we need to bring them to the RN level. We have a double-edge system. They all need to be ours. We need to stop the disparity with the V.A. pay administration premium pay, overtime compensation. I believe it should be applied equally to all direct patient care personnel. We shouldn't be distinguishing between them. And then our current support services for new technologies, we need to develop an effective support service before we implement the technology because I have the technology, but I don't have anybody that can work on it. That's your CPRS and the BCMA which is a nightmare, and that's it.

MS. BOLTON:

Thank you. Dianne Nelson.

MS. NELSON:

Good afternoon. My name is Dianne Nelson, and I'm a staff nurse at the V.A. Hospital in Tucson recently renamed the Southern Arizona V.A. Healthcare System. I'm also the president-elect of the Nurses Organization of Veterans Affairs. I work in a very busy ambulatory surgery center in Tucson. Staff nurses bring a wealth of knowledge to their work and to their veteran patients. In a recent survey NOVA members were asked to identify the most rewarding aspect of their jobs. They responded overwhelming our veteran patients. We love our patients, and we provide excellent, proactive care for them and their families. The survey revealed the most frustrating aspects of V.A. nursing included: Inadequate staffing, performing nonnursing duties and lack of time and funding for continuing education. A significant factor I feel affecting nursing recruitment and retention in the DVA was the shift to care lines and the dissolution of nursing service in many facilities. The umbrella of nursing service folded at a time when the nursing shortage began as a deluge over all sectors of nursing. Many facilities are reopening the umbrella in order to revitalize nursing and its leadership assuring quality, continuity and care and evidence-based patient outcomes. I'd like to try to address all of the commission's questions starting with decision-making. Staff nurses generally feel they are left out of the big picture when it comes to decision-making and problem-solving.

At the unit level staff can easily identify problems. However, when staff members propose solutions, at times there is a disparity between the manager receiving the input and then the implementation of a change. Many units lack a system of formal input other than word of mouth, and we all know some units are run strictly by legend. Unit staff meetings are one way for staff nurses to voice their concerns and work collaboratively with their peers on a solution. However when units are busy, then staff meetings get canceled, and information is not shared. Staff meetings should occur at least monthly in order to outline the problems and concerns of the staff and work together on solutions and agree upon and implement changes. Staff nurses do feel they participate in clinical decision-making related to patient care. They assess the patient, gather clinical data and communicate their assessment and data to the MD provider. The staff nurses do not feel they have a voice on more global facility nursing issues. As has been stated, bedside nurses are often unable to serve on hospital-wide committees due to heavy patient care responsibilities and nursing staffing shortages. Consequently, it's the nurses in the nonpatient care roles that serve on these committees. In regards to quality improvement, with a large number of nurses assigned to the formal quality improvement teams, the tendency is for staff nurses to look to that team for recommendations. Each unit seems to have a different approach to identifying areas in need of quality improvement. The other speakers have addressed the Nurse Professional Standards Boards and peer review, and staff nurses feel that peer review should also be occurring at a unit level in addition to the board. The next question addresses trust. Managers elicit trust from their staff when they are genuinely open to input and when they follow through on promises they make to their staff. Managers need to maintain an attitude of respect, have a willingness to share and also be willing to do patient care when staffing is limited. Managers should treat everyone with the same respect and concern and be consistent in their actions. They must also give feedback to the staff and communicate with them on issues related to the unit and the facility. The one word echoed throughout the responses was communication. The third question is relating to participation and decision-making. At the unit level, as I said, participation in decision-making is a reflection of the culture of a manager. If a manager or leader is receptive to staff input, treating the staff equally, consistently and with respect, the staff is more willing to give their input. One potential solution is to generate more electronic mail groups and try to do things more through the computer. Many facilities with an active chapter of NOVA, or other professional nursing organizations or unions, meets quarterly with the CEO of their facility to discuss nursing and patient care issues. Nurses also have a voice that they sometimes don't recognize when they communicate with their congressional legislative representatives. The next question relates to education. When the V.A. facilities reorganized into care lines, educational money became

relegated to the care line. It is then disbursed among all employees in that care line, but frequently the physicians receive the bulk of that tuition and travel reimbursement. Support for nursing continuing education money and travel is virtually nonexistent at many facilities. Through the EISP and NNEI money is available for obtaining advanced degrees. However, money must be restored for nursing continuing education. One thought is that we could have a \$1,000 to \$2,000 package designated for continuing education per year. This would be added to the total compensation package for nurses. This money would not be carried over from year to year and should not be tied to the facility travel budget. This would be an important recruitment and retention tool if indeed the V.A. wants to be the employer of choice for registered nurses. Many V.A.s offer continuing education classes during off-duty time using their own finances for tuition and travel. The V.A.s need to recognize and reward their quest for knowledge. Question number 5, how can the V.A. best attract and retain a quality workforce. The overwhelming response is for the V.A. to illustrate the superlative care patients receive in our facilities. The V.A. needs to be internally fair and externally competitive in salaries and benefits within the community. In order to provide excellent patient care, we need an adequate number of nurses. We need to explore all the pros and cons of mandatory patient staff ratios. The V.A. will retain nurses if it hires an adequate number of nurses and equips them with the tools they need and frees them from performing nonnursing duties and allows them time and funding for their nursing education. The V.A. will improve recruitment of nursing graduates if it provides a more flexible work schedule, competitive salaries and a formal preceptor program of three to nine months' duration. Maintaining an adequate number of staff on all tours of duties will eliminate a need for mandatory overtime and the floating of nurses between units. It will also decrease cancellations of surgeries due to inadequate staffing in the ICU and inpatient units in hiring nurses for specific shifts and eliminate shift rotation. I have more, but thank you very much.

MS. BOLTON:

Thank you.

MR. COX:

Ms. Nelson, when you're talking about the \$1,000 to \$2,000, are you saying that that's a guaranteed right for a nurse that an allocated amount of money would be given to them on an earlier basis if they so choose for continuing education?

MS. NELSON:

That's correct, but they would have to indicate what they used that money for.

MR. COX:

Right. In other words, there would have to be a check and balance in the process that there would be a right for the nurse to have an allocation for continuing education.

MS. NELSON:

Correct.

MS. BOLTON:

I want to further explore that. You're suggesting that if there were a thousand employees, a thousand nursing employees in an institution that the institution would set aside a minimum of \$1,000 a year per individual?

MS. NELSON:

That may perhaps be reaching for the moon. Maybe we could start with \$500. A lot of the continuing education seminars that nurses attend now are \$250 and up.

MS. BOLTON:

You are suggesting it would be per individual?

MS. NELSON:

Correct.

MS. BOLTON:

Thank you.

MR. COX:

One other question I did want to ask. The staffing ratios, could you tell me a little bit more about your ideas on that? I heard you mentioned very shortly about staffing ratios. Could you tell me more about that.

MS. NELSON:

I think it's an area that needs to be explored. At our facility we have an ICU mandatory staffing ratio of one nurse to two patients. What happens when people call in sick is that the nurse manager closes beds. What happens when they close beds is I'm sitting with a room full of patients waiting for surgery, and they are told they can't have surgery because there is no place to put them. So I'm on the fence about mandating staffing ratios, but I feel we could look at perhaps, you know, minimal staffing ratios as opposed to, you know, trying to mandate four to one.

