

DEPARTMENT OF VETERANS AFFAIRS
NATIONAL COMMISSION ON VA NURSING

THE COMMISSION PANEL:

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DR. ANN CONVERSO
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MS. PATILLO:

Good morning, I'm Dr. Marilyn Patillo, chairperson of the National Commission of VA Nursing. Before we start, I would like to have David Cox, to my left here, speak just for a few minutes.

MR. COX:

Good morning. It is nice to see all of you out, and I'm very excited and happy with Marilyn for holding these hearings. But we have a lot of our fine men and women in Iraq right now who are veterans, and people fighting the war and defending this country, and we need to stop for just a moment, and I would ask for a moment of silence to remember the men and women in Iraq.

(Moment of silence.)

MS. PATILLO:

Thank you, David. I would like to introduce the members of the Commission who are here and I would like to say a little bit about them, introduce them to you:

This is Dr. Phyllis Hansell, she is a professor at Seton Hall University, representing school affiliation. Mary Raymer -- yes, Mary Raymer, National Association of VA Nurses, VA Healthcare Staff Development, Central Office New Orleans, Louisiana; past Associate Chief of Staff, Salem VA Medical Center. Eileen Kingston, to my right, VA Healthcare System; Nursing Strategic Healthcare Group Chair; VA National Nurse Executive Council Nursing Workforce. David Cox, Dr. David Cox, Employee Representative, Bill Hefner, VA Medical Center, First Vice President of NVAC.

Ann Converso, Employee Representative, VA Western New York Healthcare System, Vice President UAM. Dr. Linda Bolton, Vice President and Chief Nursing Officer, Cedars Sinai Health System and Research Institute, Los Angeles, National Advisory Board on National Education and Practice, Division of Nursing, Bureau of Health Professionals. My name is Marilyn Patillo, I'm Assistant Professor at the University of Texas at Austin, School of CK Remediation something and I'm a colonel in the United States Air Force, Retired. I also want to introduce to you our fine, wonderful staff: Ms. Cathy Rick, well, she is Ex-Officio to the board. She helps us put everything in its proper perspective. She is the Chief Nursing Officer, Office of Nursing Services in Washington, D.C. and she is a past Nurse Executive at Milwaukee VAMC, Marquette University graduate. Go Marquette -- plus Texas. Thanks, Cathy

Then, Oyweda Moorer, she is the Director of the Commission, our Staff Director, past Nurse Executive representing the Nursing Service, VA Medical Center, Washington,

D.C. Our court recorder is Cathy Powell, so she will be recording our session today. But before we start our session, I would like to give you a brief background of the Commission. Oyweda, do you want to give them some housekeeping instructions?

MS. MOORER:

Couple of housekeeping items. Number one, we will ask you to please cut off your cell phones. Turn your cell phones off. And the bathrooms are to the left of the door, just you go out the door to your left. And around the corner your right, there is a bank of telephones, pay phones there if you need it. And then there is a house phone right outside the door.

MS. PATILLO:

Okay. The Commission was established by Congress and appointed by the Secretary of the Department of Veterans Affairs. The duties of the Commission are as follows:

Assessment: Consider legislative and organizational policy changes to enhance the recruitment and retention of nurses and other nursing personnel by the Department of Veterans Affairs, and to assess the future of the nursing profession within the department, and to give recommendations on legislative and organizational policy changes to enhance the recruitment and retention of nurses and other personnel in the department. A 12-member Commission made up of VA and non-VA staff as designated by Congress was appointed to carry out this charge. The first meeting of the Commission was held May 8, 2002. Since then, the Commission has held additional meetings, electronic and face-to-face, and we are using various methods to learn the situation and obtain feedback from the VA nursing staff and other state holders, in order to make good assessments and good recommendations to the Commission as submitted in a report in July 2003. A complete report is due to Secretary Principi, May 2004. The Secretary will then have 60 days to submit to Congress a report and provide the Secretary's views on the Commission's findings and recommendations, explaining what actions, if any, the Secretary intends to implement of the recommendations of the Commission and the Secretary's reasons for doing so. The purpose of this hearing is to obtain VA nursing staff input on recruitment and retention issues. The Commission places a high priority on obtaining feedback from all levels of VA staff. Over the coming months, the Commission will continue to gather data, and to hear from VA staff. We encourage you to visit our web site at www.va.gov/ncvan or email the Commission at vhaconcvan@hq.med.va.gov. I can give that all to you later. Having been given that brief background, we will move the agenda forward by laying the ground rules for documenting and answering any questions concerning this process you may have. Scheduled oral testimony will take no longer than ten minutes, written testimony must be submitted prior, and you have done so, and we take all of these will read and recommendations very seriously, so if you didn't have a chance to present orally, your written is just as good. We appreciate your hard work, and many of you have come here at your own expense to be here and we really, really appreciate it. The witnesses will be cautioned with a yellow card when three minutes are left, and a red card when you have to get up from the chair, so that the other people can

come in and everybody can have their ten minutes. And please cooperate with us. We would really appreciate it. Witnesses: When appropriate, Commission members may ask the questions, or may ask some questions to clarify certain things. Witnesses may not question Commission members. We are here to collect information. If issues in witness' testimony have been expressed in previous testimony, in the interest of time, we ask that subsequent witnesses may give an introduction and verbalize agreement with the previous testimony, and then step down. A 20-minute open forum will be conducted in the morning and afternoon, as indicated on your agenda. Anyone wishing to speak must complete a form on the registration table, and submit it to the lead Commission member, Oyweda Moorer, just prior to the speaking, and she'll get them to us. Persons speaking in the open forum will be selected on a first-come, first-served basis -- and we do have a list right now -- and they'll have an opportunity to speak for three minutes. The lead Commission member, that's me, will notify the speaker when time is up. We ask that the witnesses promptly stop talking and be seated when time is called Are there any questions of this process?

AUDIENCE MEMBER:

Good morning, I have a question. If you are scheduled for three minutes and you only use two, can you yield your time to another member?

MS. PATILLO:

Yes. Just as long as we allow the three minutes to as many people as possible

AUDIENCE MEMBER:

So I can yield it to another person and give them four minutes?

MS. PATILLO:

Okay. Somebody help me with the time. Just be very considerate to each other so people can get their two cents in. Anything else? So let's start, it is exactly 9:01 a.m. Our first speaker is Shirley Collins from the Central Texas Veterans Health Science Center.

REPRESENTATIVE:

Good morning. My question was directed at No. 5, "How can the VA best attract and retain a quality workforce?" And right now, the field facilities are challenged, the field facilities must manage their budget in a prudent and sound financial manner. When awareness of budget restraints for the fiscal year are projected, awards and recognition programs are frequently put on hold, if not stopped all together. We all know that recognition and rewards promote the right kinds of behaviors and that these recognitions

and awards should be done immediately and timely. The four factors of recognition, according to Skinner, are recognition should be specific, recognition should be immediate, and recognition should be geared to the individual and it should be spontaneous. Those are my supportive issues pertaining to the rewards and recognition, and why we should continue them. My recommendation to this committee would be to allocate a budget that is not controlled by the director's total budget and shouldn't be turned on and off. And then, additionally, we need to train nurses, particularly our new nursing leaders, that there are other mechanisms for rewards, not necessarily monetary rewards, but they need to have the opportunity to learn other mechanisms that can be done immediately. What comes to my mind is the old programs in the past where we had Motivational Dynamics I and II, that was offered to our new leadership. And I was one of those persons that was given that, and I know that it personally helped me. I learned early on how to reward and recognize staff. It was not always costly. But oftentimes, our new leadership, they don't have that information, and everything is always tied to money. That concludes my recommendation. Do you have any questions?

MS. BURNES-BOLTON:

Thank you. Could you speak a little bit now about the fact that when you -- sounds like it was part of an orientation for leadership. Is that correct? Or did they do something else?

REPRESENTATIVE:

It was after I had been a manager for a while, and then, what they did is, they introduced Motivational Dynamics and it was -- it was a program that really just educated the nurse manager how to best reward recognize employees, and how to do so timely and appropriately. They had such a good response from it, that they went on and did a Motivational Dynamics II. Now, I'm not supporting that one particular program, because there are many good ways to teach how to recognize and reward. It is just that that's the one I had access to.

MS. PATILLO:

Any other questions?

MS. RAYMER:

Do you have in your experience any recommendations for particular types of reward systems that you think are more effective?

MS. COLLINS:

I would think that time-off rewards are probably more valued by our clinical staff than is money. Having a half day, or you know, maybe hours. I understand our directors do have budget constraints, and so my remark about that was not a criticism, realizing they have goals and objectives they have to work within. So I would think time off rewards. I also think staff really love recognition in their own personal accomplishments; a pat on the back. A manager is trained to know when and how to say things genuinely, and encourage people and staff rather than just give assignments. The thing that comes to my mind is behaviors that we reward are the ones that we are going to see again. Now, in hospital settings, if someone does something wrong, we are very quick to bring that to their attention. Likewise, we need to be quick to address positive behaviors so that we see more of those types things. Is that clear?

MS. PATILLO:

Before you go, I would like each speaker to just, when you introduce yourself, tell us a little bit about your background, what you do in your facility and organization, before you start your testimony. Shirley, could you tell us just a little bit where you are coming from?

REPRESENTATIVE:

Yes, I will. I'm Shirley Collins. I'm the nurse recruiter at the Central Texas Veterans Healthcare System. I am here representing my union, and I did collaborate with my peers before coming to see if this is an issue that they would like to see presented. I have been with the VA system now 28 years. I have been a registered nurse more than 30 years. I don't want to tell you exactly how long. But the VA has been a very good career choice for me. I'm excited to share with a new generation of nurses. There are things we could do better, but there are a lot of things we are doing now that are very good.

MS. PATILLO:

Thank you. Next speaker is Terry Edmondson from the Central Arkansas Veterans Healthcare System.

REPRESENTATIVE:

Hello, my name is Terry Edmondson. I'm currently working at the Central Arkansas Healthcare System. I have worked at the VA for nine years. I work in the Geriatric Clinic. I have functioned as a nurse assistant in practically every area. I have received numerous trainings in vain, as far as promotion and recognition, but I still have valuable training to offer our Commission. Five years ago, I regrettably quit bedside nursing, as so many excellent nurse assistants have not, in an effort to gain stability in scheduling, increase in pay and recognition. I work overtime constantly on wards that are understaffed and overworked. Why not take the overtime and promote nurse assistants to

a grade that is desirable and promotes a living wage? Many of us cannot afford to participate in health insurance plans because of the cost. Myself and many other nursing assistant work two jobs just to survive and provide the basics. We work Saturdays but we receive no Saturday premium pay, and that is mandated for licensed staff. The shift differential has not increased in years, but our workload ever increases due to positions not being filled to positions left vacant. Workmen's compensation claims are at all-time highs among nursing staff. I ask, would this not be due to tremendous workload? Education, in many instances, is mandated by funding and scheduling is not always available. How many nursing assistants can afford to schooling costs up front? pay Child care is not affordable or available at this time. Providing these services could greatly reduce calling in. I urge the Commission to make the following recommendations. Manage staff and ratio by law, allow uniform allowances for GS-6 and below, start mandatory shift rotation, Saturday premium pay for nursing assistant, specialty pay for nursing staff working in special areas. Rewards exclusively for nursing assistants, on-site classroom, on-site daycare 24 hours, increase off tour weekend details, GS-6 target for nursing system based on performance in area of work. Develop after-assistance with universities so costs will be charged until funding is released. Appoint an LPN at a minimum of GS-5. Stop contracting VA jobs. Please, act swiftly to save our human resource, the nursing staff: caring for those who serve us. Thank you.

MS. PATILLO:

Terry, what is the average age of your nurse's aides?

REPRESENTATIVE:

Forty-five.

MS. PATILLO:

We have been asked to remind you to speak up so that the reporter can hear you, and speak clearly, please. Our next speaker is Patricia Lasala.

REPRESENTATIVE:

Good morning, my name is Patricia Lasala and I'm a registered nurse at the San Francisco VA Medical Center. I'm also president of the Professional Union, Local 1, National Federation of Federal Employees, International Association of Machinists and Aerospace Workers, otherwise known as NFFE/IAM. My union represents the professional employees at the San Francisco VA. First, I want to say what a privilege it is for me to have been selected by my peers to appear before you this morning to discuss what I and many others have given our lives to, namely, the nursing profession. Additionally, I would be remiss if I didn't commend this Commission and Congress for addressing the issues that affect VA nursing and those who have given so much to America, the American veteran. I have the good fortune to enjoy a very rich nursing career and I'm honored to work for the VA. I'm been a nurse for 33 years, ten of those years in the private sector and the remaining 23 years of service to the VA in San

Francisco. Most of my career has been in nursing administration. I am now, however, the president of the professional union. Quite a switch one might say, but not really. My focus now is what it has always been: First, patient care, and then staff concerns, and the supportive optimum working conditions. Since the written testimony I submitted is quite lengthy, and I would not be able to complete it in the allotted ten minutes, I will share with the committee and my colleagues a few of the comments and observations in that testimony. I started at the VA as a staff nurse in psychiatry 23 years ago. I became the head nurse, then the psychiatric nursing coordinator, and finally, the assistant chief nurse for medicine, surgery, psychiatry and patient transportation. I also sat on the Nurse Professional Standards Board for 13 years. I share this information with you so you can see that my experience is quite varied. I will focus on some of the issues of concern in VA pay administration. Locality pay. This system and the salary survey that drives it never made much sense to me. What kind of a message do we send to our nursing staff when we tell them they cannot earn a yearly salary that is as much as or more than their colleagues in the private sector? Is the message that their practice is somehow substandard and because of that, their salary cannot equal or exceed that of the private sector nurse? I think not. Yes, I am grateful that parameters such as the cost of living in certain areas are given weight when setting our salary. I am, however, weary of hearing every year, well, that's the law. Management should join with labor unions, such as the one I proudly lead, and tell our lawmakers, if you are really concerned about a nursing shortage, then you should stop this paternalistic maneuvering to set our salaries. Labor and management should have greater flexibility to bargain collectively for better salaries of all staff in the VA. Healthcare sectors in the private system know they could not function without a strong, viable, motivated nursing workforce. Their knowledge has translated to salaries that are commensurate with the clinical work expected. How many more fine nursing staff members do we have to lose before a light goes on? Premium pay. Premium pay all too often focuses on the obvious. While I believe it might be necessary to offer premium pay to nursing staff in areas that are hard to recruit for, such as the ICU, or E&A or the OR. I say pay premium pay to nurses who work in areas of significant turnover. This turnover is because the work is extremely labor intensive and viewed by some as less meaningful than the above-mentioned. I suggest my colleagues walk through medical/surgical wards some evening or night, or better yet, check out an extended care facility. This is where the back-breaking work is done. These are areas that eat up nursing registry and per diem budgets. Staff these areas better and pay these professionals for working in an area that is essential to our mission. I consider these nursing staff members the unsung heroes of nursing service. Peer review. I believe that the Nurse Professional Standards Board was an original and 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 VA system, how unfair and unreasonable the process has become. The process varies from VA to VA. If the Board was to work as it should, anyone could share it and the outcomes would be fair, but how often do we hear, "Oh, I don't want to go to her board," or better yet, "I want to go to his board, he promotes." If you think these comments are stretching the point, trust me, they are not. 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. When you through ego, temperament and a drive to hold your budget down regardless of the methods, the system breaks down, and it has. Please, spare us another task force or commission, or whatever

you think will fix this. Nothing will. It is time to adopt a pay system that recognizes excellence in practice without the caveats that make advancement all but impossible. I suggest you look at models in the private sector. The Kaiser system, for example. This is one healthcare organization we at San Francisco lose many of our new and recent graduates to. Be bold! Recognize a system that has outlived its usefulness and let's move into the 21st Century. If you do, many of us will gladly go with you. If not, you will lose a national treasure second only to the American veteran, that being those dedicated VA nurses who care for them. Qualification standards. I have no argument with setting down standards that drive our practice. However, if it was your intent -- and when I say "your," I am referring to the greater VA nursing leadership and philosophy -- to keep the bedside nurse, that nurse who comes to work everyday, and cares for the sickest of our veteran population with grace, dignity and excellent nursing skills, from ever advancing in the system, then you have succeeded. When I was interviewed for my position at the VA in San Francisco 23 years ago, what impressed me the most during the interview was when Mary Anderson, the then-Chief Nurse, looked at me and said, "The VA rewards the nurses that stay at the bedside." Tell that to a nurse who has been working 15 to 20 years on a medical or surgical unit. A nurse who gets outstanding evaluations based on his or her nursing practice. This is a nurse that comes to work everyday while raising a family or caring for elderly parents and still manages to care for the veteran, using exemplary nursing skills and interventions. Yes, they may be diploma nurses, or a BSN, be that as it may, but they don't chair interdisciplinary committees or write policies, or pen articles in leading journals, or present at national conferences. They are not nurse managers or advanced practice nurses or upper level administrators. No, they are not, but we know who they are. They are the gallant professionals and nurses who stay at the bedside. So how do we reward them? We keep them at Level I, or on occasion maybe Level II. We tell them that they don't meet this or that dimension and we know they never will. Is this how we reward the nurse who stays at the bedside? Sometimes I am afraid this is how we do reward them. I say, abolish these standards and have a career ladder similar to the ones found in the private sector. Again, I urge us to be bold. I know many nursing leaders at the national level will find a great deal of credence in these observations. Now is the time to do something about this elitist system that disrespects the hero known as the bedside nurse. Please remember, there are halls, clinics and wards of VA facilities all over this country that are filled with the pride of our profession: the VA nurse. We cannot let Thank you for affording them down. me this opportunity, and I wish you and your families peace.

MS. PATILLO:

I have a question. I had a question about some of the elements that you referenced in the Kaiser system, about the peer-review process. Could you talk a little more about that?

REPRESENTATIVE:

I was thinking about bringing it with me but I was very cognizant of the fact I had only ten minutes, so excuse me, I can't elucidate. We are losing nurses in droves in the San Francisco VA. New graduates and new nurses will stay about 11 months to a year and a half. They stay that amount of time and get an excellent, excellent education, if I say so

myself, and then they move to Kaiser because they have completed that first year of nursing experience. And their salaries are at least \$10,000 higher in San Francisco, after that first year. I don't have a ladder with me, a clinical ladder with me. But another model is the University of California at San Francisco. They also have very impressive career ladders for registered nurses.

MS. BURNES-BOLTON:

In terms of your recommendation for the non-baccalaureate nurse, how do you see that nurse being rewarded? And I'm familiar with both the Kaiser and the San Francisco system and your clinical labs, which do have some increases in it related to education.

REPRESENTATIVE:

Yes, they do, but they also have increases that relate to experience and time in service. Other than, you know, the step increases that we get automatically. But you know, I'm sure that the VA has in San Francisco, you know, I represent nurses who are there 15 and 20 years and some of them are still at Level I. A few of them are Level II, but early steps. I think there is something wrong with that. You see, when you have a nurse stay at the bedside, they can't do all of these things that I elucidated in here to move them up. They can't share interdisciplinary committees or pen articles. They are working nights, and our mission is to service the veteran at the bedside, and someone has to do it. And these gallant men and women do it. I say we should reward them.

MS. PATILLO:

Our next speaker is Jill Stokely of the United American Nurses.

REPRESENTATIVE:

Good morning. For members of the Commission, my name is Jill Stokely and I am a clinical nurse specialist employed at the Tuscaloosa, Alabama VA Medical Center, where I counsel and care for an average of 150 patients, mental health patients, at any one and at least 900 a year. I'm an active member of the Alabama State Nurses Association, representative by collective bargaining by my union, the United American Nurses. I am also on the National VA ADN Council as the business liaison person. So I hear on a monthly teleconference the information that all the ADNs today are talking about. I am testifying today as both a proud VA nurse and on behalf of all the VA ADNs of the UAN. This hearing and the others in the Commission will hold as you prepare recommendations on the future of VA nursing are of critical importance for our patients. And for those of us who provide the nursing care they deserve. In my 20 years as a VA nurse, I have had the privilege of serving some 9,000 mental health patients, substance abuse patients and post-traumatic disorder patients. In addition to the practical experience that I have gained as an ABN and BSN, both within the VA system and in the public sector. I have a Master's Degree in nursing and a Master's Degree in counseling. As a clinical nurse specialist, I treat, counsel and prescribe medications for Veterans with service in the Second World War, Korea, Vietnam, Granada, the Gulf War and Somalia. And one day I

expect to serve the Veterans of the war underway now. All of my patients are suffering with the disease of substance abuse. Many suffer from post-traumatic stress disorder. PTSD vets experience flashbacks, bad memories and nightmares that limit their ability to function in a job. All of my Veterans experience chaos in their lives and their relationships. There is no better or more important job for me and no place I would rather work than in my hospital in Tuscaloosa. I look forward to treating at least 3,000 more Veterans before I retire. The average age of, in my medical center, of an RN is 46. We have maybe three RNs under the age of 30. But you will not be surprised when I tell you that some important changes are needed to enable VA nursing to meet the needs of Veterans and nurses in the 21st Century. We need to be able to recognize and capitalize on the enormous pool of VA nursing skills and experiences; to reward and retain experienced VA nurses by matching classification and pay to our work and qualifications; and to attract more nurses to VA hospitals in the face of serious nursing shortage and a growing number of patients. I want to address two particular issues of concern for AD RNs: The Nurse Qualification Standards and the restoration of the culture of nursing in VA hospitals. As you know, the Nurse Qual Standards are the backbone of VA nursing. They define our practice, our responsibilities, and underpin our classification as VA nurses in terms of nine dimensions of nursing practice. Some day we need to fix or abolish these standards. I would say that while these standards deserve ongoing review and modification to define and reflect current standards, the bigger problem is that they are often ignored. This is especially true when it comes to Nurse Qual Standards for Nurse 2s through 4. Opportunities for advancement and the pay that comes with advancement are limited by opportunities in practice, and limited from classification to classification. In the higher classification, standards are less likely to relate to clinical practice and relate more to those who have had program management responsibility. For many of us, once we attain placement in Nurse 3 of the classification system, it is next to impossible to get to Nurse 2. Let me offer myself as an example. I meet all the qualification standards for Nurse 3 and for Nurse 4. The educational requirements, clinical requirements, and responsibilities. I prescribe treatment and medication. I educate other nurses and staff. I work on the national level representing nurses. But I am not a manager of a clinic. Although I meet the Nurse 4 standards in all ways, the only way I will qualify for Nurse 4 in my hospital, is to move away from clinical practice, away from direct patient care. That is not because the standards are wrong, but because at my hospital, as at others, the ability to meet the standards are often denied for a nurse in the clinical practice, which is contrary to the intent of the 1999 Nurse Qual Standards. Classification should be the result of pure, true peer review by the Nurse Qual Board and the recommendation should be made regardless of budget constraints. This is one of the issues the Commission should address. Even within an institution, a medical center director who holds promotion and special pay scale authority may apply different standards. As an example, the UAN is currently challenging a situation in which two advanced practice RNs are doing the same job in the same VA hospital, but are placed in two different classifications. One is a CNS and one is a nurse practitioner. And one earns \$10,000 less than the other. The second area that I want to address is restoring the culture of nursing in VA hospitals. This is a concept rich in opportunity for nurses. Let me explain it in this way. We need to empower nurses to direct patient care. That role for nurses has been in decline in today's service line atmosphere. And another example of this is that in our last teleconference call that we

had for the ADN Council, there was told to us that in one particular VA, that the medical director of the VA came to the clinic area, where ADNs have a panel of patients, and told those ADNs that they no longer had a panel. That they were there just to serve the doctors. Another recent example of the trend to reduce the ADN's ability to deliver patient care was the proposal to limit prescriptive authority by tying it to state licensure Nurse Practice Acts. Some of which are very restrictive. In the state of Georgia, nurse practitioners do not have prescriptive authority. In my state, I'm a clinical nurse specialist. I don't have it either, but I give medication because we went on this federal supremacy. I urge the Commission to assure prescriptive authorities for ADNs in every VA Medical Center. Limiting that authority is not in the best interest of our patients. It is not efficient and it is not cost effective. The VA proposal is on hold and I urge the Commission to recommend instead of a directive ensuring uniform scopes of practice and prescriptive authority for ADNDNs in the VA, similar to practice in the military nurse corps. I have already said we take the Nurse Qual Standards seriously. They are very real in our work. They define our academic standards, certification, continuing education we must have, the duties and the clinical privileges, like prescriptive authority that we use in delivering patient care, quality patient care. The reasons the standards are so real and so important is that they are set by experienced nurses who serve on the national VA and professional standards task force. But, in the final analysis, many nursing decisions are made by individual VA medical directors who may have excellent credentials in administrative or social services, but have no nursing credentials or experience, yet they have the ultimate decision-making authority and they are responsible for managing hospitals with more patients and tight budgets. There is a potential conflict of interest even for the most well-meaning director, and it is one of the reasons why my peers and I often feel like we are in a battle as we do our jobs. For our patients, for the nurses we have now, and for the first -- for the nurses we need now and in the future, we need to reshape the VA model of patient care delivery to put the RN back in the role of managing nursing care. Your recommendations can help us accomplish that and make it possible for VA nurses to practice as we have been taught to practice, and as we want to practice. Thank you.

MS. PATILLO:

Thank you so much. Our next speaker is Jacqueline McCarroll from Birmingham VA Medical Center.

REPRESENTATIVE:

Hi. I'm a clinical nurse specialist for Birmingham VAMC, and I have been with the VA system for 20 years. And I would like to share with you -- and of those 20 years, I served on the Nurse Professional Standards Board for six years. The last three years I was chairman of the Nursing Professional Standards Board. I would like to share with you some of my concerns and**eight-points. My first concern is there is inequity in pay and inconsistent practices in regard to nurse's pay scales for advanced practice nurses in the VA system. For example, at the Birmingham VA, clinical nurse specialist are on the same pay scale as other registered nurses, whereas nurse practitioners are on a separate pay scale, a higher pay scale. Whereas some 45 minutes away, at the Tuscaloosa VA,

nurse practitioners and clinical nurse specialists are on the same pay scale. We have this slogan in the VA, that we are one VA, but we are not one VA. There is inconsistencies across the board from one VA to the other as to what pay scale a nurse is going to be on. And I find that facilities that have recognized the fact that nurse practitioners -- and put nurse practitioners and clinical nurse practitioners are on the same pay scale are doing the right thing and this practice should be put in place at all VAs. The fact that nurses can't get higher pay because they have reached the top of their pay scale is quite unfair. And I recommend that a method needs to be devised that will allow nurses to get raises and pay increases, no matter what level they are. Nurses make up the largest pool of professionals in the VA system. When it comes to rendering services to the veteran patients, nurses are the primary care givers. However, the VA system has failed to adequately compensate its most valuable pool of professionals. Like the general nursing population everywhere, the VA nurses are predominantly female. Many of the nurses in the VA system are single, are mothers and heads of household. We can no longer afford to wear rose-colored glasses thinking that some knight in shining armor is going to come and rescue us, and meet our fundamental needs. Today, many of us have come to realize that the horse has died, the knight has fallen off and nobody is coming. We have to provide for ourselves. Therefore, we must be reward more economic savvy. We have realized that economics is very important to our ability to provide for ourselves, our children, and others who often come to depends on us. We need just pay for the services we deliver. Recommendation that is we must not allow the VA system to box us in pay rate traps that stagnant or totally impede our ability to advance financially. Next point. In the VHA system are highly qualified and educated nurses being overlooked for professional promotional opportunities while candidates from the private sector of equal and sometimes less caliber are being hired instead. Not hired because they are more qualified, but hired because sometimes they are friends, neighbors, and friends of friends to the people hiring them in management. This practice surely affects the VA's ability to retain nurses. For in this instance, qualified nurses have no choice but to leave the system, in order to find opportunities to advance. This practice has the effect of -- the best tool for recruitment in a facility is the employees that work within it. Because of the VHA's lack of commitment to develop and prepare its own employee pool to assume leadership positions, current nursing employees are not likely to speak in favor of a system that shows them no respect or commitment. An unsatisfied VHA employee will never seek to encourage others to The National VHA join the VHA workforce. Professional Plan Task Force made many recommendations in regards to employee satisfaction. And two that stand out to me is the fact that the task force recommended that we make more emphasis on mentoring and developing our own plan for advancement and so that we can assume leadership in the system. And also, the task force recommends that whenever a VHA employee has the skills and qualifications that meet criteria for occupying a position, the VHA should seek to promote from within. This was seen as being a sure means of increasing employee moral and creating a pool of employees that would be more protective and loyal to the system. The next point I would like to make, we need to -- more needs to be done in the area of trained individuals to be fair and efficient supervisors. Just because one has an advanced degree does not necessarily mean that they have the mental capacity, the leadership skills or the people skills needed to perform in such a role. And an incompetent supervisor is very detrimental to those under their supervision. Therefore, I recommend that when one is placed in a supervisory position, it might be good to have

them on probationary supervisory status. This will provide the time frame and mechanism in which incompetent supervisors can be weeded out. This process will disallow bad supervisors the opportunity to vegetate in positions wherein they can continue to cause professional and emotional harm to those under their supervision. My next point: Nursing Administrators do not serve as advocates for members of their service nor do they advocate for the profession of nursing on the whole. Too many of the decisions that affect nursing services, especially in regard to scope of practices, pay and reward incentives, are being made by upper management and physicians. Those who make the decisions seem to go unquestioned or unchallenged by Nursing Administrators. Therefore, nursing employees end up underserved and unfairly compensated. Nurses appear to have no voice about important issues that directly impact the nursing professional. To me, this makes nursing viewed as a lesser profession. In turn, nursing and nurses are not reinspected or recognized as a legitimate professional by other professional bodies. Nursing Administrators often do not consult with nurse employees about what they think would enable them to perform their duties more efficiently. They allow nurses to be dictated to about how they should practice or perform their duties by those in other professions. My recommendation, again, I say that do not assume just because a nurse has an advanced degree that they have the ability to assume an administrative role. Nurses who desire to be administrators should be made to take leadership classes and undergo leadership internship. In times past, more emphasis was placed on training administrative leaders in nursing, but it seems like that is not done so today, and we need to get back on track and put more money into training nurses to assume leadership roles, especially administrative roles. Like I said before, I served on the Nursing Professional Standards Board for six years, and the last three years of my tenure on the board I was chair. I say that having an assistant or associate chief nurse serve on the Professional Standards Board creates a climate of trust, whereas other board members are sometimes swayed or intimidated to vote the way of the chief nurse who sits on their board. My recommendation is that no associate chief or assistant chief nurse should be allowed to serve on the Nurses Professional Standards Board, it is better for the board to consist of members who are considered as peers to those who are being rewarded, and even the position of assistant chief or associate chief nurse exercises too much power and influence over other members of the board who are their subordinates. A situation in which an assistant chief nurse is in disagreement with the decisions of members of the board often puts subordinate them in the position of being intimidated. This can easily lead to decisions of subordinate members to be swayed in order to satisfy their nursing superior. In some instances, I have talked to other nurses who thought the Nurse Professional Standards Board membership has been disbanded in order for new members to come on the board so that the board's decisions can go the way of nursing management. And this is not fair. Next point, in some instances supervisors has used nurses' annual performance --

MS. PATILLO:

Ms. McCarroll, your time is up. We appreciate your testimony. Our next speaker is a representative from the American Association of Community Colleges.

REPRESENTATIVE:

Good morning. I am here, AACC asked me to come but I'm also here because I have an interest in the future of the VA nurses. My name is Patricia Egers, and I'm Dean of Charity School of Nursing at Delgado Community College. We are located next door to the VA on Perdido Street here in New Orleans. I need to say, as I'm hearing the various testimonies, my respect to the VA and its staff and its patients goes back over 20 years. I have clinical experience there way back when. And it is a very special place. Charity School of Nursing and Delgado Community College has a rewarding positive relationship with the VA in New Orleans for greater than 30 years. The learning that our students nurses acquire at the institution is much deeper and richer than just nursing care. It is also an appreciation of our country's history and the service that our veterans performed. It is the understanding of how being a veteran impacts the rest of the service persons' life. Students' clinical experience at the VA provides the students and faculty an opportunity to serve those who have served us. So it is a very important place. After making these heartfelt remarks, I must state that I, as an associate degree educator, am very disappointed in the hiring and promotion policy instituted nationwide by the Department of Veteran Affairs. The Nursing Qualification Standards discourage associate degree nurses from committing to working at a VA. Indeed, they cannot advance in their profession after two to three years of working as a registered nurse. Just at the time when Patricia Branner and her expert research says that nurses are starting to come into their own. The associate degree graduate has much to offer VA. They are nurses because they want to be at the bedside providing knowledgeable care. Indeed, the in-class RN first-time pass rate shows no great difference between associate and baccalaureate graduates. In 2000, the Hershel Survey indicated that the majority of nursing graduates, 55 percent obtained an associate degree. With numerous choices of workplace opportunities, why would an AD graduate chose a VAMC when the hiring and promotion policies seem to hold them back? The VA is losing nurses who give excellent professional care and who will continue to grow in their profession. The demographics of the AD graduate suggest that the graduate does not return to school immediately afterward. There are debts that must be repaid. Beyond the monetary debt, there is the debt of time that the AD students repays their family. The time they sacrifice since the degree was obtained. Most of our students are 30-something. Many are married parents, single parents, et cetera. Additionally, according to those statistics, almost 60 percent of the AD graduates hold a baccalaureate master's degree. Some AD students particularly, nursing is their second career. This student may or may not return to school. There is much learning to take place through continuing education offerings that can assist the nurses to grow and expand their role. The lifelong learning and the issue of meritorious performance as a bedside nurse seems to be ignored in that VA promotion policy. I'm a proponent of higher education and continuing ed, and appreciate the benefits for my profession. We do encourage our students to go back to school Delgado Community College but it is a personal choice. graduated approximately 400 registered nurses in the last two years, and on exit interview, not one of them chose VA as a workplace. And to me, that is tragic, because we have wonderful clinical experience there now. So there is a disconnect there. I just need to say, you have missed out on some excellent caregivers that have wanted to be at the bedside. So I would ask, as I put down in my testimony, to really look at the hiring and promotion policies, because you are missing out on 55

percent of the nurses, many of whom are not going to come there and many of whom are excellent. Also, you do have a wonderful, by your standing, a wonderful program for going back to school -- the initiative to go back to school. If you can advertise that more, you might get the experienced associate degree nurse who might be ready to go back to school. But initially, after graduation, I think many of them don't even look at VA because they see a half-closed door already. As I sit here listening to all the wonderful bedside nurses -- my background is critical care -- I hear what they are saying and I want our nurses, our graduates to have the experience in VA because it truly is a very, very special place. Thank you.

MR. COX:

Good morning. Are you aware of any research or publications that show the degree of quality of care between the baccalaureate graduate and the associate degree graduate?

REPRESENTATIVE:

Quality of care, I'm doing a presentation in Dallas this week. I can tell you that it is not quality of care. But some of the statistics I have for my presentation are the National Council of State Boards of Nursing does research every three years, and they talk to people who hire them, the graduates. And what I can tell you this is only 1.5 percent of the hundreds of people who return, like 56 percent, return look at VA as entry level practice. I can't tell you about -- my personal experience as a nurse, is the individual that's important. They don't wear their pins any more, you can't tell who graduated from where. But I know who a good nurse is and that's who I want work being with me by the said bedside. I think our graduates are bedside nurses and I agree with some of the policies you have in wanting to go into leadership one does need more initials most probably. But these people are wonderful bedside people. Well, everybody is getting a job now because of the nursing shortage. But even when there was not a nursing shortage, our graduates were sought after because they wanted to be at the bedside. That's no knock against others who wanted to do other things, but I think you missed out on good bedside nurses who wanted to be there and to stay there, but also want to progress in their career, as I'm hearing some of the people say who have spoken before me.

MR. COX:

Thank you.

MS. HANSELL:

You stated in your testimony that you want to encourage your graduates to continue their education.

REPRESENTATIVE:

Surely.

MS. HANSELL:

I believe the fact is that about 14 percent of associate degree nursing graduates return to school. What is your view on how we might improve that?

REPRESENTATIVE:

How we might improve the percentage that go back to school?

MS. HANSELL:

Yes, how can we better instill the value to continue their education?

REPRESENTATIVE:

I think some of it, we need to recruit younger people into associate degree nursing and we are trying that. We are going to the middle schools now. Our average age is thirty-something. We are seeing more young people in the associate degree program than we have in the past. I think that's part of it. A lot of our people have been there, done that, this is what they want to do right now, they don't necessarily want to go back to school. So many of the institutions now are offering wonderful benefits. I think helping to pay off their debt right now is important, because even a two-year AD graduate has thousands of dollars of debt now. You know, I think hospitals need to show that it is a worthwhile experience, because we all -- those of us who have been through it know that it is and there is a difference in the thought -- you know, and I surely encourage it, but it is difficult for us to, as educators to encourage it. They want to get out of school and they don't necessarily have on their mind ever going back to school again. One of the foundations are offering a thousand-dollar scholarship and had students who were interested in it to apply. We have 100 something students graduated; one student applied who really has a plan to go back to school. Others were thinking about it. But the majority of them want to get out and make a little money, take care of their patients and maybe go back to school later. I wish I had the answer.

MS. BURNES-BOLTON:

Are you familiar with the baccalaureate degree completion set up around the United States, and is your college affiliated with such a program?

REPRESENTATIVE:

We have two -- I think what may help in some ways is more schools are going to ADN to MSN. And I see more students, more graduates going back to school within the last couple of years with that option, to have that master's and stop along the way, get the courses they need for baccalaureate. But we are excited because we have one faculty member, we just became the associate degree platform that graduated in our first class in

'92 and now we have somebody from that class who has experience, even got her master's and is back to teach. But I see more students coming back with their transcript now, so that is wonderful. Here in New Orleans, Louisiana, LSU Health Science Center has now taken over the Charity Hospital system, they are running, it and they are offering wonderful benefits for graduates to go back to school. That is making a difference that they don't have to pay as, much money.

MS. PATILLO:

Thank you. We are scheduled for a break now, 30 minutes.

AUDIENCE MEMBER:

I have a question about the schedule. I notice that the open forum is overlapping with the witness' testimony. Is that going to be held in a different place?

MS. PATILLO:

No, no, no. The open forum will be held here; it is at 11:40 a.m. this morning. There is a slight overlap. Thank you for bringing that up. We will figure this out. Thank you. (Recess.)

MS. PATILLO:

Our next speaker, Kenneth Chitwood from Louisville VA Medical Center.

REPRESENTATIVE:

Hello, my name is Kenneth Chitwood and I'm 33 years old. I'm a veteran who served in the United States Air Force. I'm currently employed with the Louisville VA Medical Center as a licensed practical nurse. I have over 12 years of experience as a licensed practical nurse and have worked at the Louisville VA for the past nine years. While in the Louisville VA I have worked in surgical/medical sector, as well as ambulatory care, emergency room and primary care. I would like to take this opportunity to discuss a few issues regarding VA nursing today. The first issue I would like to speak on is related to qualification standards and grade levels for licensed practical nurses. At present, licensed practical nurses, or LPNs within the VA system can be promoted to a Grade 6 level. Well over a year ago, LPNs were informed of a proposal that could raise that promotion to a Grade 7 level of during that time, many LPNs within our facility provided written testimony requested by the hospital administration. This testimony was to be forwarded to a national task force to assist in developing qualification standards. As of March 27 of this year, I was unable to obtain the information on the status of the qualification standards through the task force. I have made numerous requests to my hospital administration and had been told the information is not available. It is important that any information on this topic be shared with all VA LPNs as soon as possible. LPN promotions are based a qualification standards and performance and many will need to make necessary adjustments to qualify for such a promotion. All VA LPNs should be

notified as soon as qualification standards are written and approved. It would be helpful if better communications were established throughout the VA on issues of this matter. My recommendation to this Commission is to pursue with speed any proposal that could interest promotion potential of licensed practical nurses within the VA. Last night, I was informed that this GS-7 for LPNs had been official approved last Friday. If this is the case I would also like to make a recommendation for immediate implementation of any approved GS-7 LPN standards across the board. The next issue I would like to discuss are cost of living allowances and special pay scales related to VA nurses. Currently, registered nurses and licensed practical nurses are paid on special pay scales. These special pay scales may vary from place to place due to locality. Certain occupations within the VA have been identified as require special pay. This special pay is to assist in the retention and improvement of employees. For many years now, each VA facility directive has had discretion over special pay employees regarding cost of living allowances. These directors have had no discretion over non-special pay or general scheduled employees. Historically at the Louisville VA Medical Center, special pay employees have not received the full cost of living allowances recommended by Congress. The director has used his discretion and given only partial cost of living allowances. For several years, registered nurses and licensed practical nurses have received no cost of living at all. This has resulted in many nurses transferring to other hospitals for better pay. At this time I would like to give an example. A licensed practical nurse at the Louisville VA Medical Center at Grade 6, Step 7 has a base pay of \$34,840 per year. About a hundred miles away, at the Cincinnati VA Medical Center, that same licensed practical nurse has a base pay of \$41,808 a year. This represents a difference of almost \$7,000 per year. This far surpasses the difference between the locality pay. If you were to review the difference between registered nurses at these same two facilities, you would find a much larger difference. In my opinion, this is the result of the Louisville VA Medical Center is balancing their budgets on the backs of nurses for many years. While my focus remains on special pay, I would like to discuss another issue. I would like to examine special pay versus non-special pay. How we use a licensed practical nurse, Grade 6, Step 7 on a special pay scale and a health technician Grade 6, Step 7 on a non-special pay scale for general scheduled pay in these examples. Keep in mind an LPN is required to do everything in the position description of a health technician. In addition, the LPN administers medications including injections and intravenous therapy. LPNs are also required to maintain an active state nursing license and continuing education units. Health technicians require no license. I selected three facilities in close proximity to Louisville, Kentucky for comparison. The figures used in these examples are retrieved from the United States Office of Personnel Management Web site in conjunction with each VA Medical Center's human resources. At the Cleveland VA Medical Center LPN Grade 6, Step 7 have a base pay of \$41,399 per year, while a health technician at the same grade and step have a base pay of \$34,065 per year. This represents a difference of \$6,437 per year. This amount is the difference between a special pay and non-special pay employee. At the Cincinnati VA Medical Center, the difference between LPN Grade 6, Step 7 and a health technician Grade 6 Step7 is \$6,238 per year. At the St. Louis VA Medical Center, the difference between the same two positions would be \$2,094 per year. At the Louisville VA Medical Center, the difference between the LPN Grade 6, Step 7 and the health technician, Grade 6, Step 7, is \$775 per year. In addition, I was informed on Thursday, March 27, of this year, that the additional

one percent cost of living allowances approved by Congress and President Bush would not go to special pay employees. This will now make the difference at the Louisville VA approximately \$435 per year. That is about 20 cents an hour. Special pay of \$435 per year is considered by me to be a slap in the face. As an LPN in the state of Kentucky I must pay a fee to renew my nursing license every two years. The Kentucky Board Of Nursing also requires RNs and LPNs to complete continuing education credits prior to renewing the license. These can be expensive and our facility does not pay for nor offer reimbursement for these requirements. Due to the cost of maintaining a nursing license and the responsibilities of the job, many LPNs in the Louisville VA Medical Center are considering positions as health technicians. LPN morale is low and I fear this could severely impact on the retention and improvement of LPNs within the VA system. My recommendation to this Commission is to propose a policy change or a change in the law that would take away discretion from the unit directors regarding cost of living allowances and special pay employees. I would also like to recommend to the Commission that each VA facility be required to fund continuing education units that are required by each state's board of nursing. These changes would benefit both registered nurses and licensed practical nurses nationally. These changes would also improve the retention and recruitment of VA nurses nationwide. At this time, I would like to thank the Commission for allowing me to opportunity to share my concerns, as a veteran, a nurse, and federal employee, I thank you for your time.