MR. COX:

Thank you.

MS. BOLTON:

Thank you. Larry Lemos.

MR. LEMOS:

My name is Larry Lemos, and I'm a geriatric clinical specialist at the San Francisco V.A. Medical Center. And this will be an edited version of what I submitted because I couldn't get it—even as fast as I talk, I couldn't get it down to 10 minutes. Thank you for providing me the opportunity to speak to you today. I'm proud to be a V.A. nurse, a member of the board of directors of the Nursing Organization of Veterans Affairs. I have been a V.A. nurse for nine years, and I've had the opportunity to work in three different V.A. facilities in California. During this time I've worked staff nurse, a nurse manager, a nurse educator and a clinical nurse specialist. I am presenting testimony in response to the questions what is the central issue of concern in V.A. pay administration. With 75 percent of V.A. nurse executives eligible for retirement by 2005, the V.A. is on the brink of a major crisis in nursing leadership. There are currently no V.A. training programs available for nurses who want to be trained to advance to administrative positions. Without internal V.A. training qualified candidates must be found outside the V.A. which limits the advancement of the career of V.A. nurses. The V.A. must reestablish a training program to develop our own leaders. For the nurse who wants to advance clinically, the options are even more limited. He or she may obtain an advanced degree as a nurse practitioner, clinical nurse specialist or nurse anesthetist, but they will never make it past the current Nurse III grade at my facility. I work with several clinical nurse specialists who topped out at Nurse III, Step 12, and they have over 20 years of experience with only a few years to retirement. They have no incentive to stay longer than necessary until the time comes when they will retire.

The current pay scales do not reward them for years of continued service or clinical expertise. I have only seven more years until I reach Nurse III, Step 12, and I will remain there for the eight years until I'm eligible for early retirement. If I continue at the V.A., I will remain at this step for the following 32 years or an additional 40 years when I'm eligible for my social security retirement. As a nurse in his mid-30s my options for future advancement as a CNS are grim. The V.A. must create a system where nurses are rewarded for remaining at the bedside and rewarded for advanced practice in nursing. Several hospitals in the San Francisco area such as Kaiser and UCSF have implemented such models. The V.A. should learn from their experience. In the healthcare labor market in California it is imperative that the V.A. offer salaries that are equal to that of nurses working in the private sector. While I know the law requires yearly salary surveys for RNs, how these locality pay scales are implemented is probably the most important issue that needs to be reevaluated. Each of the three facilities I have worked at in California have separate pay scales for the nurse practitioners and the nurse anesthetists while all other RNs share a third pay scale. What I find interesting is that two out of three of the advanced practice nurses, the NP and CRNA are singled out for their special contributions and are seen as needing accelerated pay scales. However, the clinical nurse specialists are not. Currently at the San Francisco V.A. the CNSs get paid about \$3,000 less per step than NP colleagues. The justification for the separate pay scales I've been told is that the NPs have prescriptive authority. Unfortunately, in the state of California CNSs do not yet prescribe. However, the CNS practice has a much broader scope than that of a staff nurse. The reality is a staff nurse may be paid exactly the same as a CNS. Two medical centers within five miles of San Francisco both recognize the CNS as a special and separate category nurse. I was able to find their pay scales easily on the Internet, but I was disturbed to see that the CNSs on average are paid \$10,000 to \$15,000 more than V.A. CNSs. I understand the national advanced practice nurse group has done a survey of locality APN scales, and every possible combination of locality pay scale was found. This issue is bigger than a locality pay issue. This is a national recruitment issue for advanced practicing nurses. I've also been told that currently CNS retention is not an issue at the facility because there are no vacancies. We only have nine CNS positions. I am concerned because 35 percent of V.A. nurses are eligible to retire by 2005, and I am sure that figure includes some of the 690 clinical nurse specialists nationwide. Recently my facility implemented a new locality pay scale as soon as the V.A. budget was passed. Only those nurses working in specific units designated as acute care areas received a total of an 8.15 percent raise. The APNs only received a total of a 4.87 percent along with all the other RNs who don't work on these designated units. What this says to the nurses at our facility is if you happen to work in the clinic or home care, your contributions are not

valued the same as your colleagues. I bring this up as an example because it was just announced that at the Palo Alto V.A., only 30 miles south of San Francisco, that every nurse at their facility received the same increase of 7.5 percent. The message of Palo Alto is very different from San Francisco. I have seen premium pay used in the V.A. system to reward nurses for working in difficult-to-recruit areas such as ICU, OR and ER. However, this is not implemented the same in every facility. The ICU nurses in San Francisco do not get premium pay while they do in Palo Alto. The message is not consistent with premium pay, and I believe this has an effect on staff morale. When I worked as a nurse manager, I received an additional two steps because of my 24-hour responsibility to the unit. During this time I supervised 50-plus nursing staff, and I can honestly say the two steps was not worth the extra responsibilities. This job is vital to the success of nursing since the majority of staff retention has to do with who the first line supervisor is. In the past four years I have seen six nurse managers come and go in the nursing home where I work. This job is stressful, and there is inadequate financial incentive for nurses to assume nurse manager positions. While I believe the intent of the Nurses Professional Standards Board is to use a peer review process, I am dismayed because the peer review process is implemented differently in every facility. Nurses who want to advance within the V.A. have to learn to play the game. Managers submit proficiencies when they want to promote staff depending on who is chairing or sitting on the board. This means that months may go by until a board that is more lenient or more likely to promote is seated, and then the managers submit their proficiencies of their staff. This is what I learned to do when I was a nurse manager. I wanted my staff to have the best chance for advancement, and so I learned to play the game. In the long run the nurses benefited, but this meant they went a few extra months without their deserved raise. When I was a nurse manager at West Los Angeles V.A., all the nurse managers were at the Nurse II level. When I transferred to Palo Alto, the majority of the nurse managers were at the Nurse III level. Now I know the nurse manager job is not that much different from station to station. This has to do with how the local board implements the qualification standards. Having been on the Nurse Professional Standards Board, I'm very familiar with the qualification standards. I have seen both strict interpretation and a very relaxed interpretation of the standards. I had to rewrite several proficiencies until I learned that if I didn't repeat the standard word for word, my RN didn't get promoted. I learned to actually write and underline word for word directly from the standards. Only then was the board convinced that the RN met the standard. When I was actually on the board, if it wasn't spelled out word for word but we agreed the intent was there, we promoted the nurse. As peers we felt it was up to us to promote our colleagues for their quality work. In these two situations the standards are interpreted differently. This was especially difficult when a nurse was

being hired. If the letters of recommendation don't address the standards exactly, then that RN is brought in at a lower level. No one besides the V.A. demands that the reference letters address specific standards before someone is hired. I have heard, although it doesn't say that in the letter, that an RN may end up losing credit for years of experience because their references might not be familiar with V.A. speech. When the nurse finally gets boarded and earns less than their previous job, they have no incentive to stay. I have also seen positions remain vacant for long periods of time delayed by the boarding process of a nurse who wants to know exactly how much they will make before they start their job. The current five grade level system is misleading because only nurse administrators are promoted to Nurse IV or Nurse V levels. If these levels exist, they should be available as part of the MPSB process where our pay is based on our experience and our education. Our pay is not based on our positions. However, this is not true. The advanced practice nurses at my facility have been told that Nurse IV and Nurse V levels are position-dependent. It's up to each nurse to determine which nurse meets the Nurse IV and Nurse V standards. These promotions must be decided by a VISN board. The rationale for this we were told is some facilities had too many nurses at the Nurse IV level. These facilities promoted advanced practitioners to Nurse Level IV. What appears to be happening is that standards are interpreted differently. In conclusion I would like to summarize for the commission my recommendations that must be considered if the V.A. is to continue to provide quality care to the veterans: That we reestablish training programs for nurses to advance into leadership roles. Ensure that funding for nursing education is mandated and not dependent on the budget each year. Develop separate career path options for nurse administrators and clinicians with clinical ladders for advancement. Each career path should have grade levels that are obtainable by all nurses. Locality pay scales and premium pay scales should be implemented in a consistent manner across sites and not at the discretion of the local facility director. Nurses should not have to worry about how the facility director is going to implement these programs from year to year. The qualifications standards and peer review process should be done away with if they cannot be implemented fairly and as intended. Thank you again for allowing me to present real-life examples of what I believe are central issues of concern in V.A. pay administration.

MS. BOLTON:

Thank you. Can you explain to me in relationship to the issue of the differentiation between what in California is identified as somewhat independent practitioners in terms of your midwives versus nurse practitioners and clinical nurse specialists and your recommendation that

they—at least I thought I heard the recommendation that they be treated the same.

MR. LEMOS:

What you'll see, the APA group, hopefully they have submitted this document to you, but they found that in some facilities the NPs and the CNSs were paid on the same pay scale. They were singled out from the staff nurses. In some facilities only the NPs got singled out and not the CNSs or the CRNAs got singled out but not the PNs, I believe. So there is a quite a variety of combinations out there. In the state of California again the CNSs have to have a master's degree, and the PNs are not required in the state of California to have a master's degree although a large majority of them do. The V.A. has seen this as a local issue in terms of recruitment, and many nurse practitioners have said that in order for the V.A. to recruit them, they had to actually look at their pay and they had to fight to have their pay localized. CNSs for the most part are not seen particularly, though we're recognized by the California board and by many states, but not all 50 states just yet.

MS. BOLTON:

My question really has to do with the differences in roles of advanced practice nurses and the group nurses and the midwives and nurse practitioners who have somewhat more of an independent practice model than a clinical nurse specialist, and so my question is more around the issue of compensation differentiation there. That's what I took from your testimony, and so I want to make sure that I'm clear about that.

MR. LEMOS:

Sure. Again the excuse has been because the nurse practitioners do not see patients and do not manage a panel of patients—

MS. BOLTON:

You mean the nurse—

MR. LEMOS:

The nurse practitioners. Because the nurse practitioners are doing that and because the nurse practitioners have prescriptive authority, they have singled them out. Now clinical nurse specialists, when you look at the scope of their practice and the responsibilities, I have 140 patients in my nursing home and up to 100 patients in the acute hospital that I see. So my scope is different than a staff nurse. All I'm asking is that the V.A.

look at this whole group as advanced practice nurses and not patchwork and single out particularly. One of the things also that I noted there are 690 of us nationwide, but we're fighting to have our voice heard.

MS. BOLTON:

Thank you. David.

MR. COX:

There was one thing you had talked something about the peer review process and had said that you couldn't get it worked out to replace it, but I don't think I heard you say what.

MR. LEMOS:

With what?

MR. COX:

Replace it with what?

MR. LEMOS:

I don't have that answer presently.

MR. COX:

Okay.

MR. LEMOS:

I'm hoping that something will come forth from the commission based on recommendations and your expertise looking at a system. I originally included in my hard copy looking at systems such as the S.F. General Hospital and UCSF and the Kaiser system. Having not worked in Kaiser, I don't know specifically about that. One of the other things I wanted to add when I filled out my demographic sheet that there is no box for clinical nurse specialists. Thank you.

MS. BOLTON:

Betty Ciaccio. Betty Ciaccio. Okay. David Farrell.

MR. FARRELL:

My name is David Farrell, and I want to thank you for the opportunity to speak here today. I work at the V.A. in Roseberg, Oregon. I was an LPN at the V.A. As I said, I was an LPN. This is how I was treated as an LPN at the Roseberg V.A. I had been a nurse in U.S. Army from 1978 to 1994. Upon my retirement I had received a total of four R coms in recognition of my nursing skills. I was recruited to the V.A. Roseberg as an LPN and assigned to the surgical floor and recognized for my skill and training in general wound care. The nurse assigned me to the skin care team, and I was the only male and the only LPN on the team. I joined the V.A. to be with and work with and care for veterans, my brothers and sisters in the military family. We had a motto in the Army that we take care of our own. To my great surprise, I found this concept completely foreign to the Roseberg V.A. I had a closer rapport with the patients as I was also a disabled veteran. The nonveteran nurses actually resented this, and I followed the critical veterans first, and to my dismay that was the furthest from the truth in the treatment I saw the veterans receiving. My co-chairman in the skin care team tried to undermine every step I made. I moved to the OR and worked in surgical clinic and assisted doctors in wound and ostomy care. This really upset the co-chairman who is an RN that had been there for at least 20 years and that in no way was I doing what she considered RN work only. I was moved to the substance abuse treatment unit and worked primarily the day shift which allowed me to be available for wound assessments and ostomy care. Due to staffing shortages I was put into the night shift. This created a direct hardship on my disability of neurology. I was unable to regulate my pain medication from the loss of sleep. You see, due to nerve damage, I'm in constant pain and back then it was only regulated by medications. I slept only five hours a day from midnight to 5:00 a.m. During the night shift it was a 180-degree turn, and trying to regulate my medications was almost impossible. I contacted the union and the chief nurse, and I was moved to the psychiatric floor. I worked primarily the day shift, evenings as well as the early shift. I was the only male LPN and disabled veteran working in there. The patients soon identified me as a person or staff person to go to, and this seemed to cause an animosity with my peers. I ignored this culture treatment, but it was taking a toll, and I began to have anxiety problems. I experienced paranoia and PTSD, but I maintained my professionalism and concentrated on my caregiving. In the seven months of my work in the psych nursing department, the nursing department was disbanded at the Roseberg V.A. and the chief first position was completely abolished, and everything was broken into these teams with the team leader having no actual nursing experience. I was singled out by their manager who was one of the staff nurses. She began to treat me differently than the other LPNs and staff people. As an example, my wife worked night shifts, and she would give me a 30-