MS. CONVERSO:

I just have a quick question about, I see your graphs here. Do you have any knowledge about the process for local surveys for LPNs? Is that, does that play into this?

REPRESENTATIVE:

It does and the fact that surveys are not completed on a standardized basis across the country allows for this discrepancies. We are told by our hospital administration that many times, when we requested surveys, the local hospitals do not fill them out or do not turn them in. So therefore, the survey fails and no money is given to the LPNs or registered nurses.

MS. CONVERSO:

Thank you.

MS. PATILLO:

Thank you very much, Kenneth. Our next speaker is Melinda Bergren, from the Nashville VA Medical Center. I just wanted to remind the panel members and forum speakers and audience members to speak very clearly and loudly so our reporter can understand everyone.

REPRESENTATIVE:

Good morning, my name is Melinda Bergren and I'm a registered nurse at the Tennessee Valley Health Care System at the Nashville Campus. I chose to be an associate degree nurse so I could be at the bedside, not in an office scheduling or pushing a pencil. The ADN gives quality care to veterans as well as the BSN. I want to thank the Commission for the opportunity to speak out for Veterans and the nurses they depend upon. I am proud and honored to care for our veterans and give them the care and respect they deserve. I go home each day feeling good that I was able to repay them in some way for serving our country and preserving our freedom many of which we take for granted. I have been to many other countries and no one has what we have in the USA. I had a patient, an 82-year old World War II veteran who helped build my facility. As I was setting up his breakfast I told him I couldn't think of a better way to serve my country than as a VA nurse taking care of the fine men and women like him who served our country and helped preserve our precious freedom. As I thanked him for his sacrifice, he started to cry and said, "No one has ever thanked me like that before." Today, as I see, we have great soldiers fighting for freedom. My concern is will the VA be able to provide our future veterans the care they deserve? I think not. As patient advocates and dedicated nurses of the VA, we are struggling on a daily basis, as front-rank caregivers, to meet the needs of an aging and sicker and growing veteran population. Nurses are instrumental in recognizing the first subtle changes in a patient's condition for impending emergency status and taking actions to prevent serious complications or death. However, with the current shortage of RNs, our subtle changes being missed cost an increase in patient complications. Currently we are experiencing a shortage of RNs, LPNs, nursing assistants, and other support staff that affects patient care. The shortage of nurses causes an increase in the nurse-patient ratio. Nurses are performing duties that support staff should provide and mandatory overtime. Decreased staffing levels is hurting my two G bed unit. My unit is responsible for administering inpatient chemotherapy, providing care for med/surg patients and providing Veterans with rehabilitative care. When I am the night charge nurse, I am responsible for all of the charge duties, team leading and providing total patient care for five to seven patients and I often have to leave the floor to deliver lab specimens, pick up blood products, or deliver patients to tests. I do not feel that I'm providing the time and care each patient needs and I often feel overwhelmed. Staffing in other patient wards is just as severe. We are routinely pulled away to work in patient areas we are not familiar with. Research has demonstrated that patient complications may be more likely to occur if caregivers float and are not as familiar with patients. Other specialty care areas such as the ER, out-patient clinics, pre-anesthesia care unit, ambulatory surgery, cardiac cath lab, bone marrow transplant, operating room and the critical care areas of both medical and surgical, are also severely understaffed leading to problems in providing high quality care. Some of our critical care beds have closed the door due to nursing shortage resulting in serious types of patients being placed on inpatient units which increases patient's acuity levels and raises the nurse to patient ratio. The more seriously ill veterans require an RN to care and LPNs are not allowed to do. The shortage of support and ancillary staff at the Nashville campus is increased and leads to staff frustration, the nurses being overwhelmed and feeling they are not providing the optimum care we want for our veterans. For example, our transport service is very understaffed. They are unavailable, and nurses are forced to deliver lab specimens, pick up blood products, transport patients and this takes nurses away from

direct patient care from where they are needed. The emergency rooms, intensive critical care unit, both med and surgical, pre-anesthesia unit, bone marrow transplant unit, and other specialty areas have had transport and ancillary services have virtually stopped, and as a result, the nurses are being forced to draw blood, transport patients and labs. We are very concerned and it is an unsafe practice that we are forced to leave the bedside and critical patients to perform duties that need to be performed by support and ancillary staff. It is wrong to put nurses' licenses on the line because the VA has inadequate support and ancillary staff. In December of 2002, some areas in the hospital participated in a voluntary survey to demonstrate the need for support and ancillary staff and the results were astounding. 998 incidences that nurses transported patients or lab specimens, 992 incidences that nurses performed lab drawings, 1,065 incidences that nurses performed environmental duties such as bed-making or floor-cleaning. 112 incidences that nurses performed duties for supplies and services and 772 incidences of nurses performing duties that are usually done by support staff, such as clerical, respiratory therapy, EKG techs and IV therapy. Patient's medication are often delayed because of the lack of pharmacists to fill the order or technicians to deliver the medication. This occurs in the outpatient area and inpatient area. One morning after working 12 hours, I was mandated to stay over another four. I sent for my missing med patients at 8:05 for my nine o'clock meds, and it was 11:15 before they came to the floor. If they were full-blown AIDS patients, it would have been of no value to given out late. That was because of the short staffing. The delay was because of the short staffing. What can the Commission do about staffing levels at the VA? You can recommend that Congress give frontline nurses a real say in staffing levels. It is the bedside nurse who understands how many support staff it takes to deliver care. The VA is not and should not be considered a business. However, oftentimes budget cuts or restraints, administration levels prevent nursing staff and support staff from being hired. Inadequate staffing increases nurse-patient ratio. Veterans do not deserve to be cared for by harried and overwhelmed nurses. How can you give the bedside nurses equal voice? Empower nurses by changing law to allow union representatives to sit down with the nursing administrations at the facility, regional and national level, to set staffing levels at minimum safe nurse-patient ratios. Minimum at my facility is mandatory overtime as a way to maintain adequate staff. When the nurses are pressured or mandated to work a double shift, quality of care suffers. I'm asking that the VA Commission on Nursing to intervene on behalf of the men and women who served our country and are fighting for freedom now. The VA Commission simply has to have an increase in the support staff and the nursing staff. The nurses need to be allowed to have a say in hiring the appropriate amount of ancillary staff, nurse-patient ratio, mandatory overtime and hiring support staff. I am requesting that the Commission support an urgent change in Title 38, Law 7422, in order for the VA nurses to be allowed with their union representatives to negotiate on all levels of management concerning these issues. I urge the Commission to support or recommend the passage of the HR 7455 and S373 that would prohibit the dangerous practice of mandatory overtime. I am requesting that the Commission recommend a change in Title 38 law to allow nurses' healthcare union to negotiate any and all items pertaining to art and employment at the VA. Thank you for your time and consideration in these matters.

MS. BURNES-BOLTON:

Thank you. Someone asked us to reintroduce ourselves. I'm Linda Burnes-Bolton, and I'm Vice President Chief Nursing Officer at Cedars-Sinai Medical Center in Los Angeles. I'm also a member of the National Advisory Counsel on Nursing Education Practice with the Department of Health and Human Services. My question to you is in relationship to your recommendation of staff nurses, setting standards relative to nurse to patient ratio as well as the staff model. What specific recommendations would you have for the Commission on how it might -- what might happen in relationships? Did you have a particular system in mind?

REPRESENTATIVE:

I'm just saying that the nurse at the bedside sees what is needed and what goes on, not somebody up in an office who has never even walked on the floor. We need to have input on this nurse-to-patient ratio. We need to be there to take care of the patient. They didn't pay for my education, and they are not paying me what they are paying me to do for me to be off the floor when I could have a patient ready to code up there, and I need to be there to see it and intervene. We need to be able to work together to see that the proper patient care is taken care of.

MS. BURNES-BOLTON:

Thank you.

MS. PATILLO:

Any other questions? Thank you, Melinda. Just to remind you the terms of the schedule, the open forum will start at 11:50 and then our recess starts at 12:00. To accommodate the typo here in terms of the timing, just make those changes in your schedule. Our next speaker is Tonetta Flennoy from the Central Alabama Veterans Healthcare System.

REPRESENTATIVE:

Good morning, my name is Tonnetta Flennoy and I have been a registered nurse for 25 For the past 23 years, I years. have been proud to care for America's Veterans on medical/surgical, geriatric rehabilitation and long-term care units all at the VA in Tuskegee, Alabama, Central Alabama VA National Convalescent Healthcare System, East Campus. I have been a geriatric clinical care specialist and am currently in case management. I have a BS and MSN. I would like to thank the Commission for allowing me this wonderful opportunity to address issues of concern to VA nurses. Nursing control over the decision-making. Adequate staffing levels are crucial to the delivery of high quality care. Reduced or inadequate staffing has resulted in poor moral and difficulty in the retaining of nurses. Recently, an RN was hired for one of the nursing home care full-time status. Our units in a observations of the low level of staff and increasing demands on staff caused her to change to part-time status. Another nurse in the same unit has

shared her concern of something going wrong when she was the only RN on duty and was ordered to give three patients blood transfusions at the same time. I remind you, this is a nursing home care unit. Nurses are putting patient care and their license at risk. In spite of the affirmation, staffing in our facility is a management decision with very little input from staffing involved in VA patient care. Typically management sees staffing as adequate. The first line bedside nursing staff do not. The mysterious process of entering patient category data into the computer to determine staffing levels is not understood and results in inadequate staffing. As patient advocates, nurses are generally concerned with how inadequate staffing affects their ability to provide quality care. The current law, Title 38, 7442, does not allow direct care staff and their union representatives to sit down with management and negotiate change and staff matters or staff to patient ratios. Nurses make life and death clinical decisions everyday. It makes sense for them to sit down at the table when clinical decisions are being made and when performance improvement processes are established that impact clinical care. Recommendation: I urge the Commission to remove the statutory roadblock that keeps bedside nurses outside the decision-making process. We need to be at the table to negotiate our staffing levels, clinical decision-making and performance improvement. Another recommendation is that there be regular real-time desk audits in areas where staff consistently complain of staffing shortages. Trust. Trust is one of the core values of our facility, and is essential for peer-review and promotion process. I believe trust is being eroded because of the current peer-review and promotion process. Nurses are not receiving promotions and peer-reviewed in a timely manner. A delayed proficiency board action equals loss of money, when a promotion occurs. Nurses have had recommendations for Special Advancement for Performance that have disappeared. This shows disrespect for nurses. Nurses perceive that management promotes some nurses based on who they know, not what they do. Trust is being eroded with educational opportunity and money appear to go to management staff, not bedside nursing staff. How can we improve trust in this system? I recommend that the Commission implement strategies to change the law so that we can negotiate change in the process. For example, at our facility, we have "Management By Walking Rounds." This concept is used to show problems and bring problems to staff attention instead of addressing genuine concerns that staff may have. Another recommendation is that staff nurse issues be given the same attention as the performance measures that determine the director's performance rating, so that dynamic made. improvements will be Attracting and retaining a quality workforce. VAs are experiencing problems with recruitment and retention of nurses at all levels. The hiring process is too long and applicants frequently accept a position in the private sector while awaiting a final decision from VA which may take more than 60 days. There is also too much lag time between an employee leaving a position and that position being advertised and filled. Once nurses are recruited to the facility, retention becomes a problem. Nurses hired in key management positions get frustrated with how the bureaucracy of the federal system is implemented. Shift rotation also impacts retention Private sector does a much better job with offering flexible work shifts and we are losing VA nurses to private sector. Another issue is lack of promotion in the system. Nurses at the end of the steps of their grade do not advance. This penalizes nurses with more years of experience. These nurses have difficulty being promoted from a Nurse 2 to Nurse 3. A measure to determine promotion and proficiency is necessary. The system, however, does not systematically or consistently promote nurses who have additional credentials, education

and degrees. They are then told education is not a reason for a promotion. However, the new qualification standards put a great emphasis on education. One nurse practitioner at our facility has an MSN, a post-graduate certificate, certification as a rehabilitation and chemotherapy nurse, and she is a Nurse 2, Step 7. This practitioner was told that to be promoted, research needs to be conducted. At this time, our facility is not approved to conduct research, and we won't be any time soon. These contradictions are degrading and demoralizing to nurses. A nurse's experience and education are equally important and should be considered in the promotion process. I have worked with AD nurses and they performed no differently at the bedside than the MSN nurses. They take the same State Board and the work expectations are the same. Another retention issue is the lack of or limited opportunities for upward mobility for nursing staff. Nurse 4 clinical is almost nonexistent, (Nurse 3 is unusual). Life as a practical nurse lacks opportunities for advancement, health technicians, coming into the facility with lesser years of experience and higher salaries. It makes no sense that their roles are changing but promotional opportunities are not. Staffing levels also impact retention significantly. VA facilities are understaffed especially in long-term care areas. Forty-bed long-term care unit with 70 to 80 percent total care patients may have one or two RNs and three or four LPNs or nurse assistants. With the increase in acuity of the patients, technological advancement, such as the Bar Code Medication Administration system, performance improvement activities and accreditation requirements, nursing staff have extra responsibility that do not include direct patient care. Staff are becoming more and more frustrated and morale is at its lowest. Facilities have discretion over hiring; why are they not using it? CK I recommend the law be changed to allow employees and their representatives to have a great force in negotiations over the promotion process. With the intent on increasing subjectivity and improving consistency and reliability. For example, we hire external peer-review persons to come into our personnel offices to look at records. Why not do that same process for the promotion system to obtain some objectivity? The negotiations would also address upward mobility for all levels of nurse staffing. Streamline the recruitment process and recruitment and rehiring performances for staff working in long-term care areas and other areas where staff turnover is higher. Locality pay for nurses. VA administration had the great potential for making nurse salaries more competitive to those in the private sector. The reality for implementation is different, private sector is not cooperating, even when they do cooperate, the final decision was in the hands of the director. One director was quoted as saying the facility has too many Nurse 3s. This director is not a good source of increasing nurse's salaries. They are balancing their budgets to the detriment of nurse. Saturday premium pay has recently been approved for licensed practical nurses. Title V personnel and other areas were not included in this change and this is a discriminatory process. They must make the same sacrifices with their personal lives and families as other staff. They are valuable members of the team and deserve the same consideration. I would recommend that the locality pay system be abolished, or that it be mandatory not discretionary. If it is mandatory, actions will need to be taken so that a fair comparison can be made within the facility's locality. Thank you.

MS. PATILLO:

I have a couple of questions. Can you be more specific in terms of the statutory roadblock that you mentioned that prevents nurses from participating in decision-making?

REPRESENTATIVE:

Title 38, USC 7422.

MS. PATILLO:

That's the second statute you talked about? And the next question, how much of your practice do you notice are GOC nurses? Do you impact caregivers in home care?

REPRESENTATIVE:

In title, I do a good bit of that because I'm a direct care provider. I do spinal cord injury, I provide direct care, patient care to that clinic. I also work directly with staff. I do education on spinal cord injury, traumatic brain injury, chronic pain patients. So, I'm involved with all levels of staff and my past experience as clinical nurse specialist in internal medicine in a 60-bed unit. I did quite a bit of interaction with staff and dealing with direct patient care issues.

MS. PATILLO:

How about families?

REPRESENTATIVE:

Yes, I do a lot of education with families. I do a lot of education training and they come through to so there are a lot of opportunities for teaching with families when the patients come to clinics, and on the wards, too.

MS. PATILLO:

Why I wonder what you just told me, is why the things you just told me are not reported in the performance measures that are reported to Congress in terms of how the VA is organized? We are doing so many wonderful things.

REPRESENTATIVE:

Yes, I agree.

MS. PATILLO:

Sara Myers.

REPRESENTATIVE:

Good morning, I'm Sara Myers. I'm the nurse clinical coordinator at the Atlanta VA Medical Center. I've been employed there for 20 years. I'm a veteran. As clinical coordinator, I'm currently involved in clinical activities daily with nursing staff in a 100-bed nursing home care unit for the home care, home-based primary care program, the community health department and out-patient geriatric clinic. In addition, I'm involved in a pain clinic in the rehab services at the VA. I'm currently mentoring two newly employed nursing staff. One is a nurse manager and the other is a clinical nurse specialist. Both of these nurses are nurse practitioners. My past experiences at the VA include staff nurse, cardiac nurse manager, gerontological clinical nurse specialist, and currently, nursing clinical coordinator. I would like to thank the Commission for holding these very timely hearings on recruitment and retention of VA nursing staff. As a past president of the nurses organization and current national board member, I am presenting the first of several testimonies which you will hear during the next few weeks. My focus is on the advanced practice nurse, specifically the nurse practitioner. I'm going to discuss issues and concerns related to the question, "Are there changes that can be made that would improve meaningful nurse participation and decision-making processes within the VA?" The response to this question have been elicited from nurse practitioners in the field where care is currently being delivered. I have organized the presentation to include a brief discussion of nurse practitioners in the VA, workplace issues, selective discussions of VA practices and recommendation. The Department of Veteran Affairs is the largest federally integrated healthcare system and employer of one of the largest nurse system in the world. Additionally, it is the largest employer of advanced practice nurse in the United States, with approximately 2,200 nurse practitioners and 690 clinical nurse specialists. These nurse practitioners are primary care providers to Veterans within the continuum care ranging from primary care, specialty care, in-patient and home based settings. The following function describes some of the areas of expertise in which nurse practitioners function in the VA. They possess comprehensive assessment skills, they determine differential diagnoses, they promote wellness and prevention, they practice autonomously in collaborations with a large variety of multidisciplinary teams and they service patient advocates and some are involved in clinical information technology. As healthcare in the Department of Veteran Affairs has been transformed over the past two a noticeable shift from decades, there has been in-patient settings to more community-based out-patient settings. These interdisciplinary services focus on quality care at a cost-effective level, and improve access to healthcare. With these changes, the demand for specialist has decreased while primary care providers has increased. Three decades of practice and research have provided evidence of nurse practitioner's ability to provide quality cost effective healthcare. They are a proven response to the evolving trend toward wellness and preventive healthcare driven by consumer demand, federal and state regulation and private payors. Health promotions services increase the effectiveness of recovery and they also reduce the number of represented episodes of illnesses. Nurse practitioners cost 40 percent less than physicians are cost effective in preventative care with the expertise in counseling, patient education and case management. I would like to spend some time addressing just some of the, briefly some of the workplace issues,

because of time, I'm not addressing all of them, but it is included in the testimony you have before you. While nurse practitioners provide safe, economic, quality comprehensive care to their patients, they are underutilized in some VA medical centers throughout the country. As medical specialization continues to grow within the VA, there has been a powerful growth in sophisticated medical technology and treatment to the exclusion of some of the baser primary care services. There are some extraordinary nurse care specialist and they pride themselves on providing quality care to their veteran patients. There is a grave concern of our patients being assigned to a time slot. For example, scheduled appointment, sometimes 20 to 30 minutes, and the type of assembly line care they are being given. This is particularly true of spinal cord injury patients who come in needing more care, a veteran who comes in according to a scheduled appointment and is seen at the end of the day. In some facilities, too few nurse practitioners are caring for too many patients. The situation is magnified in some clinics where the management of spinal cord injury patients dictate the need for more time to address their needs. Nurses in hospitals and out-patient clinics are overworked and frustrated. They must arrive early and stay late to complete the paperwork necessary when a patient visits. These nurse practitioners believe that quality care has become compromised and both staff and patient safety is an issue which must be addressed. They also reported that they spend more time performing tasks unrelated to their professional expertise, therefore minimizing opportunities for quality patient education. As a result, the budgetary cuts at one VA Medical Center, for example, the geriatric extended care center lost four advanced nurse practitioner positions, from December 2001 to March 2002. This resulted in the reassignment of the remaining nurse practitioners and the ultimate closure of the geriatric evaluation unit. This has impacted on the Medical Center by decreasing the options for the discharge of patients from the acute Medical Center, resulting in prolonged hospital stays. I would like to share with you one Best Practice model. I'm proud of it in an empowered nursing environment. This is at one facility where the concept of collaborative education as well as collaborative interaction in a positive environment is taking place. At this particular facility, there is an advanced nursing council, and it has been operational since the 1980s, it provides a forum for discussion of relevant issues and concerns of nurse practitioners. These nurse practitioners are also involved on this council. One of them serves in a capacity where she rotates in the nurse executive board and brings information back to that advisory counsel. They are also involved on clinical research teams, specialty teams such as diabetes, congestive heart failure and arthritis. There is also in my testimony examples of nurse-managed clinics which are being run very effectively, as well as wellness clinics. The recommendation I would like to present to the Commission are as follows: To develop an employment and organizational structure and climate where the nurse practitioners are integrated in clinical programs for all nursing related committees. To conduct a survey of all nurse practitioners to determine their needs and interests. To implement an on-site advisory counsel such as the model that I just presented. To thoroughly explore Best Practice models within the DVA and explore the feasibility of duplicating these models at other VA Medical Centers. The additional recommendations are in my testimony. I would like to thank the Commission for holding these hearings and the continued mounting crisis to resolve the multiple challenges faced by VA nurse practitioners must receive immediate attention. I'm available for questions. Thank you.