second phone call in the morning just to let me know she made it home safely. I was no longer allowed quote, personal phone calls, unquote but the rest of the staff was allowed up to an hour in personal calls. She also began to put me more on the night shift, and soon my health began to deteriorate, and I approached the nurse manager and informed her that only the night shift would affect my disabilities. She informed me that she did not have to recognize my disabilities and it would not be fair to take me off the night shift. I talked to my team lead who told me "Be happy you have a job and don't make waves." I then went to human resources to began looking outside of nursing for another job. I had to see my physician more frequently due to the illness and pain control issues. He wrote a doctor's order limiting nocturnal shifts. I made copies and gave them to my nurse manager and team lead. They both called me and stated that they did not have to follow the doctor's order. I told them I felt they were violating the 1976 Disability Act, and I was requesting reasonable accommodation. They both informed me that they did not have to follow the Disability Act because I was a disabled veteran, and I was not covered by it. I was kept on working two night shifts every week, and during this time I experienced my very first anxiety or panic attack. I'm not sure if you're aware of what a panic attack is. It's extremely—the first time it ever happened to me, I was completely shocked. I'm a logical person, but I felt I had to move, I had to leave or I would die, impending death. It's such a strong feeling, and I've never experienced anything like that in my life not even my military career. I had to leave the job several times on sick leave, and this had occurred to me several times. I had a follow-up with my doctor who again wrote an order all shifts but night shift I was allow to work. I turned in the copies to the nurse manager and team leader. I was called in again, and they told me they did not have to follow the doctor's order. I mentioned that to another LPN who was excused from all shifts except day shift, and I was told that that was different and that it was none of my business and that if I continued to cause waves about working night shift, they would do a fitness for duty and fire me. They put me on five nights in a row. I sent an e-mail to the nurse manager that I was working under protest. I also sent copies of the e-mail to the union, to HR, to the EEO counselor at our VA. I did work the night five nights in a row, and during that time I only slept a total of four hours and I lost my pain control, and I felt very ill. Right after I completed the five shifts I was moved to urgent care to be evaluated as a veteran. That's where I received my care under the V.A. I was admitted in the hospital. I had a systemic infection involving the lymph glands and the prostate. I told the HR while I was in the room that they were trying to kill me and that I refused to go back. So he offered me a lesser paying job and that if I didn't take it that I would have to go back to my abusers. Also during this time I had to be cathed several times by my peers, and this caused embarrassment to myself and my peers. I filed an EEO complaint. After four years of fighting the V.A. I got a hearing, and the

V.A. kept refusing my disabilities. When the case came before the hearing, the V.A. was found guilty of discrimination against a disabled veteran. My nurse manager was guilty of blatant discrimination and retaliation. Yes, I'm still out of nursing. After my nurse manager was found guilty, she was promoted. I seek to send a strong message that the nurses are punished when you seek to stand up for your rights and the rights of your patients. Our V.A. was forced to make the nurse executive position because JCAO made it a requirement. One of my recommendations is that we should have faster turnaround when these types of discriminations happen so we don't have to fight it all by ourselves for four years trying to get something done. Right out it's too late for me to go back into nursing. If you can imagine how poorly I was treated, you can imagine how poorly our veterans are treated in the Roseberg V.A. I think that if they brought back the Department of Nursing and they brought it back as strong as it was, I think that these types of things wouldn't be happening. There would be responsibility. The Department of Nursing gave strength and power, and that was where the veterans had their champions and advocated the best voice that they had. Without having a Department of Nursing and being completely powerless, every nurse is on their own. Thank you very much.

MS. BOLTON:

You added additional testimony. Will you please provide a copy of that for us?

MR. FARRELL:

Sure.

MS. BOLTON:

Even though we're early, I think we will take our break at this point in time, and we'll come back at 3:10. We'll resume at 3:10.

(Recess.)

MS. BOLTON:

We are going to get back together now. Thank you. Our next person to testify is Vera Logan. May we have your attention please. Miss Logan.

MS. LOGAN:

Thank you for inviting me to speak today. My name is Vera Logan. I work in the surgical stepdown unit in the V.A. Long Beach. I'm an RN

and have a BSN and I'm active in AFG. I have worked at the V.A. for almost 32 years. My father was a veteran and was treated at Long Beach V.A. long ago. He suggested I work at Long Beach V.A. Medical Center at the time I became an RN. I'm proud to be a nurse that serves our nation's veterans. Nursing has been the backbone of quality care for years. As an aside I'm just going to quickly mention I support stopping shift rotation, changing Title 38, 7422, to give full collective bargaining rights and the premium pay for the Title 5 people. Today with the reorganization I see lots of implements and controls of nursing. VISN directors acknowledge that the facilities that did not reorganize are performing better, and I believe that this is because the nursing department remained intact and retained its influence. While nurse managers, leaders and executives are consulted, it appears they have no veto rights with respect to nursing issues. Today more and more duties are being done by—that could be done by other disciplines are being relegated to RNs. I see political dynamics also. When physicians start rating the RN in the healthcare groups and chiefs, some nurses and nurse leaders felt that they must give priority to the physicians' agenda at meetings. They did not want to sabotage their own careers with the person who is evaluating them. There probably are negotiations over nursing issues at the executive and other levels. From the perspective of the nurses below though, they are aware that something has changed, and more and more tasks are being pushed onto the nurse by policy changes. I believe with the current management team concept that once a decision is made, all upper management must support it openly which further supports the impression that nursing has no veto rights. Now this is contributing to moral problems, and management does not really care about its nurses. Years of substantial funding are playing a critical role in this. Solution, reinstitute a nursing service and nursing education as nursing education is going to be needed to train and orient nursing at all levels as we try to compete for nurses, and onceover lightly orientation is not going to do. We need to give the nurses—to reinstate the nursing department with full authority to decide on nursing duties, evaluate skills for the tasks and assign them for the appropriate level and be sure to serve everybody appropriately. If nursing services is not reinstated, there must be a sole nursing committee that gives approval of anything affecting nursing before it is implemented. No approval, no implementation. Again I've already mentioned funding. I'm going to switch now to the BCMA. I'm not going to discuss some of the problems, only a few of the problems that I see, but it is still not working. I'm just going to give you my solutions. BCMA needs to be withdrawn from all but two to four facilities. Those facilities need to have a lot of outspoken nurses. Not all—and not reinstated until the major problems of armband scanning, drugs, bar codes, software, med cards, inefficiencies caused and other related technology problems are resolved. The problem is a lot of nurses are developing a lot of bad habits. They learned to make it

work. Making it work and bypassing the very safety features that it was designed for. So to break their habits, you need to pull it out until it's fixed. Okay? You need to consider that all meds need to be on the med cart, and that includes narcotics. Walking back and forth to the Pyxis machines creates inefficiencies let alone signing in and out of the computer if you go to do that. The V.A. central office needs to identify and purchase highly reliable technology equipment. As it stands now each VISN is making the same mistakes, in many cases buying equipment that doesn't work, and sometimes, and not sometimes, but many times it's budget that's controlling the purchasing of equipment and not whether it is the best equipment to get the job done. If you're going to have a careful evaluation of technology on the end line user because what it is doing is shifting more and more workload onto the end line user; and if you do it right, the BCMA takes longer. They have the OMNI, and that takes longer where OMNI SPD or the supply tech counted supplies and put them on the shelf. Now the nurse takes them off the shelf and counts the supplies and enters it into a computer. That is a waste of nursing time. Just signing in and out of the computer is eating up nursing time. A nurse's day is full of interruptions and shifting priorities, and they have to walk away from the computer frequently; and if they sign out every time, then it becomes inefficient. You can eat up a lot of time that way. Okay. On the interdisciplinary level Congress needs to address financing of the V.A., and increasing staffing levels is critical. You've already heard that. I think executive management needs to have more time in meetings with staff nurses and closer to their work areas and in smaller groups. And much of the proficiency problems have already been addressed. So I'm not going to repeat that. Thank you.