MR. COX:

Ms. Myers, do you have any data that deals with the advanced nurse practitioner pay, how it corresponds with physician assistant pay, or any information you can share on that?

REPRESENTATIVE:

I don't have that data here with me but I know there is data out there that reflects that the PA's pay is much higher than nurse practitioners. That was something several nurse practitioners and I talked about, but I did not focus that on that in my presentation but that is an underlying issue in many VA Medical Centers. The difference between the nurse practitioner and the PA pay.

MR. COX:

Thank you.

MS. HANSELL:

Hello.

REPRESENTATIVE:

Hi.

MS. HANSELL:

I enjoyed your presentation. My question to you is related to data. Do you have any data that has demonstrated the effect of the care provided by nurse practitioners in terms of cost savings and improvement of patient care outcomes?

REPRESENTATIVE:

There is data out there. There is an article in the Veterans Health System Journal, 1998, members of the Advanced Practice which was written by Counsel within the VA, which speaks to cost effectiveness, and they outline the conditions such as congestive heart failure, and talk about distinctions between the pay. I do have that reference available if you would like it.

MS. HANSELL:

We would appreciate it. Thank you.

MS. BURNES-BOLTON:

Thank you for your presentation. In relationship to -- you said you were mentoring more currently a manager and currently a -- or were a --

REPRESENTATIVE:

I'm a clinical nurse specialist.

MS. BURNES-BOLTON:

What role do you see in terms of the nurse practitioners assisting in improving the practice of staff that nurse practitioners might play?

REPRESENTATIVE:

I see it as a critical role. One of these is the empowered nursing environment that I mentioned. Nurse practitioners are mentoring staff nurses at that facility. They are very satisfied and are enthusiastic about doing it. I chose to -- I was one of the panel members for the selection of the nurse practitioner and the clinical nurse specialist in the nursing home where I supervise the nursing staff. We have had several applicants, I think we had ten applicants, and we decided that we would choose nurse practitioners for this nurse manager position and clinical nurse specialist position. There is literature -- I'm not sure that there is a lot of research literature but there is literature out there that point to the improved quality of out-patient care and evidence based as it relates to nurse practitioners or advanced nurses specialists at gerontological nursing homes.

MS. CONVERSO:

Thank you for your presentation. I was interested in what thoughts you might have for alternatives to the assembly line care we are providing, and what the role of the nurse practitioner might be?

REPRESENTATIVE:

Nurse practitioners, the nurse practitioners I spoke to regarding this issue are working almost as staff nurses in primary care teams. My recommendation is they head those teams, that they be involved as leaders in those times. I think the nurses are very good organizers, planners, and I really think they can do a much better job.

MS. PATILLO:

Is there a difference between the way CNSes -- we are all under the ADN umbrella, so you do have CNSes and nurse practitioners to serve as clinical experts for your staff and

then who consult with maybe different patients and maybe perhaps do the grand rounds? Does that occur in your facility?

REPRESENTATIVE:

They do. I can share with you at the nurse home care unit, the clinical specialist was hired in January. Before that, I was the senior -- I continued to be the senior consultant on the VA's National Collaborative Team. I have now been mentoring her to take over that so she is doing her rounds, which is a big issue within the VA. She is also doing the room rounds with the therapy nurse. So I see those as expanding roles for those types of positions in the VA.

MS. PATILLO:

If I could understand, the nurse practitioner is under medicine and the CNS is under --

REPRESENTATIVE:

The nurse practitioner I have as nurse manager is under nursing. There are some nurse practitioners who work within primary services license. There is also, in my nursing home there is a nurse practitioner who works on the medicine. She provides the medical coverage for patients on a 50-bed unit. On the other unit is a PA. I just made a recommendation that we hire another nurse practitioner for the other unit, where the PA is currently working, because to be perfectly honest, the performance to the outcomes of the nurse practitioner far exceed that of the PA. That is no reflection on PAs, but this is what we are seeing.

MS. PATILLO:

We understand. Any other questions? Thank you so much. Next is Cindy Hudgins.

REPRESENTATIVE:

I would like to thank the Commission for allowing me the opportunity to give my recommendations. My name is Cindy Hudgins. I'm from Central Arkansas Veterans Healthcare System, Little Rock. I work on the Little Rock campus. As we have two I'm RN. I looked forward to coming a BSN as compared to different ones. to work at the VA, I did medical clinical in my nursing practice at the VA, and upon graduation, became a VA employee. I have been there for 14 years now. But for 14 years of my nursing career is a very small price to pay for the Veterans who have served us very well. I presently work on a 17-bed oncology ward as the night charge nurse. Staffing is quite a concern with oncology patients as we must have licensed personnel and not always an adequate number of them to make medication administration in a timely effort because of the pain that these special Veterans suffer, because of their cancer. When a patient must wait even five minutes, that is too long. With only one licensed person on the unit to do that, you may be giving other people medications and that is a harsh reality. Education is encouraged and mandated for promotion, however, schooling is linked to the

staff meetings, a vicious cycle that must be broken. We are not always given the time to go and take the classes we need and as our licensure requires now in the state of Arkansas, those continuing ed units which was added in the last two years. Rotations are mandated and a stable schedule is a pipe dream. The peer-review process is subjective and inconsistent with new standards requiring a BS, BSN or master while a degree is respected, please don't starve us to death, into a BSN. The number of Nurse 3 positions available are tied to the budget. How many employee jobs require commitments to the workforce outside of the work area, outside of scheduled work times? ADNs are appointed at demeaning levels and LPNs are appointed at a GS-3 to a 5. Nursing assistants receive little reward or recognition. They receive no Saturday Premium Pay for Saturday work, while working side-by-side with LPNs and RNs caring for the same patients who deal with specialty pay. On behalf of our Veterans and those who care for them, please recommend the following changes. Saturday Premium Pay for all federal workers, not just nursing staff who work on Saturdays. Mandate staffing level ratios by law; change the law to Title 38, USC 7422 to allow nurses to sit down and negotiate on direct patient care issues. Minimum appointments of advanced practice nurse to a Nurse 3 with centralized boarding at a Nurse 4 and 5 level. Minimum appointment of LPNs at GS-5. Automatic promotion based on performance to a Nurse 3, stop mandatory rotations of shifts. Specialty pay for specialty areas worked. Stop contracting our federal jobs. Develop a balanced system for education facility so that funding is never a problem. Recently we have had people who have come in and the funding is not there and they have to drop from the programs. As the family member of veterans who have served in previous wars and use our VA system, and as a family member who, I have family members who are in the Iraqi conflict at present, I do not want to see the care of our veterans diminished any more than it already has. Thank you for allowing us, my colleagues, this opportunity to voice our concerns and give input into how we can do our jobs better.

MR. COX:

You stated that you did clinical affiliation with the VA as a student nurse and then came to work for the VA?

REPRESENTATIVE:

Yes, sir.

MR. COX:

What enticed you about the VA from that clinical affiliation to come to work for the VA?

REPRESENTATIVE:

I think it was the men. They are a lot easier and a lot more generally to take care of. They don't seem as demanding, but I have never worked with a lot of women, but it was a real nice work environment at the time. And that's why I went.

MS. RAYMER:

Did you have a student affiliation at the VA?

REPRESENTATIVE:

Yes, I did a psychiatric and medical rotation through the VA.

MS. RAYMER:

Do you think that impacted on your decision?

REPRESENTATIVE:

Yes.

MS. CONVERSO:

Thank you for your presentation. This is probably a million-dollar question, but I was interested in what your thoughts are about eliminating the mandatory rotations? What are your thoughts about getting rid of that? Is it possible to get the good staff we need to cover 24 hours?

REPRESENTATIVE:

I believe we can do it. A lot of the community hospitals offer expanded tours which the VA is very restrictive on expanded tours. They strictly wants us to take eight hour shifts where I feel we could work 12-hour shifts and do it successfully. As you come in, most of the time, new people are put on night tours, in the community, and we could specifically take from there.

MS. CONVERSO:

Thank you.

MS. PATILLO:

Thank you very much. Next is speaker is Terrienne Tuskes from West Palm Beach VA Medical Center.

REPRESENTATIVE:

Good morning. My name is Terrienne Tuskes. I work at the VA Medical Center in West Palm Beach, Florida. I appreciate the Commission's time to allow me to speak on behalf of the nurses at West Palm Beach, Florida. The nurses are very important in advocating for the patient also. Nurses are the only advocates many of our veterans have. Nurses have to be the advocates for our nation's heroes. I am an RN, who has an BSN and MBA with specialization in health system management. I have 18 years experience working as an RN, most of the time in critical care, I now work in ambulatory care, out-patient surgery. Some of the topics I wanted to address are the RN promotion process. Many VA facilities are experiencing problems with recruitment and retention. Even those who don't currently have a problem will in all probability experience one in the future. In addition, we are seeing nurses who apply to the VA, are hired and then leave, after they realize that the opportunities for career advancement are extremely limited at the VA. The result of an average age of the VA nurse being higher than the average community nurse is out passing the general population of RNs. Therefore, as our nurses retire we are not going to have anybody to replace them, because nurses are not coming in, because of the fact that their careers are being stagnant. Unlike private facilities, excuse me. Unlike the VA, private facilities do not use cumbersome and highly subjective processes for promoting the nurses. The VA designed Nurse Qualification Standards to address promotion for nurses. Unfortunately, management interprets the qualification standards so their own benefit without considering the experience and motivation of VA nurses. The qualification standards are over-cumbersome and do not reflect true clinical practice. The standards do not value the clinical nurse who remains stagnant in lower grades. Nurse managers and educators are the only ones that appear to be promoted to Nurse 3 and Nurse 4. Waivers are not previously considered for promotion, it is relatively easy to subvert the intent of the Qualification Standards. Nursing executives are requiring that potential waivers recommended by the facility boards be reconsidered. As managers pick the board members, they become simply an extension of management. Allowing directors to make final determinations regarding waivers is another conflict of interest. The staff promotion helps to maintain the budget and possibly influence promotional opportunities and bonuses for upper management. A solution is to allow the employees to be heard through their elected union representatives, enable them to have a more equitable and fair process for promotion and not keep people stagnant. The second topic is staffing levels at the VA facilities are understaffed. VA patient are sicker and older than the community hospital populations. In addition, VA requires much more from the nurses in the way of administrative and clerical duties than a community nurse. This is evidenced often in sickness and in injuries. Less skilled employees are being substituted RN care because they are cheaper to employ. For In out-patient clinics, fewer nurse practitioners and porters are being required to see more and more patients, nurse practitioners are mandated to care for the same level and number of patients as physicians and in the same amount of time. More and more administrative and clerical duties are mandated. Patients, nurse practitioners and nursing staff, become more and more frustrated. The error rate increases and patients are potentially at risk. Statements of concern to management are met by threats to careers. Professional licenses are at risk of insufficient staffing and the inability to provide the needed quality of care. The VA balances the budget by cutting staff and requiring existing staff to take on more and more responsibilities, leading to a decrease in the quality of care and increase in the potential

risk to the patient and the professional. The solution, once again, is to allow the employees to be -- their opinions and their thought processes. We pay all of these employees because of their education and ability to make decisions. However, we don't let them make the decision regarding things that affect patient safety. We need to allow this to happen by union representatives who are elected by these staff members. The nurse locality pay. The VA currently uses a cumbersome and highly subjective process to set nursing pay by facility. There was past direction from Congress to change the process and make it more equitable and objective by using third-party surveys where available. At my facility, the third-party survey was obtained and by plugging in the recommended formulas it indicated that the RNs should receive a 13 to 20 percent increase. Other local VAs facilities received raises that reflect these survey numbers. They received raises -- the director at the facility has the final authority. By all accounts from those present, he was very upset by these findings and directed the representatives of human resources to go back and rework the statistics, until they arrived at the numbers that supported the minimum rate of inflation mandated by law. Now that Congress has voted to increase the minimum amount, there is now consternation at that VA on how we can legally rework the survey to support the new amount. As for Darrell Huff in his book, *How To Lie With Statistics*, he states "The secret language of statistics so appealing in a fact-minded society culture is employed to sensationalize, inflate, confuse and oversimplify. Statistical methods and other statistical terms are necessary in reporting the mass data from social and economic trends, business conditions, opinion polls and the census." But without writers who don't use words with honesty and understanding and readers who know what they mean, the results can only be semantic nonsense. As previously stated, this is a significantly conflict of issue as management, of directly affected by the overall salary budget. Locality pay in Miami, Florida is higher than in West Palm Beach, Florida. They earned specialty pay. West Palm Beach is considered the rest of the United States. However, according to bankrate.com, cost of living comparisons, an employee would have to make 4 percent more in West Palm Beach to have the same buying power that they have in Miami. Once again, we must change the laws to enable to employees to be represented, and to have their opinions and their thought processes, the things that we do pay them for, to do the job that they do and also entitle them to be able to determine what is safe and what needs to be done and have the ability to represent their choice. Nurse practitioner issues. The registered nurses provide the highest quality of patient care. They work in clinics with physicians, seeing patients, identifying medical problems, ordering and interpreting medical tests. Ordering medications and evaluating the patients according to the nurse practitioners designed plan of care. All studies show that the care is highly comparable to that of the physician. The VA uses many nurse practitioners as a very cost effective alternate to physician salary and better continuity. Unfortunately, the current VA regulations allow them to take advantage of these employees, even in terms of pay and promotion practices. Nurse practitioners, despite their training, education and responsibility, are in many facilities and are limited to staff nurse pay. Although the vast majority of nurse practitioners function in medical roles, standards are used to evaluate them. Because it doesn't reflect the actual practice of the nurse practitioner, it only becomes a paper exercise. The VA redesigned the RN qualifications several years ago. In every revision in the videotape distributed to all facilities, one of the benefits was an exchange that was designed to reward the clinical expert nurse, i.e, the nurse practitioner, by allowing them to be

promoted beyond the staff in your levels. However, once management began to realize the potential impact to their budget, they unilaterally decided to disregard that portion of the revision. The ultimate blow to morale to nurse practitioners is still being felt across the nation. Some of the facilities have attempted to address the pay inequality by creating special pay category. Unfortunately, this is left to the director and the nursing executive of the facility as to whether to institute these provisions. Therefore, a very large contingent remains with no opportunities with career advancement unless they wish to pursue a management position. Nurse practitioners desire to be clinical expert quality care to patients. They do not wish to become managers. However, they deserve to be paid at a rate that equals their education, skills and level of responsibility. Participation of frontline staff in making decisions regarding clinical practice once again, we hire our people and we hire them based on the fact that they have the ability to make decisions, they make life and death decisions regarding patients. However, they are not allowed to make decisions regarding staffing levels or anything else. Management tends to pick who they have on their committees, they are either management personnel or they are extensions of management. Some --

MS. PATILLO:

Thank you. Any questions? Next speaker is Maryanne Lewis from NAGE.

REPRESENTATIVE:

Good morning. Thank you Madame Chair. I have to say I disagree with the characterization of Cindy Hudgins that men make good patients. When my husband and two boys get sick, they don't seem that cooperative. My name is Maryanne Lewis and I'm the Director of the Congressional Affairs for the National Association of Government Employees, hereafter referred to as NAGE. We represent over 13,000 nursing and Veterans Affairs employees. On behalf of our national president, Mr. David Holway, I wish to thank you for allowing me this opportunity to speak today. I appear before you today to address the issues that the Commission seeks a solution to and show our desire to assist and facilitate the Commission's efforts to improve the current state of affairs for VA nursing staff. I would like to thank and acknowledge the Commission for recognizing these difficult times for VA employees, for holding these hearings and for allowing the many voices affected by VA department policy to be heard. As a member of the VA National Partnership Council, the NAGE has worked closely with the Department of Veterans Affairs to improve quality care conditions for our veterans and enhance the working conditions for the VA staff. Those who are in fact entrusted to implement the recommended improvements. NAGE looks forward to our continued participation in this mission. Our focus today is on the recruitment and retention of nursing staff. The importance of this discussion is underscored by the current national nursing shortage, along with the expectation that a larger number of nurses will retire over the next ten years, than new nurses will join the workforce. In addition, the current challenges our nation faces, both domestically and internationally, it is important that the Department of Veterans Affairs proves to all generations that those who answer the call to service can rest assured that their country will be there for them. The people at NAGE represents VA employees who served their country by caring for those who have sacrificed much to

serve our country. With threats of a shrinking VA budget along with an increasing national deficit, our nursing staff will need to rely on many various support systems to ensure the highest quality of medical for our Veterans. It is crucial that during these difficult times we do everything possible to retain the professional respect our medical personnel and VA employees deserve. The Department of Veterans Affairs was historically viewed as a stable, secure and desirable workplace for potential employees looking to enter the workforce. However, changes in the system and the lack of confidence in its program, has diminished our ability to attract and retain the best and brightest. We continue to struggle to maintain adequate staffing and the resources to provide necessary optimum care for our veterans. Hence the VA is no longer the employer of choice. A previous person receding me at the microphone from the community colleges, she stated the statistics of the graduating class. I think as you can judge by the reaction of the audience that was a very troubling statistic. One of the VA's most valuable resources is its nursing staff. In recognition of the need for a strong nursing workforce, the Department developed the Qualifications and Nurse Standard Board to appoint nurse for promotion based on objective and consistent criteria. This board chose to make an independent and fair evaluation would encourage individual development, education preparation and innovation in nurses by rewarding, and not limiting, the advancement of nurses who have attained the required clinical competency. Built into this system of promotion to show appreciation for the experience and knowledge a nurse has earned over the years, is a provision allowing a waiver for the education requirement under the Qualifications and Standards Board. As the standard currently reads, a BSN or bachelor of science degree is required for promotion. The waiver of this rule is available to RNs to help level the playing field for nurses who have many years of valuable experience and knowledge but may not have had the educational opportunities or degrees as others do, doing the same job. It was designed to exempt nurses who otherwise meet all criteria for promotion and have a long-standing record of competency and dedication to the VA to be eligible for advancement. Many of these nurses joined the VA when a BSN was not as common as it is today. Many of these nurses with long-standing records of dedication to the VA, have not had the opportunity to go back to school for a bachelor's degrees or may not have the money to do so. However, these nurses do the same jobs as those with bachelor's degrees and under the waiver are evaluated instead on their achievements as outlined in other criteria. We are concerned that the VA is not properly utilizing the waiver option as an incentive for non-BSN nurses to advance. We are concerned that the majority of nurses who qualify for the waiver are predominantly minority and older women. We feel that proven good services should be rewarded at all levels of education and should not neglect any employee because of age, gender or race. By not implementing this system of educational waivers sends a strong message to the shrinking available nursing workforce not to apply for jobs because you are already labeled at the VA in your career as opportunity limited. The waiver option must be recognized, utilized and encouraged by the boards. The Department of Veterans Affairs needs to extend the waiver for the BSN requirement until there is no longer a national nursing shortage which is not expected any time soon. If the VA wants to stick to the BSN requirement, the very least it can do is make possible the option for non-BSN nurses to obtain their degrees, while for BSN to obtain advanced degrees. Simple adjustments in scheduling or leave considerations for those seeking degrees should be mandated along with supplemental funding from the VA to local

administrations to help cover the cost of temporary personnel adjustments. The ability to advance one's education is a benefit that is highly sought after in the medical field, and a benefit provided for in most private organizations. The VA needs to compete with the private organizations to recruit and retain the best. An employee's service, years of service should be a significant factor in pay and promotional decisions and should weigh as heavily as the education level. Because the organizational value of the nurse increases as that nurse gains experience and knowledge, the VA should recognize and reward the dedication of an employee, especially an employee who is otherwise qualified for promotion. Although the Qualifications and Standards Boards were designed with good intentions, they have failed to meet the promise of a fair and consistent pay and promotion system. The boards are inconsistent in their application of the standards because of the subjectivity in the interpretation of the criteria. This criteria from which promotion is recommended, yields to subjectivity because of the vague nature in which the standards were written. Even the "Interpretive Guidelines," available to assist boards in following the criteria, are not written strongly enough to prevent subjectivity from interfering with their results. When a nurse is denied a promotion or a pay raise, the nurse is not informed why they were denied, nor are they offered a recommendation for improving their standing to make them more eligible for promotions in the future. Without these recommendations the promotion process defeats itself into a passive-aggressive form of discipline resulting in employee confusion and overall job dissatisfaction. The boards should be required to supply with every denial, a promotional opportunity plan that describes in clear detail the specifics of what the RN must do to obtain the appropriate clinical competencies. The RN should be provided at his or her request a coach or a mentor to help achieve the promotional goals. If the nurse achieves the criteria outlined in the plan, the nurse should be promoted the following year. Should a nurse appeal a denial, the appeals process for denied RNs must also include an explanation from the appeals board defending their conclusion, including input received from the RN to the appeals board and allow a representative of the nurse's choice to be present at board proceedings. To ensure the integrity of the boards, an independent third-party or union representative should be allowed to observe the proceedings of the board and the appeals process to support the VA's effort to apply the standards without discrimination. Some VA directors already employ this technique with great success, resulting in higher morale among nursing staff. All votes of board members should be confidential to prevent potential pressure from other board members to sway a vote. All board members should receive joint labor management training on the Qualification Standards to increase consistent interpretation of the standards. To ensure equitable treatment of all medical staff, the law covering Title 38 employees should be clarified to allow unions to negotiate over the promotional process.