MS. BOLTON:

Thank you.

MR. COX:

Ms. Logan, what version of the bar code medication administration are you currently using?

MS. LOGAN:

I'm not sure, but I think it's three.

MR. COX:

Okay. That was an issue that we had where we were discussing here as to which one you were currently using. When you say end shift locations, tell me more about that.

MS. LOGAN:

Well, currently literature has well addressed that shift rotation is an unhappy or an unhealthy lifestyle; and as the nurses are getting older, it's much, much harder for them to make the adjustment from shift to shift. And studies show that, but more and more than that it shows that constant shift rotating from an early age to the older ages are causing early heart disease in women and healthcare professionals. Now if we're going to extend the life—of the working life of the older nurse, you have to stop shift rotation. At least four people I know about have retired when they would have liked to have continued working simply because they can no longer handle the shift rotation.

MS. BOLTON:

What is your solution to covering weekends and nights, nights mostly in terms of shift rotation?

MS. LOGAN:

A significant pay differential to attract them to those areas.

MS. BOLTON:

In relationship to your recommendations, you seem to be recommending or suggesting that technology, before it is deployed in a unit or an institution, needs to be examined sort of across the V.A. system as a whole and the decision-making about the deployment of that technology be influenced by the degree to which those end users are going to be able to apply it and that recommendations are made about changes in it before it's fully deployed; is that correct?

MS. LOGAN:

I think so. I think—I don't know where it was—BCMA was piloted, but it was very underdeveloped, and as a consequence there have been lots of problems. They did not identify equipment that consistently works so that when you go in to scan, you're not scanning three or four times. And even the bar codes on the medications if they're a wide bar code, they're harder to scan than if they're a narrow thin line and those kinds of things so that everybody could have purchased working technology up front, okay? A lot of nurses like BCMA, but in order to make it work oftentimes they will scan a couple of times; and if the scanner is not working or not functioning that day, after that then everything is manually entered, and

it's the only way they can work and get medications even out reasonably on time.

MS. BOLTON:

Thank you very much. Sue Albert.

MS. ALBERT:

I'm Sue Albert. I'm Assistant Dean of Allied Health College of the Canyons; President, Southern Section California Organization of Associate Degree Nursing Program Directors; representative and member of the National Organization of Nursing Associate Degree Program. My question—and I'd like to thank you for allowing me to testify today. My question is my addressing the current V.A. performance nursing staff peer review process, promotion, recognition, respect and rewards. Currently the V.A. qualification standards require a baccalaureate degree in nursing or in a related field promotion beyond the entry level of Nurse I. This requirement prevents AD nurses from advancing in their careers and forces them to attain a baccalaureate degree in order to perform the responsibilities previously shared by all registered nurses within the V.A. system. After reviewing the nursing qualification standards for the V.A., I could not help notice that the description of the Nurse I, Level 1, is that of a licensed vocational practical nurse. When I look at the description of the Nurse III role, I note skills that AD nursing graduates possess and utilize. An associate degree nursing graduate takes the same national licensure examination as the BSN graduate. They perform at least as well, and many times better on the exam than BSN graduates. Studies to determine the level of difference at the bedside on entry level into practice have been unable to demonstrate a difference. Practice at the bedside is a major component in developing clinical expertise. AD graduates frequently possess certificates in specialty areas and a nurse is now able to become a clinical nurse specialist without a master's degree. They perform well as QI coordinators, clinical coordinators and recruiters. You need only ask non-V.A. hospitals how they perform in these areas. From the first semester in nursing school they learn teaching-learning principles and leadership skills. It is a requirement of the Board of Registered Nursing that all registered nurses possess these skills. Prior to graduation AD students have a semester of nursing leadership in which they gain experience in team leading and in primary care nursing. They make patient care assignments and take responsibility for the care of groups of patients. They are required to set priorities from the start of the program. They evaluate their performance and that of their team. I feel that any registered nurse is in a supervisory role. They are responsible for all people on their team and the level of their practice. They work to improve

their own skills and that of their team. They develop a congenial relationship with all members of the healthcare team. They frequently are mentors for new nurses and nursing students. Because they are more focused at the bedside, they are truly special mentors. All AD nurses learn the nursing process and are capable of assessing patients, identifying problems both actual and potential. They develop plans based on sound nursing theories and available resources to take action on these problems. They are creative and innovative in their approach to patient care. They must be able to use critical thinking to successfully complete the nursing program. They know how to develop measurable goals and how to adjust practice to meet them. These nurses provide care in a safe therapeutic environment. Research is not a priority with them. Patient care is. This does not mean that they cannot participate in research studies or use patient care techniques based on the latest research. They do understand what constitutes good research and how to look for the validity in the results. All AD nurses are capable of identifying ethical issues and taking appropriate actions. This is threaded throughout the entire curriculum. They are capable of functioning as ombudsmen for patients when their rights are threatened. Many AD nurses are members of such organizations as the American Nursing Association. They are self-directed, and they work to improve their knowledge and skills. Usually the skills they gain are what are needed for improved patient care. If the VA would look at any AD curriculum, it is easy to see that the students learn the skills and this knowledge in the program. The proof is in the NCLEX and studies of performance at the bedside. It is very difficult for me to understand why the V.A. does not allow them to utilize their knowledge and skills to their fullest extent. Currently, we are experiencing a nursing shortage of such huge proportion such that it is a national healthcare crisis. I can't imagine the V.A. is not affected by the nursing shortage also. And the AD programs across the nation supply 60 to 70 percent of the nurses out there. It seems to me that the V.A. is failing to utilize and support a very valuable national resource, the AD graduate. My recommendation is that each nurse is reviewed, promoted, recognized and rewarded based on his or her individual performance and not simply on education. If the nurse is doing the job, they should get the credit and the opportunity to move up the career ladder. With family responsibilities, job responsibilities, the difficulties inherent in getting a degree after graduation and the cost of the degree, these students are at a major disadvantage. It would seem to me that the V.A. is not respectful of the contributions of these nurses by not allowing them to move up the career ladder. Thank you for allowing me this opportunity to testify.

MS. BOLTON:

Thank you. I have one question for you. Do you agree that the NCLEX is only for Entry level?

MS. ALBERT:

The NCLEX is testing for entry level, but I'd like to point out the National League for Nursing Accreditation Commission has only one real difference between the bachelor's nurse and the AD nurse and requirement for their programs, and that is the research components. All the rest are the same.

MS. BOLTON:

I'm going to your statement about the requirement relationship to Level III. Isn't that only to test everyone that graduated from an accredited nursing program in the United States and see if it's safe to practice?

MS. ALBERT:

It does do that. When you look at the Level III nurse, it's exactly what they're testing for.

MS. BOLTON:

Thank you. The final speaker that we have on our list at any rate is in terms of—and I will go back after he speaks and see if the other two individuals have arrived is Bob LaDu.

MR. LaDU:

Good afternoon, ladies and gentlemen. My name is Bob LaDu, and I'm a licensed practical nurse or an LPN, with 28 years of experience. I work at Portland V.A. in the acute psychiatry unit. I served in U.S. Army between 1974 and 1996. I have a Bachelor of Science degree from the University of Utah. I'm a member of NAFLPN, the National Association of Licensed Practical Nurses, a professional organization. I come to bear testimony of my experiences as an LPN and an employee at the Portland V.A. Medical Center. Typically one year of formal education separates the LPN designation from the RN. Most of what a nurse learns about the practice of nursing they learn while on the job. As an LPN I was trained to perform all aspects of the nursing process to include assessments, diagnoses, planning, implementing and evaluation. The nursing process requires constant evaluation to ensure proper nursing care. This is best done by nurses who serve on the front lines of nursing care. LPNs typically have more direct contact with clients than RNs, and they are in a better position to assess, diagnosis, plan, implement and evaluate than anyone else. That having been said, the ignorance of the RN administration when it

comes to the role of the LPN is pervasive. LPNs are undervalued, disrespected and harassed. Recently I was asked to go out into the community to provide vaccinations for our veterans. As a condition of performing these duties, I was told that all of my time would be paid including the projected three to four hours of drive time. This gave me the opportunity to earn overtime wages as a form of compensation for additional work in travel. After a week of travel, I returned with the expected number of hours including drive time. My supervisor informed me after the fact that she would not authorize any overtime. When I objected, I was sent before a board of inquiry and accused of fraud. After more than a year-long process, I was exonerated and my supervisor told me—my supervisor was told to pay the overtime. She decided to pay only a portion of the overtime; and when I objected to that, she indicated I could take the issue up with another board of inquiry. When I asked about the process, I was told that it was frequently used to get rid of nurses. The cost of this investigation, from my investigation, I was told was \$150,000. I was asking approximately \$200 in compensation, and I felt responsible to the taxpayers not to pursue this. Not long ago I was given the invitation, as all nurses were, at the Portland V.A. to apply for membership on various committees. I applied to three different committees the same day the invitation came to me. After several months of silence I inquired about my status and was told by each committee chair individually that LPNs were not given positions on the committee because the committee didn't deal with LPN issues. Those committees were the professional standards, the clinical standards and the education committee. At the Portland V.A. LPNs have no means to address their issues without going through an adversarial RN administrator. As an LPN I've been advocating for others by writing letters to Congress and the Senate. I've written to Audrey Drake, Cathy Ricks and Secretary Principi. I have had minimal response, and I feel these people are either ill-equipped to deal with the hard issues regarding LPNs or they just don't want to deal with them. In addition to an increasingly adversarial workplace, the LPNs are exposed to the same or greater risk than their RN coworkers. We are asked to do the hard jobs that include lifting, dealing with body fluids, urine, vomit, feces, performing dressing changes, drawing blood and starting I.V.s, et cetera. We work the same long hours and do the same basic nursing care as RNs. LPNs are not given the respect or representation which they deserve. Evidence of this is abundantly obvious to those willing to objectively view the various work environments in which an LPN is employed. One example of this is to look at members of this commission and examine the number of LPNs included. For that matter look at nursing boards and committees throughout the V.A. system. There are over 500,000 LPNs in the U.S. As an organization that employs the most nurses in the U.S., one would think the V.A. would offer more respect to the LPN. Most LPNs would not put up with this type of overt harassment, but they're harassed in other

ways. On Monday I met with the chief of nursing to discuss the new qual standards. During that meeting she indicated that LPNs cannot do assessments. This was common inside a discussion among the LPNs who were also present to which she responded maybe what you call an assessment and what an RN calls an assessment are two different things. My response to that is a rose by any other name is still a rose. The environment at the Portland V.A. stinks of cronyism and is increasingly adversarial for the LPN causing many LPNs to quit nursing or seek employment in other areas. Many LPNs have found employment in areas requiring less education and skill. We have some who have reached GS9 or GS11, a pay level that they would not have attained as an LPN. I have been a GS5, Step 10, for over 10 years, and my pay approximately equates to \$36,000 a year. In an effort to address these issues, I formed an LPN e-mail group to help LPNs stay informed by the opportunities at the V.A. and to help educate them about current laws and standards. After the first several e-mails went out, I found myself denied access to my LPN peers by nursing administration for the stated reason "You don't have the approval of nursing administration." The practice of narrowing the scope of practice of LPNs is common and done arbitrarily. I was trained as a burn trauma intensive care nurse. Now I work on a psychiatric unit where we routinely need blood draws, I.V.s or EKGs. I've been trained to do these procedures, and yet I'm not allowed to. As my supervisor has told me "If we allowed you to do that, we would have to pay you for it." Instead my unit routinely calls a special team made up primarily of LPNs to do this work thus denying me the opportunity to do my job and keep up my skills. My suggestion for solutions include number 1, one respect the LPN by A, ensuring LPNs are represented on all commissions and committees dealing with nursing. B, create an LPN advisory board at all V.A. medical centers to assist administration and LPNs with issues dealing with LPNs. This would go a long way in reducing the adversarial work environment by allowing the input into such important items as the new qual standards for LPNs. I don't understand how LPN qual standards could be determined without more LPN input and suggest that this change of practice be instituted to assess those who are in charge of making such decisions. Number 2, develop a career ladder for LPNs that allows them the opportunity for promotion even when they are topped out, as I am, at a GS5, Step 10. Many secretaries and janitors get paid more than I do. I'm willing to work with the Veterans Administration to ensure fair and equitable treatment for all employees and clients. I stand ready to serve and only ask you to offer me the opportunity. I'd like to read a statement by Vasche Bernargo (phonetic), an attorney, a healthcare ethicists and also an LPN. He says "The RN community's definition of nursing as a profession excludes LPNs. It is one thing to accept the idea of supervision, but it is quite another to realize that those in charge have systematically pursued policies and procedures which result in the isolation of LPNs from the mainstream of

nursing and healthcare. This is inconsistent with any notion of equal opportunity in the American sense and reflects poorly on the moral integrity of nursing as a profession.” In a statement from Cathy Ricks who is the chief consultant on the Nursing Strategic Healthcare Group, she says—

MS. BOLTON:

Thank you very much. We are going to start the open forum, and the first person to testify will be Crystal Barber. I will remind you that during the open forum you will have only three minutes to speak.

MS. BARBER:

My name is Crystal Barber, and I'm a case manager in patient rehab at West Los Angeles.

MS. BOLTON:

I can't hear you. Speak into the mike.