MS. PATILLO:

Ms. Lewis, your time is up.

REPRESENTATIVE:

Thank you.

MS. PATILLO:

Any questions? I'm sorry, we do have a question, if you don't mind.

REPRESENTATIVE:

Not at all.

MS. HANSELL:

Are there any formalized mentoring programs within the system that you are aware of, to help nurses develop in their career?

REPRESENTATIVE:

I am not aware of any formal or articulated policies regarding that. But as we all know, in a work environment, we do see that people take certain people under their wing and mentor them along. I see you're shaking your head.

MS. KINGSTON:

No, David asked me if I knew of any and I don't.

MS. PATILLO:

Thank you. Natalie Floyd is our next speaker from Birmingham VA Medical Center.

REPRESENTATIVE:

Good morning. I am Natalie A. Floyd and I'm from the Birmingham VA Medical Center. I'm an adult nurse practitioner. I started out at the VA after college in December of 1983, and I have remained there until now. I am representing several nurses at the VA Medical Center. Mostly the advanced practice nurses, clinical nurse specialists, the nurse practitioners and registered nurses. We thank you all for the opportunity to come here and speak and for you to listen to our issues. Today I'd like to address the current Nurse Qual Standards. As it presently stands, clinical nurse specialists and advanced practice nurses are limited to no higher than a Level 3 nurse. At that time, after step 12 or 13 they are "locked in" to something. This concerns me that many bright, intelligent and hard-working nurses that desire to achieve higher heights. After they arrive at their final step, their continued outstanding work their only reward for is if they get it, a cost of living raise. Presently the Qual Standards are unavailable and unattainable for clinical nurse specialist and advanced practice nurse and for registered nurses. Several of us have applied for the level four nurse and were refused. On one issue, I have a very nice letter from a Nurse Professional Standard Board that listed the nine areas and how we did not achieve those areas. If you wanted to meet with the chief nurse or with the chairperson of the board, you could have actually scheduled a meeting, and which I did. The other letter basically says that unless your current duties change please do not attempt the level four

any more. And I have got that copy here with me if you all would like to see it. left the VA system and we have Some unfortunately have lost some wonderful nurses. One of them I know is in Florida, one is in Georgia and we have lost some excellent nurses because they got to Level 3, Step 12, Step 13 and they could not go any higher, and they left. So we have seen an outflux of outstanding nurses. Some nurses have gone into the private sector, but the bottom line is that we have more nurses exiting than entering this great system. Therefore we ask that your committee recommend that the current Qual Standards are re-reviewed and make them available for all highly qualified nurses. There is not a single nurses asking for anything that they don't qualify for. We just wants them to be fair, equitable and attainable. There is a cadre of nurses who chose the executive track. They have been promoted to level four. As far as the pay issue, currently there is an inequity in the pay for clinical nurse specialists, advanced practice nurses and registered nurses. You can drive south of Birmingham to Tuskegee, you can go west to Tuscaloosa, you can go east to Atlanta, and those three facilities, nurses earn several thousand dollars more than the Birmingham VA nurses do. Currently one of my clinical nurse specialists or nurse practitioner students just left and went to Atlanta. So as you can see, we are losing some bright, talented nurses. A suggestion might be for each administrator or personnel specialist at every VA and all of each business to actually meet and decide how they can come to some comfortable middle ground about salary. Presently, a lot of nurses are going where they can get higher wages and lower cost of living, if the personnel managers could meet and talk about this. Hopefully then more nurses would remain at facilities where they actually started. And believe it or not, most people still want to graduate from college, and go to work at a facility, and hopefully, retire from that same place. The VA, a system that we all love, can be a very valuable and wonderful employer. However, because of the current two issues, they are losing some of our best and brightest talent. Regarding the Nurse Professional Standards Board. Currently, that is an issue that has come up several times. We have a staff nurse in the clinic who actually was promoted to Level 3. She is the only one in her group who still remains at Level II. Someone on the board congratulated her on her promotion. When she got her letter, she was not promoted. Again, the following year, she went back before the board and did not become a Level 3 nurse. She is working around seven to ten nurses who are all Level 3s and she is the only one left that is still a Level II. Management so far has not shared with her the reason as to why she has not been promoted to the Level 3 status. A friend of hers told her that basically, the Nurse Professional Standards Board approved it but someone on the executive board rejected it. That is an issue that she is specifically asking that we address. If you elect Nurse Professional Standards Board members, they make a decision, who has the final say-so? The board or the executives? As far as the composition of the board, we recommend that there be separate boards for several reasons. One board should be divided up into advanced practice nurses and clinical nurse specialists only. The next board should be team associates and LPNs. And a team associate is a person right now who actually has clinical and administrative duty, and they are earning more than a licensed practical nurse. But we have it so we need to address that. But we are recommending that those two entities be on the same board. Registered nurses should have a separate board. And for each board we ask that you consider having a separate salary scale. We are asking this board to review the salaries and to possibly re-review the current Qual Standards at each level. When nurses don't qualify for the next level, we are asking that management or some realm of that, meet

with that nurse with quickness, discuss with them why they did not meet it, and foster and cultivate their talent and their skills, so that the next time that they try for it, hopefully they may get that promotion. If not, we will continue to see all serious outflux of our best and brightest nurses, leaving the VA medical system, again, a system that they love, and taking care of the patients who we also love. Thank you for your time and your attention. Thank you.

MS. PATILLO:

Any questions? Thank you very much. We are going to do our open forum now. We are going to allocate 20 minutes as planned. So we will go into our recess just for a few minutes. I have a list of people here, I would like to just give you the names so you will be ready. And you will have three minutes. So it is Linda Jernigan, Marsha Joy, An Ho Deeter, Douglas Flanagan, Charles Jenkins, Debbie Joe, and Roy Presswood. Let's see how we go with those people, with Linda starting, please.

AUDIENCE MEMBER:

I would like to thank the Commission for their time, and the opportunity to speak before them today. My name is Linda Jernigan. I'm an LPN at the Emergency Room at the Tennessee Valley Healthcare Systems, Nashville Campus. I am proud to be a VA nurse. I feel privileged to get to take care of those who so unselfishly gave of themselves so that we can have the freedoms we so often take for granted. When it comes to retaining quality workforce where LPNs are concerned it comes to one word, respect. There is no respect for the profession of practical nursing. LPN stands for licensed practical nurse, that is what it stands on my license for the state of Tennessee I went to school for one year, a full 12 months, and had to pass a state licensing exam. Yet, when I started working at the VA in 1988, with three years of hospital bedside nursing experience, I was basically a nursing tech that could administer medication. LPNs top out at the GS-6 level, so there is not much room for advancement. Lots of the LPNs I know have topped out several years ago and still have a minimum of five years to work before they are eligible to retire. We have become increasingly frustrated over the issue of advancement for LPNs. We must have formal schooling, clinical training and a state license. However, many LPNs leave nursing to work in other areas of the VA where they can be upgraded to GS-7s and above. We have recently been told Congress approved legislation that would allow for LPNs to be upgraded to the GS-7 level. However, it is expected that the OPM and the VA are establishing more strenuous guidelines and additional job requirements in order for the LPN to upgrade. We are currently functioning at a level that exceeds the GS-6 standards and we feel we should not have to meet additional standards to be upgraded. LPNs at the Nashville Campus are upset when other positions in the hospital are upgraded to GS-6s because they do not have the same level of responsibility for patients and their jobs do not require licensure. We make only 59 cents an hour more than these people. We are supportive of others getting an upgrade but we are restricted. We feel this is a lack of respect for our profession. LPNs in the emergency room, SICU and MICU working side-by-side with RNs are not getting compensated for their critical care experience. LPNs in the VA system are not entitled to critical care pay while the RNs are receiving critical care pay. This is unfair to the LPNs. Why can I work

in a critical area and not be entitled to critical care pay? I have been going to school part-time the past three years. I will have to take a \$4,000 a year pay cut when I complete my education and become an RN. Thank you.

MS. PATILLO:

Marsha Joy.

AUDIENCE MEMBER:

My name is Marsha Joy. I'm a registered nurse with the Tennessee Valley Healthcare System, Nashville Campus. I work on the ambulatory care department and subspecialty clinics. I want to thank the Commission for allowing me to be here to testify today. I am here because I'm proud to be a VA nurse and I enjoy caring for the servicemen of this country. My husband is a veteran and my late father is a veteran. I have two nephews serving in the Air Force on standby waiting to be deployed. I have a great deal of respect for the men and woman to serve and to protect our country. However, I do not believe that the VA is giving the respect to the Veterans they serve by continuing to place patient care at risk by contributing to the nursing shortage. The Qualification Standards are contributing to many career nurses leaving the VA and this makes it unable to recruit nurses because of the advancement is impossible to meet. The standards are not geared toward helping most of the staff nurses advance but they are geared toward the administrative. We feel Qual Standards are unfair and makes it difficult for nurses to meet the objectives. Due to extreme restrictions in the Qualification Standards, it is difficult for nurses to advance from Nurse 1 or Nurse 2s, or 3 to 4 with an MSN. I believe most nurses in the VA are not the administrative type or the corps nurses and frontline caregivers, yet they perform on the same level as 2s and 3s. It is impossible for the staff nurses to advance because the standards require the nurses to leave their patients when staffing is low and patient ratio is high. The standards are so broad-based that staff nurses will not be able to meet these standards. The requirements are that the nurse's individual contributions, or the efficiencies of nurse practice is beyond an individual unit effort. They must encompass specific goals that are impossible for staff members to meet. Every nurse in the VA should have a right to advance to the best of their ability based on their experience and actual job performances. I strongly urge them to launch an investigation of the legitimacy and fairness of the Qualification Standards. Additionally, I recommend that the Qualification Standards be made equitable as to the staff and nurses, substituting years of experience as a guide, as opposed to work performed. recommend that the VA I recommend that clinical nurses be automatically grandfathered into Nurse 1, and additionally, Nurse 1 to Nurse 2, Nurse 2 to Nurse 3. I recommend that the Commission issue the change in Title 38 law in order for a nurse to be represented by union with respect to their promotions, peer-review process, disputes, employment process, disputes over the application of the Qualification Standards and professional conduct. Thank you.

MS. PATILLO:

Next is An Ho Deeter.

AUDIENCE MEMBER:

My name is An Ho Deeter, and I have been a nurse for 25 years. I'm from the VA in Little Rock, Arkansas. I got my LPN in 1977, ADN in 1984, BS in 1990, and I'm working on my BSN. I will graduate in December this year. I am glad to be here. I am happy to hear your ideas, and I am hoping we all can work together so that we can change our working place to a better environment for us and for our patients. Who wants to help the people and the Veterans? We do. Who cares about the people and the Veterans? We do. We feel very frustrated we are overwhelmed because we today, because cannot practice a quality job. The average age of the RN is 45. I see many people are leaving the service without replacement. I want to tell you about one of them, for instance. Her name is Sharon. I hope she doesn't mind if I talk about her. She was one of the best nurses we have. Because she could not handle the stress, she took a deep cut of more than \$10,000 a year to work as a secretary. Then she retired early, one year, after she get to 55 years old. Can we afford to let our nurses retire early as soon as they can because of the terrible working conditions? Of course not. Today, I want to address this question, Question No. 5, how can the VA best attract and retain a quality workforce? In the Nurse News Week magazine, April 15, 2002, there was a formal research study by the Nurse News Week Journal executed to conduct a landmark national research study of RNs in the United States, to learn the career intentions and positions of the work environment. The study showed that the impact of staffing problems on quality care in the year 2001 had witnessed a negative impact on the quality of patient care from in-patient ward setting and other ward settings. No. 8, an increase in the turnover of experienced RNs. B, a greater number of patients per nurse. C, more acuity in patient population. D, an increase in overtime, the problem resulting from those nursing shortages and the amount of time nurses have to devote. Thank you very much.

MS. PATILLO:

You can submit that, please, if you don't mind, and also the article from Nurse Week 2002. Thank you. Next is Douglas Flanagan.

AUDIENCE MEMBER:

My name is Douglas Flanagan from the Atlanta, VA and I am here to represent all the LPNs at the Atlanta VA. Our Commission to look at our pay morale at that facility is almost nonexistent. We ask, we plead to this scale and even the GS-7 is not enough for the LPNs. You have Qual Standards for the RNs. Have Qual Standards for the LPNs. Some of us do take ACLS and critical care classes and we have the certification but we get nothing for those. There are committees at these facilities, like the ethics committee, and the patient care committees, that are manned by all RNs. They are not the only ones that take care of these patients. LPNs and NAs do, too. At least have one LPN, one NA on the board to give our input. They ask for none of our input. They have peer reviews for RNs to give them recognition and rewards. The LPNs get nothing. We are not considered nurses. They'll call and say, "Let me speak to the nurse"; I'm an LPN." "I want to speak to an RN." I have had nurse managers say, "Well if you go back to nursing

school, you will become a nurse." I'm already a nurse. I do almost everything they do, except for taking blood. We verify and then I can add it. I don't do IV push. I'm certified, I took the critical care course and passed it. Why can't I get anything for that? Our LPNs are pleading with you, please, do something about this, the way the LPNs are treated within the VA system. And that's all I have.

MS. PATILLO:

Next is Charles Jenkins.

AUDIENCE MEMBER:

Good afternoon. My name is Charles W. Jenkins. I currently work at the Jackson, Mississippi Medical Center. I have been employed there for approximately eight years. Six years of that time I spent as a nurse assistant. I'm currently a supply technician. I'm also a representative of the American Federations of Government Employees. So I represent the interests of all nursing service personnel. I have daily contact with these nursing service personnel and I am also a service connected veteran of the United States Navy. I know my time is limited, but I would like to make a few critical points. As a service connected veteran, and since we currently are at war, I think it is totally deplorable and criminal that we are not implementing something to give nursing service staff the opportunity to sit down and negotiate with management over the situations on the shortness of staff and everything that directly affects direct care providers. If we truly support our troops, then to support them we have to support them when they get back here. It is just like asking the troops to go to Iraq without a weapon. We are asking our nursing service personnel to perform duties without enough staff. That's like asking the soldiers to go to war without a weapon. It is deplorable. I will give a quick example. We had a situation on a ward at the VA Center where I work. The director's father was on the ward. He knew they didn't have enough staff. He told one of the nurses, I want more staff for my father. We didn't have the staff. So he had the father moved to the ward next door who happened to have more staff that day. After his father left that ward, did he come back to see if there was more staff for the everyday veteran up there? No. He didn't follow up. We tried to meet with him about staffing. He doesn't meet with us. He sends it to the next level. This is consistent at VAs all over the nation. Nursing service personnel work with the veterans seven days a week, 24 hours a day, 365 days a year. They are the ones who are providing the care; they are the ones who should be able to sit down and tell everyone what they need, and what is needed for the best care for our veterans. Again, I thank the Commission for giving me this opportunity to sit up here and give my small input on what is going on every day. Please make the right decision. have a change. I recommend that we have to you make it a law, beat down the doors of Congress, I mean literally beat down the doors of Congress and the Veterans Affairs and the President, let them know what the nurses at the VA are going through. Thank you.

MS. PATILLO:

Thank you, Charles. Debbie Joe?

AUDIENCE MEMBER:

My name is Debbie Joe and I'm from the Jackson VA Medical Center, Mississippi. I'm going to talk about staffing level, as we are very short-staffed. This floor specializes in chemotherapy and also med/surgery patients. On the average days, we only have three licensed persons which consists of LPN, RN, and two nurse assistants. If we had more staff this system could be prevented. For example, on March 8 and 9, we have had five patients fail and one missing patient within 48 hours. Also, my recommendation is that we need more permanent staff, not PRN or an agency nurse, because most of them leave work undone, such as assessment and discharge that they know that they are responsible for. And so, the regular staff have to go back and take care of all of the work that is undone, and take care of the notes, all the discharge and admission notes that are left undone. We are limited at the telemetry floors and we have no telemetry monitors. We are specialized in telemetry and we don't have telemetry techs to watch the monitors. And that would prevent patient from leaving telemetry without nurses knowing the patient has gone. The missing patient who left the floor was on telemetry. That's why he came to the telemetry monitor. If we had telemetry tech monitors, if he took it off, and he just walked off the floor and walked outside, and left the hospital -- if we had the telemetry tech, he would watch the monitor and we would know, and say, they'll call us and say his monitor is off. Thank you

MS. PATILLO:

Let's listen to Roy Presswood, and he will be our last.

AUDIENCE MEMBER:

Good afternoon. My name is Roy Presswood, and I work at the Veterans Administration in Birmingham. My complaint today is that I have been working at the VA Hospital since 1992, I was hired as a part-time employee, working four hours a day, five days a week. I worked that job, and I was writing to EEO in Big Pine, Florida, with no success. I was not being hired or picked up by the VA Hospital in Birmingham. I finally wrote to the Merit Protection Board and the Merit Protection Board forced them to hire me and give me an eight-hour job. Before working at the VA, I worked at Long Beach Naval Shipyard for nine years. Before coming back to Alabama, I was a WGA pipefitter at Long Beach Naval Shipyard. I have applied for several, over 20 different jobs at VA, and was denied each job, due to the chief of my department had went to each chief that I applied for jobs, and I was "qualified but not accepted" for over 20 jobs from 1992 to present. I was given this full-time job by the American Protection Board in 2001, by the Merit Protection them to give me an eight-hour board, forcing 20 years working for the federal job. I don't have enough time to qualify, even though I have government, by me working part-time for nearly ten years. I am requesting right now at the VA to be transferred out of this department. The reason why is the chief of my department would not hire me is because of the Family Medical Emergency Leave Act that I had to use due to my father passing, and my mother is ill. And that's the reason she'll not let me be promoted in the dietetic service, nor any other service that I qualify for. of the other 20 jobs. I get a I was qualified for 20 different positions. I was only interviewed three times for all letter from

them stating I was qualified but not accepted. And that's the end of the story for them. No interview or anything of that nature.

MS. PATILLO:

Thank you very much. I appreciate it. Your time is up. Thank you.

AUDIENCE MEMBER:

Thank you.

MS. HANSELL:

Mr. Presswood, what department are you employed in?

AUDIENCE MEMBER:

I'm employed in nutrition, food service, dietetic service.

MS. HANSELL:

Thank you.

MS. PATILLO:

We'll recess until 1:30. (Lunch recess.)

MS. PATILLO:

Let's get started, first, Maureen Reilly, South Texas Veterans Healthcare Systems.

REPRESENTATIVE:

First of all, I want to introduce myself and let you know who I am. I am Dr. Maureen I'm a veteran. I am a spouse of Reilly; a veteran and I am the daughter of a deceased World War II veteran. I'm a Certified Registered Nurse Anesthetist, so we are the advanced practitioner nurses that you don't see. Because if we do a good job, you forget us. I'm currently a full-time employee at the Audie Murphy Division, South Texas Veterans Healthcare System, San Antonio, Texas. I'm here to speak to you on behalf of the Nurse Anesthetists as well as Association of general nurse anesthesia providers across the entire system, including Puerto Rico. I thank you for the opportunity to voice our concerns to this forum because often we are not heard. We are kind of the warrant officer in the nursing profession. We have one foot in medicine and one foot in nursing, and sometimes we never know where we really are. But I would like to present a number of questions and plausible answers for those questions. The practice of Nurse Anesthesia in the VA represents the largest pool -- the largest pool -- of CRNAs employed in the federal sector. We employ more CRNAs than Army, Air Force and Navy on active duty.