MS. BARBER:

My name is Crystal Barber. I'm a rehab case manager at West Los Angeles with the VISN. I'd like to talk about a couple of points. First is sick leave use is one of the greatest barriers between management and staff. If the sick leave use would be standardized across the nation in the V.A.s and VISNs and units, it would create equal policy, and it would allow the employees to cash their sick leave out when you retire. It would stop a lot of the abuse of the sick leave. You can save your money for when you get ready to get out. The second is ergonomics. I'm seeing a lot of computer-related syndrome problems, shoulders, neck, carpal tunnel and tendinitis in my work environment. Proper workstations, proper chairs, proper lift machines and anti-glare screens for the computers would help a lot for the staff. Thirdly, inadequate supplies. Nurses have to look for wheelchairs, gurneys, scrounging for I.V. poles, compression devices and glucose machines, and it wastes a lot of nursing time. Fourthly, there should be disability insurance for nurses. If you start at the V.A. and injure yourself within a year or two, you don't have sick leave, and there is no disability policy for the V.A. nurse. We have no state disability. And to get disability from social security, you have to be about dead. The next one is when RNs retire, I have a lot of friends who would have come back to the V.A. and would work one or two days a week. However, there is a policy that you can't hire the RN back without her losing her annuity. So often they don't want to deal with the registry; and had we been able to employ them one or two days out of the

week, they would have come back and worked like when another nurse is off for two days. And the last thing is I wish that we would be able to fire people who are threatening and not doing their work so that us who want to do the work, can do the work. A lot of us were involved in a situation where we had to deal with a colleague who about a year ago we were scared to death that he was going to come to the V.A. and one day lose it and probably shoot us. And in the end he shot a family member and is in prison. So there were plenty of times that management tried to submit things because of union issues, but for whatever reason we can't get rid of people that in the private sector would have been gone in a day. Thank you.

MS. BOLTON:

Thank you. Sheila Brown. Let me just remind you that in front of us we have empty spaces on our sheet which suggests that some of you perhaps filled out some document but didn't give it to staff. If she doesn't have a completed document like this, then your name is not on this list.

MS. BROWN:

Sheila Brown from West Los Angeles Med Center. My concerns—oh, and I'm an NA. I support the ratios for the NAs. One of my concerns is the acuity that the V.A. has put forth for the NAs. They're saying that each NA should spend 15 minutes with each patient which is not realistic. That's 45 minutes, 24 hours, 45 minutes for each patient which means each for each shift there is 15 minutes to spend with a patient. It's not realistic. I'm asking that they do away with the acuity system or add more staff because it puts the patient in an unsafe zone, and it's also putting the nurse in an unsafe zone. Also one of my other concerns is to—excuse me. My voice is leaving. In the process of having less time to work with the patient, it's also putting the nurse in a situation where there may be patient negligence as well. That's one of the concerns that we are—that we don't want to be put in that situation because the patient is looking at us saying "Well, that nurse is not spending enough time with me. I didn't get everything I needed from that nurse." So that's when you get like in a negligent situation with the patient. And there's one more thing. I wanted also to address the premiums for Sunday, not getting them Saturday. Now I feel the NA should get the Saturday premium as well. My Saturdays and my Sundays are special to me too. If the RNs can get it, I think the NAs should be able to get it as well. That's it. Thank you.

MS. BOLTON:

Thank you. Elenita Santos. Elenita Santos. No? Jennifer Smith.

MS. SMITH:

Good afternoon. My name is Jennifer Smith, and I'm a nurse at the West L.A. Medical Center. I'm currently a case manager in the surgical department of care at West L.A. On behalf of my peers here at West L.A. I'm glad I'm here to represent them at this forum. Also I realize that my time is limited. I believe there should be a task force developed to look at the staffing ratio at West L.A. V.A. Currently the staffing ratio on the medical/surgical unit is 12 to 14 patients to one nurse. This compromises patient safety, and it affects staff morale and it causes an increase in staff off sick and creates a bigger shortage on our own already burdened system. It is hard to believe that with a nursing shortage, the charge nurse on the medical/surgery unit is involved with staffing when the unit is on the off-tour. When a nurse calls off on an off-tour or sick leave, the charge nurse is responsible for staffing the unit. The nurse has to call all the units of the V.A. or call a nurse who has just left the unit less than eight hours to return back to work for overtime. This burden should be removed from the nurses who are already working with scarce resources. The nurses should not be involved with staffing. There should be staffing units designed for that purpose. The public has a negative image of the V.A. The nurses from Kaiser, UCLA, Cedars, et cetera, think a V.A. is an awful place to work. This negative image worsens our hiring power and creates a bigger nursing shortage. Kaiser has a nursing staff patient ratio which is 5 to 1. We still have 12 or 14 patients to 1 nurse on the medical/surgical unit at West L.A. This is how burnout occurs. It increases absenteeism, injuries, which makes our shortage even worse. I believe that this commission should implement a task force and revisit the nurse-patient ratio or staff mix and implement a staffing department at West L.A. and remove the burden of staffing from the nurse. The nurses are needed at the bedside. Thank you for listening.

MS. BOLTON:

I wanted to be clear about your statement. Are you saying that 24 hours a day, both during day and night, a registered nurse is assigned 12 patients at West L.A.?

MS. SMITH:

In the medical/surgery unit where I worked for five years, I was only the nurse on a pod with 12 to 14 patients out of every given shift, day, evening or night.

MS. BOLTON:

Thank you.

MS. SMITH:

Thank you.

MS. BOLTON:

Estreluita Legaspi.

MS. LEGASPI:

I hope I get the message across in three minutes. I'm an ICU nurse from Long Beach V.A. I've been a nurse for 26 years, and out of that 13 years is—I'm so nervous -- 13 years is in the V.A. system. When I received the notice on the e-mail about this, I make sure that I come here to listen, but not to speak out. I just wanted to know what's going on in other V.A. systems. I have a special concern being an ICU nurse. It is a well-known fact that in almost all the hospitals ICU nurses are always an area that has been a hard time of retention. To be an ICU nurse or any other speciality unit is hard. Why not apply the actual experience, the credentials of ACLS and CEU specialty specifically for ICU RN to qualify for that position in a sense because with those special qualifications you are the one that the hospital can rely upon to float in any other unit, not only in ICU. Requirement extends to—let's talk about the ACLS code blue situation. It is a fast-paced unit. Not everybody can float there. We don't have ancillary help because it's a primary care unit, but in the V.A. hospital they are aware and recognize to have all these credentials but are not compensating us. Other intercommunity hospitals, even the Registry or the traveling nurses recognize us, but not the V.A. system. Qualified ICU RNs in the V.A. system have to move from one V.A. hospital to another V.A. hospital to get that compensation. I want to tell you what I experienced last week when I took my ACLS recertification. During the (inaudible) the input on writing the code, we started with sinus rhythm. Of course, of the mega code algorithm was implemented. Finally the patient converted in sinus rhythm. The preceptor asks now what are you going to do? The staffs who works in the floor who are aiming to go to ICU said—thank you.

MS. BOLTON:

Thank you. Mary Anderson.