There are currently in excess of 530 employees employed primarily on a full-time basis, and out of that 530 employees, less than 50 are either contract CRNAs or part-time. So the majority of us are full-time. The average age is slightly older than our nursing colleagues, which is 52. And ours is 52 and growing, which is older than the general CRNA population, which is about 48. 50 percent, and this is the one statistic if you don't remember anything else I say, please remember this: By the year 2007, 50 percent of my colleagues, including myself, will be eligible for retirement. 50 percent. These numbers are in excess of our normally predicted turnover rates and I will talk about that in a second. We, like our nursing colleagues, are an aging profession, but unlike our nursing colleagues, rely on the workforce for our survival as advanced practice nursing speciality practitioners. Without baccalaureate-prepared critical care nurses, we cannot fill the seats in our graduate schools for nurse anesthesia. Let me briefly outline some concerns from my CRNA colleagues, voiced both on a one-to-one basis, as well as responses to a recent national survey conducted by a VA CRNA who is completing her master's thesis. The concerns were diverse, but they can be filtered into a series of three major themes, and I will go over them for you. Number One, we want to remain to be the caregiver for the veterans providing high-quality care and cost-effective care, but first we must recruit new graduate CRNAs while retaining our senior CRNAs to mentor those young CRNAs coming in. Finally, we want to maintain the standard of practice that CRNAs have come to know in the VA system. Let me first address the issue of high-quality care. VA CRNAs work in a variety of nursing practice settings, again, similar to our nursing colleagues. There are several models of care. Let me address this so you understand our practice settings. In nursing, we may practice as primary nurses or in a variety of team care concepts. This is similar for CRNAs. Primary nursing is analogous to independent practice in the VA -- and this is another important thing to remember -- this is a model that exists in several facilities where the CRNAs are the sole provider -- sole provider -- of the Team nursing is analogous to the anesthesia care team. And in the Anesthesia Care Team. In this approach, a patient may be cared for by several team members, including the CRNAs, resident or an SRNA. Student registered certified nurse anesthetist. This model is often considered the best one for our veterans, second only to the fact that the acuity is so high for the veteran population. Our goal is always the delivery of high-quality care, but we are guided by the philosophy of a caring art. Many nurses will defend the concept of primary care, that is, one registered professional nurse caring to the patient's total care. However, the current nursing shortage has created a vacuum that needs to be filled. In many cases, third-tier providers have been added to fill those vacuums. In other words, care being delivered by a variety of nursing extenders. We now face a similar crisis in the delivery of anesthesia care. While there is a place for all providers they must be used as intended, and we all know that doesn't always happen. In the case of the CRNA in the VA shortage, a third tier has been added to the Anesthesia Care Team recently. As you-all are well aware, in the care of nursing care extension, a variety of providers in the past has shown a decrement in overall care with an increase in adverse events. As you know, this is documented and supported in research literature. We fear this will be the case in the face of the addition of the Anesthesiology Assistant as another member of team. As recently as this week, we were in Washington last week discussing this, and the AA has been added to the VA 1123, which VA 1123 is the guiding document for anesthesia services in the VA. One thing I didn't mention but I assumed you know, CRNAs do not come under nursing in the VA system. We come

under either surgical or anesthesia license. The reality is the CRNA having the right to work in the public sector is not a problem; the problem is adding this provider to the care mix. And this was strongly opposed to by the CRNA members of the National Federal Advisory Committee last week. These concerns echo the concerns of many CRNAs providers across the VA, and an interesting point, a number of anesthesiologists as well. AAs are educated in one of two schools in the United States; only two schools exist. They have produced approximately 800 graduates since the inception of their programs in 1969. AAs are not recognized care providers in all states. In fact, at this point, less than 17 states currently allow their practice. Unlike CRNAs or MDAs, they possess no nursing/medical generalist education. Also, there is no requirement for any patient care experience prior to attendance at either program. They may have an undergraduate degree in philosophy or mechanical engineering. The only requirement is that they have "an undergraduate degree." At this point, it is extremely evident that they do not possess the basic developmental period needed to foster the growth of critical thinking skills that are so key in the delivery of care. They are trained to function as physician extenders; however, since there are no national standards, state-to-state regulatory bodies are different, and the level of supervision varies widely. For instance, in Texas, AAs can be supervisors on a four to one level. Four to one ratio. In Ohio, depending upon the expertise of the AA, it can be a one to one level. The lack of consistency will only be perpetuated in our system simply by the fact that they are being added as a provider without the benefit of a job description, scope of practice or even familiarity by many stations with their abilities or what their functional expectations are. Hastening the addition of a provider without proper preparation of the system is a setup for potential patient disasters. The protocols established for hiring and creation of a job category need to be followed in order to preserve the high quality of care our veterans have come to expect and do deserve. We recommend, we would request that the Commission recommend that the appropriate process be followed for inclusion of this provider in our practice and in our practice settings. May I address the next point in solving this impending vacuum of providers? In an effort to be proactive, the National Anesthesia Service has formulated and implemented strategies that have either been stalled or completely blocked at the VHA level. It takes approximately three years to educate from application and entry into a program through certification for a CRNA. In an effort to "grow our own," our proposal for a VA/DOD educational program was conceived over two years ago. The U.S. Army has a long-standing program -- I am a member, so I'm prejudiced -- well known for the level of excellence in both the didactic and clinical portions of the programs. The average cost for tuition for a graduate anesthesia education runs about \$30,000. The cost per year to educate a CRNA is approximately \$66,000. The DOD program would charge us \$8,000 for tuition for the first year for the student and the VA would be responsible for the second year at no additional tuition cost to the system. included the cost of a director This proposal also to facilitate students' progress through the program as well as acting as a faculty member at the Phase 1 site, which is located in San Antonio, Texas. VHA executive level appropriations committees disapproved this process and proposal. We have a revised proposal for a much smaller program with three students, attending in Augusta, Georgia, with no clinical director, to begin hopefully in the fiscal 2004 class. This is a beginning, but it does not fully address the problem. We would ask the Commission to explore and endorse the original proposal as it was submitted in 2002. It makes dollars and cents -- it makes sense. Our recruitment efforts

for new graduates have been abysmal- a reflection of the locality pay system. While it is not the philosophy of the VA to be a pay leader in the community, we must be at least competitive. And if we are not competitive, we are not going to attract the young, motivated practitioners that we need. In a recent national survey conducted by the chief nurse anesthetist at the local VA, Nurse Laura Cohen, who accompanied me to this meeting, only one hospital, one hospital surveyed out of 76 had a competitive salary for a beginning new graduate. Many station directors continue to use locality surveys at their discretion without the input of CRNA staff, or they disregard completely the results of the locality pay surveys. Our national average for both entry level pay as well as senior positions falls several thousand dollars below the national average. In some locations, new graduates' starting salaries are as much as \$30,000 below the community.

MS. PATILLO:

I'm sorry, your time is up. Thank you so much. Are there any questions?

MS. BURNES-BOLTON:

In relationship to anesthesia assistants, is there a national certification exam for those individuals?

REPRESENTATIVE:

There is an exam given by the ASA. The physicians.

MS. BURNES-BOLTON:

Is it part of your recommendations that if these are utilized, they would be the required to have a national certification exam, pass that?

REPRESENTATIVE:

Our recommendation is it needs to be looked at, and yes, they need to pass the exam. But they are not a licensed provider in all but 17 states. So how can they come into the and function, when they can't system have -- or if they don't have a licensure with regulations? If you don't have regulations, how do you create scope of practice?

MS. BURNES-BOLTON:

Thank you.

MS. PATILLO:

I have a question about some workplace issues. Do they have any problems calling you Dr. Reilly, your physician friends?

MS. RILEY:

Absolutely they do. And I have been formally counseled for that. I tell them that in fact, I have the real degree; theirs is a technical degree. When I introduce myself to my patient, I introduce myself as Dr. Reilly, your nurse anesthetist working on the anesthesia care team today with Doctor So and So, who is your physician anesthesiologist. So I do use it, but it is troublesome to them.

MS. PATILLO:

Thank you. Next witness, Cynthia Brown.

REPRESENTATIVE:

Hi, my name is Cynthia Brown. I am an employee of the VA Medical Center in Dublin, Georgia. I have been an employee there for 18 and a half years. I would like to thank you for this opportunity to speak to you today about these issues and concerns facing VA nurses, RNs, healthcare workers, and nursing assistants, and also on behalf of the Veterans who are a unique group of people that I have enjoyed working with over the years. But they also have a concern about the quality of nursing staffing, overtime and pay. For they know to fall short in any of these areas, the result could be disaster. Over the years, VA nurses seem to have faded into the background, as if all else takes first place. Now is the time we must take a look at VA nurses and focus on what is an important part of VA: Skilled qualified nurses and the lack of them, and why. One of these reasons is poor recruitment. The VA doesn't have a national and professional incentive to attract and retain a skilled workforce. For years, just by being the VA, it was enough to bring in qualified nurses. Not any more. At one point, it was the most sought after federal job, sought after by nurses and others but not any more. But for whatever reason, whether a lack of vision, or through oversight, the VA has become the worst place to work, especially for skilled nurses. The private sector has moved leaps and bounds ahead in some areas, mostly financial areas. There has been -- excuse me. There have been money put into all parts of the VA. The nurses seek to have the crumbs that fall from the table. There must be a real effort to put money in nursing to locate new recruits and graduates, even if that means recruiting directors from schools, on-site schools, and VA affiliation. But there has to be something other than the leftovers given to better the workforce. Because in light of these things, this has caused a gulf in our employee force. And just by word of mouth, the VA has also sustained a loss. Because if asked, most VA nurses will not have a good, glowing report to give. How do we change? Knowing nurses leave for most of the same reasons they are recruited: Lack of security, pay advancement, locality pay, premium pay, grade levels. The skilled nurses are coming in with high expectations and in six months to a year, leaving because of the lack of these things. We can start to change by putting together a financial package that would at least rival the private sector. Hold on to skilled nurses that are here with advancement. Promote RNs and LPNs in a timely manner. Year after year, they worked hard to ensure that these professional nurse get boarded according to regulations. VA managers over and over again have used unnecessary language in performance evaluations so as not to board RNs and LPNs. But listen, there is an RN that has not been boarded in ten years, Nurse

1, Step 1, because it was said in an evaluation that there was a language barrier. She is of Asian descent. None of her patients have any problem understanding her. An LPN who was not boarded because her first line supervisor would not or could not write a correct evaluation. The performance evaluation was sent back to her on several occasions with instructions, and the first line supervisor could not or would not write up the evaluation correctly. This LPN had to get outside legal help to get her the advancement. These kinds of things have left a bad taste in the nurses' mouths. It is hard for them to say, Come on in, the water is fine. It causes VA nurses to fall way behind in the financial arena. They are moving out of VA into other areas to better take care of their families and to get advancement they are qualified for and deserve. Nurse assistants have not been upgraded at Dublin VA in over 20 years. Some have retired with 30 years and not even been able to move beyond the GS-4, Step 10. We are one of the more qualified nurse assistants in the VA. Our position description reads: Have the ability to do trach care, superpubic area, Foley catheter care, internal and external wound care, extensive and superficial, and the list goes on. In talking with nurse assistants at other VAs and finding out that they are GS-5 without having these requirements, it is very hard to understand, except to say this is a great wrong. We once were great additions to the system but this is not fair or equal treatment. In the last few years, the LPNs were added to the ranks of being paid Saturday premium. The nurse assistant was not. We work right along beside the LPNs and RNs, but we do not get paid. Nurse assistants should also get paid for Saturday premium or stay home on Saturdays. The award system that was in place is no longer being given. And that's one -- the only way the nurse assistants could get a little advancement. VA have made it impossible for school attendance for nurse assistants by not being able to do, or will not try to work the schedule to pay an attendant to have enough people to work the work not scheduled. Upward mobility went up in smoke. A lot of nurse assistants apply and if they are received, would have to go to school, study, work in between school to try to at least just keep up. Some give up, others don't make the grade because you can't serve two masters. There must be a concept of empowerment. Nurses at most of the VA facilities cannot or are not being asked to participate in any decision-making or problem-solving. Upper management are not even in the trenches and do not have a thumb on the pulse of the problem. Empowering the staff, beginning at the lowest level, will breed improvement. This will bring about ownership, instead of "their VA", it would become "our VA." We must change the way the system works. We need more staff and better conditions, as well as pay. It makes no sense. Nurses are tired at the VA. Thank you.

MS. PATILLO:

What is your background?

REPRESENTATIVE:

I have been a nurse assistant for 18 years.

MR. COX:

At your VA, according to the date I have here, you are a GS-4 with 18 years experience a nursing assistant. What would as you say the breakdown of nurse assistants -- are most of them GS-4s, GS-5s?

REPRESENTATIVE:

At my VA in Dublin, all nurse assistants are GS-4.

MR. COX:

You have no GS-5s at all?

REPRESENTATIVE:

I think we -- maybe one, but he was in a special pay area.

MR. COX:

Thank you.

MS. PATILLO:

Thank you. The next speaker is Paula Davis, Dorn VA Medical Center, Columbia, South Carolina.

REPRESENTATIVE:

Good afternoon. My name is Paula Davis. I am an LPN. I work at the Dorn VA Medical Center in Columbia, South Carolina. My RN license lies dormant at the State Board of Nursing offices in Columbia, South Carolina. I would like to tell you about my unsuccessful attempts to work as an RN in a Mental Health Service Line at Dorn VA Medical Center. I have worked for the past 25 years at Dorn. Seventeen of those years has been in the area of mental health. During the time of my employment, I have received superior performance ratings, as well as satisfactory ratings when superior ratings were no longer awarded based on performance to Title V employees. In November 1999, I completed the requirements for an associate's degree in nursing. I took the N-Clex exam in April of 2000, and became licensed to work as an RN. I had spoken to the director of the Mental Health Service Line, Dr. Earl Burch, approximately six months before I graduated, and asked him what were my chances of being allowed to continue my work as an RN on our unit. His response to me was, I am sure that we can find something for you to do. In June of 2000, I made a written request that I be allowed to work as an RN on 106-East. I received a written response that the two nursing assistant vacancies were going to be filled by two LPNs. He never addressed my question. In April of 2002, the director announced in a meeting that he would be hiring three registered nurses for in-patient psychiatry. Human Resources advertised the

position and I applied in April of 2002. On approximately August 12, while on duty, I received a call from the director's secretary, informing me that I had an interview with the director and my head nurse. On August 16, I received a letter from Human Resources stating that another applicant had been selected for the remaining position as an RN on my unit. I called the director's secretary and was reassured that it was indeed an interview for a job as an RN. I reported on Tuesday, August 20, and at the onset of the interview, I expressed my concern about the interview as I had received notification from Human Resources that someone else had been selected. The director informed me that there were problems with one of the applicants and that I was being interviewed and would be given serious consideration for the RN position. I would like to point out that two applicants had been hired but for some reason, did not report for duty as had been agreed upon. After the director and the head nurse refused to hire me for the position of RN, I requested feedback for their belief to what I needed to do to prepare myself for a position as an RN in in-patient psychiatry. After one month, and after I sought out the director in the corridor, and asked him for a reply to my request for feedback, he responded. His response was that I was not hired because an RN with experience was what they wanted. Since that time, I have appealed to the nurse executive who told me that if it was left to her, she would hire me, but that she could not force the director to hire me. She promised to speak with both the director and my head nurse. She did speak to my head nurse, but since I believed that the new RN's arrival was imminent, I told the nurse executive that she need not take any further action. Everything that has happened to me in applying for an RN position in in-patient psychiatry is directly contrary to the promotion by the Dorn VA Medical Center and the National Workforce Planning Group. I believe it is the practice to hire graduate nurses as well as nurses that have not practiced for several years. I want to continue my work in an area where the patient population intrigues me the most. I have a personal resolve to provide the best possible care for those patients, while growing through experience. Having worked as an LPN on the unit for the past 17 years translates into lending my knowledge and support to at least five JCAHO surveys, as well as countless high-stress and often dangerous episodes of the patient care. Regardless, it was always and still is my goal to put veterans first and to try to promote a safe and therapeutic environment. I would like to point out that the RNs hired for the three positions, one of them was a former VA employee; the other two nurses never -- did not have any experience with the VA. I would like to point out those nurses hired for the position had to receive orientation and training to the ward to include BCMA and CPRS. I have been using BCMA and CPRS for several years, and I was overlooked in the selections made. Based on my experience, observations and working with the RNs on my unit, I know that I would have been able to perform as a competent RN with minimal orientation and supervision. The experience that I have as an LPN is not a myth, it is an essential ingredient in my moving from a novice to an expert. The Nursing Workforce Planning Group stated "The registered nurse is at the center of the nursing workforce. As the national pool of qualified and available registered nurses continues to diminish, the ability of each VA facility to effectively retain the nurses already on staff becomes increasingly critical. Retention of nurses, especially those with valuable experience, are recruiting nurses into the possibly more important than workplace." I have learned a lot through my practice as an LPN on the unit. I have 37 years of experience as an LPN. For me to have to prove myself, then ultimately be denied the opportunity to demonstrate my abilities is in conflict with the VA's response to the national nursing shortage. For my

solution, in-patient psychiatry now at the Dorn VA Medical Center is now regarded as a specialty unit. Consider starting a nurse preceptor program for those nurses whose interests lie heavily in mental health. Also, factor in the amount of experience an LPN brings with him or her, when he or she becomes an RN. I want to thank this Commission for allowing me to voice my concerns about how the managers at the Mental Health Service Line in Columbia, South Carolina, have devalued me in my effort at upward mobility.

MS. PATILLO:

Thank you.

MS. BURNES-BOLTON:

Did you complete, after you passed the exam, did you complete any type of an RN internship program at that VA, not necessarily in the Mental Health Service Clinic, but anywhere within that particular institution?

REPRESENTATIVE:

No, I didn't.

MS. BURNES-BOLTON:

Are you aware of transition jobs that are available through the VA, for individuals who are going from LPN to RN?

REPRESENTATIVE:

No, I'm not.

MS. BURNES-BOLTON:

Thank you.

MS. PATILLO:

Next is Shashi Bhandari

REPRESENTATIVE:

My name is Shashi Jadson, an advanced practice nurse. I'm employed at the VA in West Palm Beach for approximately six years. My current area of focus is in geriatrics in the care facility. I would like to take this opportunity to thank the Commissioners for allowing me to advocate for my nursing colleagues and our profession. My nursing career of 15 years reflects many of the changes in our profession. I started as a nursing assistant in a community hospital while pursuing my baccalaureate degree in nursing.

The support I received from the RNs and the nurse managers was key to fulfilling my educational pursuits. A year after receiving my BSN, I decided to pursue a clinical track as an advanced practice nurse in a certificate program. The hospital where I was employed paid in full for this advanced training and assisted with adjusting my schedule so I could attend school full-time. I then went on to pursue a master's in public health because as a nurse practitioner, I realized that in order to promote health and prevent disease, the healthcare system needed to empower our clients by educating them. But in order to educate and empower, one must listen first. After being a victim of the downsizing trends of the '90s, I left my extended nursing family and came to provide nursing care for Veterans. It only took me a day to realize how the healthcare needs of the veteran are unique. All of my patients are heroes. Many who still carry the emotional, physical and psychological scars from their service. I am proud to care for these men and women. It is because of them I became an advocate for systemic change to improve patient's safety and quality of care. I became an advocate for the healthcare staff so we would be patient advocates at the unit level, patient level and visiting level. Unions gives nurses and other professionals a place in our practice. As a union official, nurses often share concerns with me that they would not discuss with their managers. In today's work environment, unions are essential in protecting the rights of employees and to providing an preponderance open democratic forum for issues to be addressed. The union is not an adversary to management. The goal of the union is to safeguard our public interests and to amicably resolve disputes. Management is accountable not only to its employees but to other influences that happen to impact their decision. Therefore, it is imperative to afford union officials the opportunity to appoint nursing staff to the committees so that the focus is not one-sided. The VA in my opinion aspires to be the employer of choice. How can the VA expect to be the employer of choice for nursing professionals when it puts its nursing staff through performance reviews unlike any other in the medical field. The Qualification Standards are nothing more than a means to avoid promoting individuals, it makes it more difficult for the nurse who has been in the system a long time to move up the ladder. It appears the VA does not value its nurses who have been loyal to them through thick and thin, those nurses who have served their country's Veterans through more than 15, 20 and in some cases, greater than 25 years. Nurses were informed educational waivers would be available for those who have the incentive. In actuality, those waivers have not been offered to staff for consideration for promotion, and nurses have no choice but to remain stagnant as they are unable to meet the Qualification Standards of higher grades As it stands now, the perception exists throughout the VA that those who remain at bedside or who focus on a clinical track are not rewarded for any more dedication. The standards do not value the clinical nurse. At the same time, nursing staff with years of experience is not going to enhance your career but only hamper your upward mobility. In addition, the Qualification Standards were rewritten with the hope of providing more guidance for nurses. However, it only muddied the waters with respect to the advanced practice nurse. Some may remember the videotape which nurses reviewed to better understand the revised standards. In this tape, it was stated that nurse practitioners in a clinical practice would be eligible to be Nurse 4 level. We were then promoted to a told that was not the intent of the Standards and that in order to be promoted to a Nurse 4, the advanced practice nurse needed to be in a role that was physician-specific. This has become a demoralizing issue for CNSs around the country. CNSs are mandated to be certified at a minimum, however have no minimal

point of entry into the pay scale systems. PNs can enter the system as Nurse 2, Nurse 3 and in some cases even as a Nurse 1. At our VA, PNs and CNSs are the same pay scale as RNs. It is also disheartening to the advanced practice nurse to know that our non-physician counterparts are paid more and have less education. The Commission should recommend that 7422, which is the regulation that governs Title 38 employees, the law should allow VA nursing professionals to negotiate over the pay and promotion process while involving an objective third-party review. It would stand to reason that the employer of choice would do everything it can to attract the most qualified on the staff. However, the locality pay system is not set up to retain or recruit nurses but only penalize them for working at the VA. Surveys are done but then the medical center director has discretion over affording pay increases. It does not matter that they are paid much less than counterparts. We are told that no recruiting and retention problem exists and that there is not enough compelling evidence to warrant a pay increase because the problem does not exist now. A problem does exist when Medical Center directors are only willing to offer a minute increase to avoid offsetting their budgets. Waiting for the nursing staff to leave the Medical Center is ludicrous and it only increases the burden for those left behind. The community standard is to reimburse nurses with higher skill level. Our VA prefers not to do that. Intensive care unit can make the same or less than surgical unit nurse. Congress should amend Title 38, USC 7422, to allow RNs and other VA healthcare workers to negotiate over the pay-setting process. The employer of choice is still functioning in an antiquated manner by rotating its staff from days to night and back again with no off time. This schedule is not the standard of care in the community. In fact, the community designates staff for each tour of duty. However, at the VA, floor nurses are scheduled to work a shift on the day tour and two days later, be scheduled to work nights and then back on days again. New graduates and younger employees may not be able to accommodate this type of schedule due to family obligation, so therefore they do not accept positions at the VA. This type of scheduling is physically and emotionally draining. Given the average age of VA nurses exceeds the community average, this can only increase the risk to patients and jeopardize the employee's license as well as their health. Studies have shown that sleep deprivation affects one's circadian rhythm, which is reflected in one's performance. It is just not safe practice to rotate staff from one shift to another on a routine basis. Again, the Commission should recommend that Congress amended U.S. Title 38-7422 to allow nursing staff the ability to negotiate over staffing and scheduling practices. The federal government in its effort to give the employer a choice is now relying on active outsourcing. I believe most would agree that Veterans are dedicated, committed individuals who demand their country's attention when they are in need. They are entitled to have trained professionals rendering their care. Cost is always a driving force in healthcare today. In this case, federal employees are more cost effective given they are usually paid less than the private sector. In addition, out-sourcing bids have been known to backfire. It is known that they'll increase rates after contracts are negotiated. The years of federal employment that are spent by the veterans nurses, the experience this specialized training brings to the table cannot be compared to those who have not served their country in this capacity. VA nurses have traditionally done what is requested. They have learned computers, they have learned cutting edge education, they have adjusted their shifts and changed their lives to meet the needs of the VA. Now more than ever in these critical times the VA needs to listen to

their nurses to find constructive and flexible ways to achieve patient care demand while remaining employee friendly.

MS. PATILLO:

I thank you very much, Ms. Chase. Are there any questions?

MR. COX:

Referring to the pay scale at your facility, so that I have a better understanding of it, you are telling me that an advanced practice nurse who comes to work at the West Palm Beach VA, would be on the same pay scale that a nurse BSN graduate or an associate degree graduate? That the staff RNs and the advanced practice nurses are all on the same pay scale?

REPRESENTATIVE:

That is correct. Is up to the discretion of the chief nurse and director whether or not a specialty pay scale should be added for nurse practitioners. It is perceived there is not a recruitment and retention issue, so I believe we're the only ones in the VA without a pay scale separate. So yes, we start at the same pay scale.

MR. COX:

You believe you are the only ones in your group?

REPRESENTATIVE:

I believe so.

MS. HANSELL:

Is there a requirement for an advanced practice license?

REPRESENTATIVE:

The advanced practice license in Florida is a dual license, the RN and the certified advanced practitioner. Once you have completed the required training, it is mandated by the VA Nurses that you be certified, which is not a community standard as well.

MS. HANSELL:

Thank you.

MS. PATILLO:

But it is the standard in many communities. I want to talk to you about the shift rotation. Is that in Title 38, USC 7422, that all VA nurses rotate shifts?

REPRESENTATIVE:

It is a common practice throughout the VA --

MS. PATILLO:

Is it mandated?

REPRESENTATIVE:

It is mandated at our VA and I believe is throughout the nation.

MS. PATILLO:

Thank you very much. Next is Kathleen Pachomski from the Memphis VAMC.

REPRESENTATIVE:

Good afternoon Madam Chair, Commissioners, Madam Court Reporter, everybody. My name is Kathleen Pachomski. I'm a 50 year old, grade 3 RN with 25 years of service, and I'm also a disabled veteran of the United States Navy. I served in the United States Navy as one of the first 30 females that were assigned to a combat naval ship, aboard the USS Sanctuary. I subsequently served as a drill instructor, a master training specialist, of which only one tenth of one percent of drill instructors ever elevate to that level. You must rank within one percent of your class within the Department of the Navy. I subsequently served on a submarine as a submarine tender, and I was the assistant personnel officer for 1800 shipmates. I currently serve at the Veterans of America and for them everyday as a med/surgery nurse, telemetry nurse and spinal cord specialist at the VA Medical Center in Memphis, where I also receive my healthcare. I'm a member of the VISN-9 on the subject of retention and recruitment, and was appointed by Mr. Don Dandridge. And I completed an assignment to the VISN which is Capital Realignment Foreign Hands Services. In addressing your questions, I would like you to remain cognizant of the fact that my testimony today is my own: a nurses' perspective from the trenches. My testimony is not intended to be disrespectful or place blame, but testimony in which I can be concise, honest and forthcoming. I don't have a doctorate in literature. I just want to talk to you and ask that you indulge your ear. You have already heard a lot of statistics for your mind, and I will talk to your heart. You asked me to discuss the financial issues. I answered you no. My issues are simple. There is inefficient utilization of the nurse recruiter position and there is a lack of succession planning. My recommendations are that nurse recruiters must be utilized to their fullest extent, they must keep abreast of current trends in technology to make them competitive in the private section. I also would like for you to please bring back the graduating nurse technician

program. Reestablish those relationships and involvement with our community, nursing schools and mandate upward mobility. You asked me to what extent the nurses are in control of decisions related to nursing practice and delivery of care. I answered little to none. My issue was that many of the department's nurse execs and leaders, with no disrespect, are not from within the VA system. Their depth of knowledge is shallow and the management style is patterned after the private sector. This results in a lack of autonomy and micromanagement of highly skilled employees whose talents are being underutilized. For both patient care and nursing employment, the VA differs markedly from the healthcare private sector systems. Nurses are first and foremost advocates for their patients. When it comes to advocating for the needed staffing levels, the law places and gags us into silence at the decision-making table. My recommendation, it is incumbent that our leadership engage the collaboration between management and clinical staff. This lack of collaboration imparts a feeling of not being valued. Employees tend to see it as authoritarian and inflexible. We must change the overall attitude of negativity in our workplace. In order for the employees to feel valued and to provide a continuum of quality patient care, they must have a definitive position at the decision-making table. The only way, Commissioners, this will take place is to have Congress revisit Title 38, USC 7422 and allow registered nurses and other healthcare staff to negotiate over these items of interest. How can trust be better established between nursing staff and nursing administration, between nursing staff and facility administration? The answer to these questions are the same. Trust is elusive. It is something which is not given but which is earned. If you want employees to trust you, you must lead by example. To maintain an effective service, you need to communicate on a regular basis. The only time that the average nurse in the VA system hears from management is when it is bad news. As quoted by an unknown author, "The person who gives the pat on the back," and I'm not talking about money, I'm talking about a pat on the back, "wields the power." We must praise in public, counsel in private, and for heaven's sake, we must have confidentiality and reinvest in our own human capital, which I addressed some ten years ago in writing to a VA conference. I read in RN Magazine an article written by RN Fiorina. She was discussing in this article problems regarding workplace issues in general, and she stated in part, "Leadership is no longer about command and control, hierarchy, title or status. It's not about finding blame. Leadership is about making a difference, creating positive change. It's about getting things done and getting rid of everything else that doesn't contribute. It is about encouraging every employee. It is about empowering every employee. It is about reinforcing core values, articulating a vision and then setting people free. Leadership is about trust and giving authority back to where it belongs." Leave behind this old school and let's utilize the cooperative approach, better known today as, buzz words, "participative management." How can nursing staff at your facility better participate in this decision? Use our Best Practices. While maintaining the confidentiality of our patients, let's use what we already know through lessons learned. Quit reinventing the wheel. How can the VA better retain nursing staff, education and training? Frankly, this is my -- the most important part of this whole testimony for me. Management within the VA needs to fundamentally know each RN and develop their retention capability. Upon hiring, management must identify those nurses who are clinically inclined and those nurses who are administratively inclined. Nursing administration must have enough mentors, preceptors and educators in place to appropriately train these people. Management must ensure that the National Nurse

Education Initiative remains intact. The number one reason why the nurses are not participating in this is not because they don't want to, but because in their work schedules, there is not enough flexible time allowed in accommodating their schooling. It is not, I repeat, because of a lack of interest. The agency also needs to expand this program to include the LPN and nursing assistant to participate in the program, thereby promoting upward mobility within nursing service. How does the VA best attract and retain a quality workforce? Be more visible to the public. We cannot technically advertise. I don't know if you know that, most of you. Legislation must be changed to allow the Department to advertise more openly when and where it is appropriate. Nursing staff should participate in the community projects, Career Days, March of Dimes, Make-A-Wish Foundation and so forth. The employees could wear shirts with logos, talk to community leaders, participants, and thereby retain and attract potential employees. If we know how, this is our time to shine. The eyes of the world are upon us. We must motivate ourselves to loyalty, commitment and dedication. The central issue of pay is simple. The average Nurse Professional Standards Board has a lack of knowledge regarding the community standard of pay. For example, Nurse N recently hired at our facility had 29 years of experience in dialysis, 12 as a head nurse. She was hired in as Grade 1 level because she did not possess a BSN in nursing. Recommendations are, nurses who are assigned to departments outside nursing service that do not provide direct patient care should be reclassified from Title 38 to Title 5. This is not a very friendly subject for labor organizations but it is imperative. These nurses should be given the opportunity to return back to patient care, and if they don't want their appointment, then give it up. If a GS person wants to apply for a job in engineering, they have to be a wage grade employee. There should be no exceptions within the nursing service. Facility directors, at the recommendation of the Chief Nurse Exec, assign nurses to the facility Nurse Professional Standards Board. This process is neither fair nor equitable as the Board is not a true peer review but a management review. Registered nurses should be allowed to choose the employees to serve on the board. There should be greater flexibility in grade levels and reviews that permit grades to be adjusted based on level of experience, level of acuity care, et cetera, to give more money to the nurses who are working at the bedside. And the legislation must be changed. RNs need to have third party, mutually independent persons who can review the promotional data as to why a step increase was not recommended when warranted, or the failure of the board to grant a waiver. In closing, I would like to thank each and every member of the Commission. As a registered nurse and disabled veteran, and member of the VISN9 nursing subcommittee for the National Commission on VA Nursing, I am both humbled and grateful for having had the opportunity to provide this input to you, and confident that the Commission will provide to Congress and the secretary those recommended legislative and organizational policy changes which will ultimately enhance the recruitment and retention of nurses and nursing service personnel within the Department. God bless America.

MS. PATILLO:

No. 1, I want to commend you for your service to your country. No. 2, what is your position?

REPRESENTATIVE:

I have two full-time jobs. Full-time as president of the professional union, and I work full-time on evenings. I average approximately the same amount of hours on evenings and nights working on those three areas, spinal cord, telemetry, and med/surge.

MS. PATILLO:

You are not a nurse manager?

REPRESENTATIVE:

No. Everybody has a mission, and I ended up in this one.

MS. HANSELL:

I just have a quick question. I have a point of clarification. When you started talking about the abuse of flexible grade levels of reclassifying certain people into Title 5, I missed that point.

REPRESENTATIVE:

All right. It is pretty simple. But nurses are, I believe, Title 38 because --

MS. HANSELL:

Right. I know.

REPRESENTATIVE:

When nurses are assigned, especially outside nursing services, they ought to be assigned to quality assurance where they function. Their knowledge of being a nurse does help but the fact of the matter is, they are not providing bedside care. My intent was that the we are down to crunch time. You know, you go to the dentist for a toothache; you don't go to a nephrologist. My point is we need people back into bedside. We already have the resources; we just need to bring them back into the fold.

MS. HANSELL:

So what you are saying is those at the bedside should be in the Title 38, and use Title 5 for like quality assurance, administrative...

REPRESENTATIVE:

Title 38 registered nurses who are currently being paid the same salary I'm being paid and not doing elective nursing can get back in the trenches. It is time. We don't have the

luxury. See, we were very large, and then we did the proverbial down-sizing, just like corporate America did, and we are finding out that we went a little bit too fast.

MS. HANSELL:

Thank you.

REPRESENTATIVE:

You are most welcome.

MS. RAYMER:

Just to clarify the point about the advertising, actually, that was sort of changed, so we can do that.

REPRESENTATIVE:

I'm thinking of the big picture. I'm talking about TV. We tried to do an ad just in -- must be very recent?

MS. RAYMER:

Not really.

REPRESENTATIVE:

All we could do was the local paper. We wanted to do a commercial spot. I had radio, some radio people I do business with in Memphis were willing to put in an ad, but they wouldn't allow us to do that. So we are the best-kept secret.

MS. PATILLO:

Thank you so much.

REPRESENTATIVE:

You are most welcome, and I'm grateful.

MS. PATILLO:

Next speaker is Susan Ornelas. thank the Commission for my

REPRESENTATIVE:

Hello, my name is Susan Ornelas and I would like to colleagues and myself to address you on these issues. I have been an LPN for ten years at the Little Rock Veterans

Administration. I have worked in several areas, completing several certificates for which there is no compensation. I am extremely proficient, very flexible, my evaluations have always been exceptional. This counts for little when you are capped off nationally at a recently, this has been changed GS-6. Although to a GS-7. However, many LPNs are employed as GS-3, barely a living wage. Many LPNs work two jobs. Many work many hours of overtime. I, myself, average 80 hours a month of overtime. We are given patient assignments where they have little to no input. I ask you, aren't we the experts in patient care? Staffing levels are decided by administration. They have very little knowledge of what frontline caregivers need to deliver adequate patient care. But do we want to settle for adequate patient care? I don't think so. Education is encouraged, if not mandated, in some instances. However, support for education is not always available. Funding is a major concern. Worker's compensation claims are steady on the rise among nursing staff. Could it be because of our tremendous workload? Nurse's aids work hand-in-hand with licensed nurses on weekends but do not receive Saturday premium pay. Scheduling does not always complement people's school or home life. Rotation from day tour is mandatory. The practice is archaic and detrimental to our health. No other facilities require day rotations. Single parents have special needs. Why not bring in programs such as 24-hour affordable daycare? This could help reduce call-ins from signal mothers with no babysitters, and reduce some of the overtime. Many excellent caregivers are giving direct care in an effort to gain an education, respect, and often more pay. I urge the Commission to stand on behalf of the VA nursing staff and chart the course for caregivers everywhere by recommending the following. No. 1, appoint LPNs at minimum GS-5. Remove national caps and provide for automatic promotion based on performance and evaluations. No. 2, allow Saturday premium pay for our nurse's aids working on Saturdays, as they are working and giving up their Saturdays, just like everyone else. No. 3, mandate patient ratios by law and allow our nurses to sit with administration to negotiate the needs of our patients and staff. No. 4, implement weekend incentives and increase shift differentials to make off tours more desirable. No. 5, develop charge accounts with local educational institutions so funding will not be an issue. No. 6, available and affordable 24-hour on-site daycare. No. 7, stop contracting out federal jobs. Let our veterans receive care from their hospital and their nurses, and not a contractor whose major concern is the bottom line: Profit. I thank you for listening to me.

MS. PATILLO:

Thank you very much. Are there any questions? Thank you so much. The next speaker is Maria Johnson, Birmingham VA Medical Center.

REPRESENTATIVE:

I am Maria Johnson from Birmingham VA Medical Center. I started my career in the Phillipines theater. I came to the United States in 1973. I have 10 years work experience in the private sector. I started at Birmingham VA 20 years ago as the nursing coordinator, and eventually nurse manager. Since 1998, I have been a staff nurse at Birmingham Medical Center, Out-patient substance Abuse Clinic, Healthcare For Veterans and the Mental Health Clinic. I have been at many institutions, in many different positions. As you can see, I have been at both ends of the spectrum. I would

like to address nursing care and staffing. Birmingham VA Nursing Executives have not designed or created staffing models for delivery of care. Collectively, they are stagnant and devoid of innovation. This allowed facility management to dictate to them where nurses are to be assigned and advised. While nurses comprise the largest segment of the VA health workers, VA nurse health workers are not valued and respected. For example, nurses are assigned to share cramped offices while other services have individual offices. Nurse executives rarely advocate for the nurse in the multidisciplinary meetings, and they listen without opinion as to how these leaders plan where and how nurses will be practicing. Their recommendations are often implemented without question, and input from the working nurse and ancillary staff. This is perceived by nurses as "thinking more about going up the ladder than advocating for their nurses." They are not treated as the most important member of the team and not respected by facility leaders. This has contributed to very low morale among the VA nursing ranks, and has created a negative perception of VA nursing practice. Facility administration nurse executives mostly exercise dictatorial management style, without participation or input from nurses. Our opinions are rarely solicited even when management decisions are not well thought of. Poor communication between the leaders and grassroots workers often leads to confusion and frustration. My recommendations to the board are the following: Nurse executives must develop or design innovative staffing models for delivery of care. Must develop and employ new staffing ratio to reflect nurse-patient acuity ratio. This continuum is currently being used by the Advocate for Nurses, who let nurses believe they are genuinely interested in their welfare instead of their own upward mobility. Must be more interested in relationships with human beings. Must insist on the inclusion of nurses in multidisciplinary programs to enhance their role as valued and contributing members of the team. Must empower nurses and individuals in decision-making and problem-solving processes without making them feel that only facility leaders and nurse executives can make sound decisions. Birmingham VA Nursing Service has continued to utilize the Functional Statement Criteria Based Performance Standard that was implemented in June 1997 by the former Chief Nurse. These standards were developed without input of opinion and need from staff nurses. The references used in 1997 continue to be the Qualification Standards of today. There are no new performance standards developed by former and current nurse executives. After a new Nurse Qualification Standards was passed in November, 1999, the nine Dimension Requirements in the new standards were inserted here and there in the old performance standards. The overall rating is based on the sum total of the numerical ratings. The criteria are subjective and not based on observable behaviors. The standards are mostly generic. It is not specific to your area of assignment. Nurses are assigned to areas they are not -- they have no expertise and competency in, causing them to be very concerned about their personal safety as well as their patients' safety. Reason? That's what facility and physician leaders want. ACNS associates serves as Chairperson of the Nurse Professional Standards Board and intimidates their handpicked subordinate members. VA Nurse Executive in collaboration with staff nurses must develop one performance standard for nurses in similarly situated settings so that there is uniformity at every VA system. These standards must be measurable, performed-based and not subjective. This forces the standards to be uniform and would be beneficial. This is the numerical rating being used by Birmingham VA to complete the nurse's proficiency ratings. It is not based on measurable behaviors and is extremely subjective and promotes extreme dissatisfaction among staff nurses. Must be

trained to develop standards based on the Nurse Qualification Standards passed in 1999, and implement it immediately. The old standards are currently used to complete proficiency ratings and are too generic and inappropriate. Must get input from RNs in different settings areas. Must develop clinical competencies. Discontinue the antiquated ones they are using now with this misleading paperwork to show the VA that the nurses are competent. Remove the ACNS from Chairperson of the Nurse Professional Standards Board in order to change the negative perception of the RNs about the NPSB. Reinstate the Special Advancement for Performance which has been arbitrarily halted by management. Have performance standards in place before assigning RNs to new areas. Nurses must receive appropriate orientation to their new assignment and not thrown to the wolves before they are competent and ready to perform on the job. Reinstate the preceptorship program that was so successful in the past. Currently, nurses are assigned as charge nurses before they are ready, which overwhelms them and causes them to leave the VA. More emphasis in recruitment of nurses at the expense of retention of nurses who have been loyal to the VA for years. Nurse executives have not developed a nurse satisfaction survey to assess their nurses' job satisfaction/dissatisfaction. Loyal nurses perceive nurse executives as not a proponent of upward mobility. Choice nursing positions are awarded to nurses from outside the VA, even when there are candidates of equal or better qualifications in the VA. They do not subscribe to the notion that satisfied nurses are the VA's best recruiters. Nurse executives have systematically added new responsibilities without removing some of the tasks that may be performed by nurse assistants or other support groups, nor have they recommended to human resources to hire the staff to support nurses. My three daughters are currently seniors at the UAB School of Nursing. In the past, these nurses have had clinicals at the VA. When I was in management, I have hired so many nurses from the UAB School of Nursing, that I have hired in the summer as student nurse technicians. Because this practice has been discontinued at the VA, they are -- the perception of the students, from what I hear from my daughters and their classmates, is that they are not interested in going to the VA because they have -- they like their practice better in the private sector. At the UAB Hospital, they have a program where they hire student nurses, and they hire them after the fact. To me, I understand that the VA is having this program where they pay your student loans. My recommendation is, pay the tuition now, while they are in school. The State Nurses Association are paying my daughter \$600 a quarter, if they practice in the VA so many years as a pay-back. They pay them \$600 on their tuition. So reinstate the student nurse tech summer program and help them pay their tuition while they are in school. Also, develop innovative and flexible scheduling that is competitive with the private sector. It has been a long time since we have had seven on, seven off. At that time, we still -- we have the director of your Commission that was the one that developed that program, and nothing has been developed ever since. Develop a nurse satisfaction survey trying to assess satisfaction or dissatisfaction of nurses so that corrective action may be explored. Promote nursing autonomy and independence and not give the nurses that they are feeling watched over as if they had no expertise. Promote an environment of respect and recognition of nurses as an invaluable and equal contributing members of the multidisciplinary team. Pay nurses who have been loyal to the VA. They must receive retention bonuses just as new nurses get recruitment bonuses. Hire nurse assistants to assist nurses in patient care.

MS. PATILLO:

Thank you. Thank very much, Ms. Johnson, for your testimony. Any questions? David Mollett from Columbia, South Carolina, from Dorn VAMC.