MS. ANDERSON:

It's my pleasure to speak to you. I speak softly, and so let me know if you can't understand. My name is Mary Anderson. I'm from the Veterans Administration Hospital of West L.A. I've been here two months. I am a nurse for 32 years. I worked in Saudi Arabia for 10 years, in the Emirates for two years after that, and I just returned to the United States. I am glad that I had the opportunity and have the opportunity to work where I am with the patient population I'm working with. I would like to address safety and security issues that I have identified that may exist in all the federal facilities, the veteran facilities, but my own reference is the West Los Angeles. Terrorism is real. I look at terrorism from—the country I come from is Israel, but the targets you look at are the people who are interested in producing casualties and in making political statements. Since 9/11 and Free Iraq terrorism is a concern for all people. This includes nurses, this includes patients, and this includes the government. I think that the Veteran Administration facilities is a prime target only from my background in the Middle East and being acquainted with some of the philosophies that you learn to acknowledge do exist whether you agree with them or not. We have a large—the West Los Angeles and most of the V.A.s are in large cities. These cities with large populations a great target. A federal government facility is a great target. Military patients are a great target. They could achieve three goals with one hit. Now what I'm purporting is we get serious about security and safety of our staff, of our facility and of our patient population. I suggest embedding someone who is in the government. There's different sections of the federal government who's experienced with security other than as a facade but as a reality. The next issue I'm going to move on to is one that was new to me, and I'll be quick, is this boarding process. Okay. Since I am new to the system, I looked at it and tried to figure out how it works. It's part of a culture that I'm new to. Okay. The action is recruitment, retention and promotion. The process is boarding. The outcome is to provide proper nursing care for military patient population. We have to look at where the process—

MS. BOLTON:

Thanks, Ms. Anderson.

MS. ANDERSON:

Thank you.

MS. BOLTON:

Sheila Carter.

MS. CARTER:

Good afternoon. I may not need a microphone. I talk pretty loud. I will just get the mike out of my way. I'm Sheila Carter from the Long Beach V.A. I'm an LVN. One of my issues I would like to speak on is LVN pay. It's a real big problem in the Long Beach V.A. We have LVNs that have been working at the V.A. for like 20, 25 years and they're not making as much as nursing assistant health techs. I was listening to Bob, so I don't really need to talk on some of the issues that he discussed. He covered a lot that is happening at the Long Beach V.A. also. We have even a nursing assistant right now that's retiring from the Long Beach V.A. and has 25 years in, and we have an LVN that's at the V.A. that's been an LVN for 20 years, and she is not making as much as the assistant that is retiring right now. That's a big problem. I've been there 16 years, and I've been an LVN for—this is my tenth year. I came in as a nursing assistant, and I started at a 57. I came in the door as a 56 in 1987. And I'm a 67 now as an LVN, and I think I came in at \$15,000. I make 36,500 now, and this is almost 17 years later. Another issue is I do support the per diem pay for the nursing assistant and all the other staff that works throughout the V.A. on Saturdays. I feel they should be premium pay also. Another thing I would like to cover was—oh, the solution that I have for the LVNs for their pay is maybe changing the pay scale, maybe we can look at LVNs becoming LVN1, LVN2, LVN3, LVN4, LVN5 and LVNs coming in the door coming in the door at—they're coming in the door at \$28,000 a year. That's not realistic, and maybe they can come in the door at 5, 10 and then go from there with our pay scale. I know that national is looking at the LVNs as 7s right now. I did get that message also.

MS. BOLTON:

Thank you.

THE WITNESS:

Thanks. Judy Maxwell.

MS. MAXWELL:

Thank you. My name is Judy Maxwell. I'm from the Loma Linda V.A. Medical Center, Loma Linda V.A. Healthcare System. I'm also president of the United Nurses Association, the union of healthcare professionals at our facility. I agree that trust is extremely important. Trust can be better established and maintained with more regularly scheduled staff meetings where there is an open forum and nurses are giving answers to their questions. At the V.A. Loma Linda healthcare we have town hall meetings held by the director, by the chief nurse and by our network director Mr. Ken Clark. Many employees are able to attend, but there's always room for more. Sometimes direct caregivers are the last ones that are able to attend, and I think that it would be nice to be able to provide some coverage so that the direct caregiver can attend. To the next one. Staff can better participate making decisions and solving problems when they're included in the plans at the unit level. Frustration is met when there is not time to give input due to a short deadline. Sometimes we're not told about things until the deadline is coming up in a few days, and it would help to know ahead of time that we have the lead time to put in for something or give our input. At the V.A. at Loma Linda unions are included at various points in the organizational level such as the Safe Med committee, the Network Planning Performance Improvement Council, but it's more important to have more than just one voice from that union. On to number number 5. The V.A. can attract and retain a quality workforce by encouraging the staff to pursue higher levels of education, additional training and helping to provide the funds for it. And under number 7, some technologies that could be used to aid an aging workforce by working shorter shifts to fill in where needed such as a minimum of three to four hours on a shift, scheduling retired staff who wants to continue to be in the workforce directly through the V.A. rather than through a registry and, therefore, by offering them at least additional—

MR. COX:

Thank you.

THE WITNESS:

Thank you. Yvonne Gallers. Luisa Burkes. Angela Burrell.

MS. BURRELL:

Hi, everyone. My name is Angela Burrell, and I'm a registered nurse at the V.A. Medical Center in West L.A. I have my BSN. I am an MSN student. Right now I serve in the role as off-tour supervisor. In my career

with the Veterans Administration I had an opportunity to work to view nursing from various perspectives, as a clerk, as a manager, and in addition a case manager and supervisor. I came to the conclusion that our nursing has had to do more with less. I believe that the V.A. would be an attractive place of employment if we take value in our nurses and we trusted and showed appreciation for our nurses. In the phrase nurses are required to do more with less, I mean in terms of less money, less time and less resources. I worked on a nurses' committee for the last four years, and this is supposed to be a thing for celebration for all our nurses and to recognize all our nurses. There are events where nurses are rewarded with money from the director's pocket in addition to plaques, roses, et cetera, and we have progressed to just tickets or cake and punch. It's true. You are required to meet the nine dimensions of nursing practice as established by the Nursing Practices Standards Board again doing more with less because nurses on the floor have less time to participate in committees, to do workshops, and this is because of staff restraints. Because of this we are not able to accomplish these objectives affecting the big vision. As our group supervisor I found the staffing on off-tour hours inappropriate because after hours usually the staffing is less. I believe because it's the belief that patients are sleeping and there is not that much activity going on; but as off-tour supervisor, I find that nurses are working with less, less support staff. On average there's one lab tech, one day tray, one EKG tech, one RN who may be the charge nurse. I find myself as off-tour supervisor intervening, being there for my staff hands on, and that's why I wear scrubs. The V.A. takes pride in being excellent in innovation. We're leaders in technology. Our nursing triage telephone system is a recognized role—

MS. BOLTON:

Thank you very much.

MS. BURRELL:

Thank you.

MS. BOLTON:

We are going back to two other individuals. John Royce, did he ever show up? No. Betty Ciaccio? Is there anyone else who did not bring forth their paper who wishes to present testimony? If not, we want to thank you all very much for attending today, and we look forward to hearing from you as we stated today. Also e-mail the commission to provide additional comments. Thank you for coming.

I, the undersigned, a Certified Shorthand Reporter of the State of California, do hereby certify: That the foregoing proceedings were taken before me at the time and place herein set forth; that any witnesses in the foregoing proceedings, prior to testifying, were placed under oath; that a verbatim record of the proceedings was made by me using machine shorthand which was thereafter transcribed under my direction; further, that the foregoing is an accurate transcription thereof.

I further certify that I am neither financially interested in the action nor a relative or employee of any attorney of any of the parties.

IN WITNESS WHEREOF, I have this date subscribed my name.

Dated: _____

SHERYL HILTON MEYER

CSR NO. 2852