REPRESENTATIVE:

Thank you. My name is David Mollett, registered nurse from Dorn VA, South Carolina. I would like to thank the Commission for the hearings and the opportunity to provide testimony. I'm an AD graduate and a registered nurse for 26 years. I have been with the VA for 20 years. I'm a staff nurse on the Psychiatry/Mental Health Service Line. I'm also a disabled Army veteran. I was promoted to Nurse 2 about 1988. I now find myself stuck at the top of that grade with no opportunity to go beyond it for the past four years. I have not been boarded by the Nurse Professional Standards Board since 1999. Not because I wasn't notified by the Board, but I was called as a witness in an EEO hearing, which was dealing with the lack of a nurse being promoted by name on the list with a number of others who had not been boarded for this amount of time. Due to the lack of staffing, the request for a work schedule to attend school has been unattainable. So even though money has been made available through the VA, the National Nurses Education Initiative, the staffing constraints prevent this from being a viable avenue for myself and many of my colleagues. The Nurse Qualification Standards as written and the rigorous interpretation that the Standards Board applies toward some nurses make it nearly impossible and even prevent RNs from finding themselves as being stuck at the top of the grade. As we, and that is the VA, begin to compete in the future for the nurses, recruiting the new nurse graduate, for what would surely be mostly AD programs, and assuring the ceiling of Nurse 1, will make it impossible for recruitment and retention of those skills. The same skills in care that has been and continued to be guaranteed to myself and fellow Veterans will not only be lacking, but missing from the largest Healthcare System. I have three adult children. I have not encouraged any of my children to become nurses or work for the VA. My daughter is a freshman at University of South Carolina, BS program. She is aspiring to be a nurse practitioner, and that is very scary. Not because of my recommendation, because of the teacher. And I have heard others give testimony this morning about how we could be actual recruiters. But what comes into play is morale from working at the VA Medical Center that we are not doing that job and I think we can do something to address that. One recommendation I have to improve VA nursing administration support for education, one is to provide the availability for school schedules for employees wishing to further their education through the use of the VA funds. Establish staffing levels adequate to cover the mission of the VA, to include coverage for identified succession planning, as in nursing and all other services regarding the qualifications standards. VA needs to re-evaluate the educational requirements that is now your standards for promotion. Nurse Professional Standards Board needs to follow a consistent format in interpretation of the Dimensions of the Standards. Nurse managers need to be held accountable for timely and accurate documentation in the proficiency as it relates to the appropriate Standards Dimensions. Nurse executives and directors should be given authority to increase the steps of any grade based on pre-established criteria. Nurses should have the same rights as other employees to grieve over promotion decisions. Nurse Professional Standards Boards should be rotated every three years at

least. Some that -- there have been people that have been on the board for 15, 20 years, sometimes we start to get biases out of those boards based on that. Another issue I would like to address is how can VA better attract and retain a quality workforce? I think one thing we have to start with is treating everyone fair and equitably. There exists differential treatment of employees within the VA, based solely on the position the person holds. As an RN, I worked with employees on the weekend that don't receive Saturday premium pay. Even though these employees, nurse assistants, food service workers, facility management service, secretary, give up the same quality of life away from their families to provide quality service to our veterans and facility, they are excluded from the pay entitlement. This sends a clear message to employees and potential employees that the VA don't value all employees the same. My recommendation in regards to that is to take the discretion away from directors, and mandate that all employees working weekends will receive Saturday premium pay. That's it. Thank you.

MS. PATILLO:

Thank you. Any questions?

MS. HANSELL:

Have you given any consideration to attending one of the accredited online RN, BSN programs that are available?

REPRESENTATIVE:

Yes. Yes, once upon a time I have. Currently I would not. I'm one of those nurses who, sitting with my veteran time, with 23 years in the system, by 2005, I'm 51 years old, so in four years there's going to be a dilemma, what am I going to do since money is being dangled in my face? Will I stay with the system or just retire and go with another system and do something else for five or ten years.

MS. PATILLO:

Thank you. Eugene Phillips now, Central Arkansas Veterans Healthcare System.

REPRESENTATIVE:

Hello. My name is Eugene Phillips. I would like to thank the Commission for allowing my colleagues and me to address these issues and concerns. I have worked for Central Arkansas Veterans Healthcare System for a total of seven years, two of which I worked for staffing agency. I saw wonderful opportunity to grow and expand my career. I have worked on a geri-psyc unit in North Little Rock and the surgical unit in Little Rock. I spent most of my time in Little Rock on several floors except for MICU, SCCU or ICU. I love to serve my Veterans; however, nurse staffing is so critical that I question the job I do, and leave wishing I had the time to research many of my -- and do more for our veterans. Many times, one nurse is responsible for as many as 40, ranging from Category 2 to a4, Category 4 requiring the most hands-on care. Our budget often does not provide

for enough of the essential supplies such as toiletries, patient cleaning products and laundry supplies. Weekend supplies are even further diminished. We are constantly asked to do more with less. We face a daily fear of losing our jobs and the having our jobs contracted out. The bulk of the worker's comp claims are filed by nursing staff. I myself have been hurt at least five times. Nurse assistants work side-by-side on weekends with RNs and LPNs. However, we are not compensated with Saturday premium pay. The shift differentials have not increased in many years. There are no weekend incentives. Education is encouraged, but in reality, staffing does not allow for a competitive school scheduling. Funding becomes a major issues for nursing assistants. When many times it is not readily available, we cannot afford to pay schools upfront. Shift rotation is mandatory. Rewards and promotions are rare. I myself am a GS-4, Step 5, but many of the LPNs are GS-3s. This is what I am requesting the Commission to make as following recommendations: Mandating staffing rotation by law; allowing uniform allowances for GS-6 and below; stop mandatory shift ratios; Saturday premium pay for nursing assistants; and No. 5, specialty pay for nurse assistants and staff working in specialty areas. No. 6, rewards exclusively for nurses. No. 7, on-site classrooms. No. 8, on-site daycare available 24 hours a day, seven days a week, because the hospital does not shut down. No. 9, increase off tour and weekend differentials. And if you take this in mind, please stand up for our veterans. Please stand up for those who care for those who stood up for our country. The reason why we are here is for Veterans who served our country. And my father is a vet. He has been in two wars, the Korean and Vietnam war. And I treat these patients with dignity and honor, as if they were my father.

MS. PATILLO:

Thank you very much.

MS. CONVERSO:

I do have a question. I have heard it two or three times a day and I apologize because I guess I don't understand it. I think I have heard a couple of times today about uniform allowances. You do not receive that?

REPRESENTATIVE:

No.

MS. CONVERSO:

I have been with the VA for a while, and that's a shock for me.

REPRESENTATIVE:

As far as the uniforms, we need enough pockets on the uniforms if we have uniforms.

MS. CONVERSO:

I get it.

REPRESENTATIVE:

One in the front and one in the back don't cut it.

MS. RAYMER:

One more question. Could you restate what you said about the rotation? I think I missed that.

REPRESENTATIVE:

Rotation --

MS. RAYMER:

Were you supporting rotation of tours?

REPRESENTATIVE:

No, I'm not. I'm not supporting rotation. Because, you know, not everybody can rotate.

MS. RAYMER:

Thank you. It just seemed like what I heard was that you were supporting rotations, but you were not?

REPRESENTATIVE:

Shift rotation is mandatory for us. But some of us, as parents with kids, we cannot rotate. It is either day or night.

MS. RAYMER:

But you are suggesting to the Commission that we address the issue of rotation shifts?

REPRESENTATIVE:

Correct. Some managers put up a schedule and let you fill in the blanks. The next week, it is not like that.

MS. PATILLO:

Thank you so much, Eugene. Next we are going to do our open forum. It is not in the schedule because we made an oops. We forgot it. So we are going to scoot it in here, and then we're going to cut into our break now. We can do well with ten minutes. So if you don't mind, I request your indulgence to allow us to make this insertion. The people that I have, in terms of who signed up to speak to us for the afternoon session, are the following: Christina Mounce, Lisa Hartmann, John Hudson, Adrienne Rias, Dai Long, and Margaret Howard, for three minutes each. If you would like to address us. Christina?

AUDIENCE MEMBER:

My name is Christina Mounce and I work at the Fayetteville, Arkansas VA. I have been in nursing for 20 years, the last 15 at that VA. When I started in nursing, I was a nurse assistant. I had the opportunity -- this is in the private sector -- to go to school and get my LPN. When I started at the VA, I was an LPN. I was almost an ADN at that point, but there was not an ADN program available in the area at that time, and I didn't repeat my nursing and not want to have -- well, there was an ADN program but I only lacked two classes. They wouldn't accept me without repeating the whole 72 hours, and they didn't have a bachelor's available. Later on, there was an RN program that was available through the VA, that paid for my salary while I went to school, if I lacked one year of completing my degree. And I was able to complete the degree with that help, plus some reimbursement for books and tuition and not lose out on family income. I think a lot of the ADN nurses are people that have gone back to school later, after they have started a family, and they don't feel that they have the time or the finances to invest in a bachelor's degree. I have worked in assorted areas like the telemetry step-down unit. Then acute medical with oncology, mental psychiatry, in-patient unit, and I'm now in the mental the clinic where there are two nurses, and we take care of each six clinicians' worth of patients. Doing telephone triage and assessing those patients as they come in to see the doctors. We really feel bad because a lot of times we don't have time to handle the triage as soon as we would like to be able to and get back to those patients within the 24-hour period we would prefer to be able to. Now, I do say that our VA has a feeling of extended family between the staff and the veterans. It is like they are almost an extended family and we try to help each other out. When we are working shorthanded with nurses, a lot of times, the vets help take care of each other. Or they'll come and get the nurse if they need the nurse to help out with something. One summer I spent working there, I was the only RN on the in-patient unit for about six to eight weeks because of the other RNs being out on sick leave on the day shift. I did not feel safe. Sorry.

MS. PATILLO:

Thank you. Any questions? Okay. Thank you very much. Lisa.

AUDIENCE MEMBER:

Hi. I'm Lisa Hartmann, I'm an employee of the Nashville National VA, 25 years. I am a true VA nurse. In 1985 the Nashville National VA sent me to school through the Upward Mobility Program. The program paid my salary, tuition, bought my books, white

uniform and everything else that I needed. I am currently working in the Ambulatory Care Department in Nashville, as a screening nurse. I work in chemotherapy. I'm often asked why I stay at the VA, and it is really simple. I stay because I'm honored and privileged to take care of these veterans. I feel like it is a mission entrusted to me to take care of the veterans, and I'm saying thank you for my freedom and for protecting me as an American citizen. You have heard a lot of things today. Most of it has been covered. But there is a group that has been left out, the loyalty of dedicated VA nurses. We have been with the VA for years and years and years while many other people have come and gone through the reinvolving door. We do not feel like we are compensated or appreciated by administration. The newer nurses get retention bonuses, we do not. We had one area compensated for retention bonus at our Medical Center. We were just as short-staffed as this other area. We also have a lot of valuable experience and longevity that benefits the patients. I had a patient come in the emergency room. I coded him three times the other Sunday night. He was a dialysis patient. This guy came in with a heart attack. I knew the signs and symptoms of this patient, and his special needs, because I knew him from working with him. We saved his life several times because we are familiar with him. We provide excellent care and we are cheap labor for the VA, because we cannot -- once we are at the top of our salary range we cannot go further. There are no extra raises. Once you get to Nurse 2, Step 12, that's it. You have no more pay, of course if you don't meet your Qualification Standards. If you don't have a degree, you are not going to go any further. LPNs don't get promoted. According to current laws, we don't have -- we can't be the pay leader. I think it's USC 7422, the one that you have heard about all day. They prohibit the VA from being the pay leader. We have no choice but to become an employer of choice again by improving ourselves and rewarding our careers as nurses. I would like for the Commission to overturn that legislation. Let us recommend to Congress to do that. Let us be the pay leader again. We have got to attract people with better schedules and better hours. Also, you need to reward the stable nurses, the career nurses like myself, and many of all these other nurses that you have heard today. How about suggesting a retention bonus on a tier schedule? When once you have been in the tier five years you get \$2,500, for example, and go on throughout the system that way. That would have to take a congressional action I'm sure. Also, we need to have our unions representing us in having a say in our staffing levels, and our nurse-patient ratio levels. And we need to be able to sit down with them and negotiate. We are left out of committees at our VA. The bedside nurse, the out-patient nurse, there is no time for these nurses to go to meetings. We cannot leave our patients. We don't have nurses to cover us. So your administrative-type nurses, they are the ones that get to go to the meetings and make decisions. The corps nurse needed to be included in all those decisions. If we are rewarded with pats on the back and money, we're going to work harder for you guys and for the veterans and the VA. The only people that are going to benefit from that is going to be the veterans, because we will provide the best possible care for them. Thank you for your time.

MS. PATILLO:

Thank you very much. Next, John Hudson.

AUDIENCE MEMBER:

My name is John Hudson. I'm a registered nurse, Title 38, Vice President of the union. A couple of problems I wanted to bring up. One is lack of respect and abuse of trust. According to the polls, nursing is the most respected profession. However, it seems like it really doesn't carry much weight. It is not really very deep. I'm reminded of the country music song about talking the talk and not walking the walk. Also. It seems like the Rodney Dangerfield profession at times: You get no respect. Louisville, in our example, recently we became the sixteenth largest city in America but our nurses are close to the lowest paid in the VA system. We are paid 12 to \$15,000 less than many hospitals in the area. That's like 20 to 25 percent. And I just find it really hard to believe that anybody who has got a high school degree could not resolve that problem, to make it fair and make it equitable. The solution to that problem is to bring the salaries up to the area equivalents, and I think that would help in recruiting and retention. Another problem is the distance between nursing staff and nursing administration. The purpose of this meeting here is to give feedback, but there is a feedback within the system that we are not using. Most nurses rarely, almost never see the nurse administrator. A staff nurse would have to have a very difficult time being heard if they want to get feedback to the nurse administrator. Our hospital administrator gives an open meeting once a month, and the nursing administrator should too. Most of the equipment, the techniques were never demonstrated or used by the nurse administrator, and our knowledge is by hearsay. She should get regular feedback from the staff who actually uses the equipment. Third problem is inappropriate use of mandatory overtime. I doubt that there is any nurse who would object to mandatory overtime in rare and unusual circumstances. However, mandatory overtime is a staffing technique which is really inappropriate. So the solution to that is not using mandatory overtime as a staffing technique. Nurse managers and nurse supervisors should be included in the pool for mandating because then they would have a greater sense of the difficulties of the situation, and could provide some response and input into it, and hire faster, and so on and so forth. In finishing, nursing is a very demanding job. It is actually several jobs. Many times the patient is going through the most stressful thing in their lives, and nurses cannot function effectively around these patients without absorbing and internalizing some of these stresses. Nurses do functional application of technology, knowledge which is constantly changing. Often emergencies arise that can be life and death, and keeping up with the ever-changing technology is stressful. Another thing, it is physically stressful assisting in removing ill, demented, and sometimes very heavy patients and uncooperative patients with conditions of understaffing, which can be very stressful. Some of these factors possibly contribute to the factor that according to Donna Verlander, nurses have a six times greater incidence of suicide than the general population. Thanks.

MS. PATILLO:

Thank you, John. Okay, Adrienne.

AUDIENCE MEMBER:

Hello, I'm Adrienne Rias, LPN at Central Texas Veterans Healthcare System in Temple, Texas. We do not just want a pat on the back. I would like to ask the Commission to eliminate the GS-7 boards due to unfair practices. At my facility, when we are not advanced to a GS-6 or GS-7, we are not told why. We are given the same form back. Example: Judgment. Well, my judgment is to take care of my patients, keep them safe, and give them the dignity they want. I think that you should use good judgment. I have been -- I am a GS-5. I have been an LPN at the VA in the VA system for 13 years. I have over 20 years experience. I worked a part-time job in pediatrics and I get bonuses every six months. I get a \$250 bonus about every six months. I make more money in my part-time job compared to my VA job. We have GS-3 LPNs starting to come into the VA system. It makes no sense. We need to use common sense in order to retain the nurses and to attract nurses. We are our best advertisement. When I go out into the community and they say, well, how do you like the VA, how is your pay, can you go above it? I can't lie to them. I'm a GS-5. It makes no sense. One thing I wanted to mention, at our VA, they gave the nurses on some floors -- not all floors, and I didn't get it -- a 10 percent retention bonus. When we got our cost of living, they took five percent back. That makes no sense. We should be given a promotion which is based on experience and the time that we have worked. They should give us back the prepaid tuition. That was very -- that was a very good thing for all of us, especially for me. I'm a single mother of two, and I raised four other children besides them on my GS-5 pay. But we are going to make it even if I have to go out into the private sector. I don't encourage young people to come into the VA system. Most people that do come in, they take their year's experience and hit the door. We are training them, I train them, orientate them and they still hit the door because they are not promoted. When they see me working hard, side-by-side with them and I haven't been promoted in all these years, they didn't see that happening to them. That's not for them. I'm asking to eliminate the boards, because if you are already black-balled, somebody don't like you on the board or whatever, you will not be advanced. And also, give nurse assistants Saturday pay, because without them I could not do my job long-term, and they do need a uniform allowance. With pockets in front and pockets in back.

MS. PATILLO:

Dai Long.

AUDIENCE MEMBER:

I'm Dai Long and I'm from Central Texas VA Healthcare System in Temple, Texas. I'm RN, BSN. I started out as an ADN, went back to school and got my BSN. Been there for ten years with the VA. I like my job a lot. I work in the emergency room. I like so it much I drive 75 miles one way to get there and 75 miles home. I do think there is a lot of things that can be improved and I do think we need to do those things to keep our nurses there. And she is right. We are the best advertisement. If you are there and you are happy and you like your job, you don't mind saying, Come to the VA and work, it is a great place to work. They treat you well, they pay you well. You have to honestly tell

somebody -- if you tell someone that and they come to work there, they will come back to you. Promotions need to be based on performance in your specific unit. You should not have to meet things you cannot possibly do. We are not evaluating our bedside clinical nurses. If we don't have those nurses, who is going to take care of the patients? Who is going to take care of the Veterans? The big push is on education and I understand that. I am a BSN. That's why I went back. You don't get anything for that when you go back to get your BSN. And you should tell the people that too, that you are not going to get a step because you got your BSN. But if you get everybody educated and they become educated, what are you going to do with them, where are you going to put them? Who will be there taking care of those people on the floor? You don't see very many. I haven't seen any. Please, the shift rotation should be eliminated. You could get some the regular staff and new input from employees. Can they work those hours? Why not put everybody on a set schedule? That's another thing that would be good for young nurses coming in. We need them to establish a new workforce. They are coming in as a young nurse and if they have a specific shift, whichever one it is, they know exactly when they are coming to work and going home they can make arrangements for around their family and children. But if they get shifted back and forth, it is more difficult and they'll not do it. We still may need rotation. Fine. Offer an incentive for those people willing to rotate. Give them an incentive pay. agree with the retention They'll do it. A lot of people don't mind rotating. Retention bonuses, I bonuses. Right now you get a pension because you have been there ten years. It would be the nicer to add a thousand dollars for ten years. Or \$1,500 for 15 years. Something that shows people we really appreciate the fact that you have stayed all this time. That gives them something to look forward to. That keeps the staff very positive and that keep them more present there. And that helps them to improve their staffing, their attitudes and that will be reflected in their work. Overtime and staffing. If you eliminate mandatory overtime, which is difficult to do, I understand, but maybe you can offer something extra for people that will stay over. Right now we can't even fill out a schedule without it having scheduled overtime on it. We have a scheduled overtime to fill out on the schedule. We have got nine nurses for 24/seven. That's not going -- it doesn't work out well. Paying for advanced skills would be a great incentive for a lot of places. They used to do this in some VAs. I'm not sure -- ours doesn't do it. But if you worked in ICU or the emergency room, and you had to take ACLS, you had to complete and do the critical care course, you got two steps. A lot of places don't give anything. They don't give us anything here. That would be nice, because then you are paying everybody the same. And everybody works very, very hard. But if you have to take a little bit extra, you are going to have to pass on these things that are a little harder. It works to give everybody a little bit extra for that. Administration could be a little more flexible and understanding, trusting and respectful of the staff. The staff does need to be involved more in what is going to be happening on their units, knowledge in decisions that are being made about what is going to happen there. Maybe their input is not going to be what you want to hear always, but sometimes what they say is going to be something you can use in making the decisions. Personally, I agree that sometimes you had a -- if you are going to keep people there, make them stay over and continue to rotate shifts. A VA daycare might be a good idea for somebody to -- if they could run it, have it at a reasonable charge and that way you know your children are there, it would be easier to come to work, it would be easier to know your child is

downstairs if you want to go down on your lunch break and check on your kids you can do that.

MS. PATILLO:

Thank you so much.

MS. BURNES-BOLTON:

My question for you is in relation to the pay for advanced skills. Were you suggesting -- I want to make sure I'm clear, were you suggesting, for example, nurses who are certified by the Oncology Nursing Society, or by the Emergency Nurses Association, or by the Crippled Care Nurses Association, should get some differential in pay.

AUDIENCE MEMBER:

That would be good, too. But a lot of times you can take a certification test, anybody can, and maybe you should get something for that too. But ACLS has got to be kept up. Every two years you have to go back and take it. It is something that you are required to have. You have to have it to work in the ER, in the ICUs. You have to have appropriate courses and pass it. Those are difficult to do sometimes. They are harder, you have to have extra skills.

MS. BURNES-BOLTON:

You were not really talking about advanced certification, you were talking more about those things, those minimum job requirements to work in certain areas?

AUDIENCE MEMBER:

Exactly.

MS. BURNES-BOLTON:

Thank you.

MS. PATILLO:

Thank you very much. Margaret Howard.

AUDIENCE MEMBER:

My name is Margaret Howard. I'm employed at the Central Alabama Veterans Healthcare System, East Campus in Tuskegee, Alabama. I'm a registered nurse with 24 years experience in caring for our nation's veterans. For over 24 years I worked as licensed practical nurse prior to receiving an associate degree in nursing. I would like to

express my appreciation to the Commission for allowing me to have my voice heard. Oftentimes we walk around the workplace unhappy because we have no one to bring our issues to that can really make a difference. First, I'm addressing the question, does the VA have the financial incentives to attract or retain the skilled working nurse force. If not, what does the VA need to do to be able to answer with a resounding yes? I feel the VA has the financial and professional assistance to attract and retain the skilled workforce, but the process is not being used effectively. Skilled nurses are often offered lower salaries than the private sector offers when they seek jobs. Undergraduates start at a lower salary, we are not competitive enough to bring in more staff. Another problem is the long wait time in the processing of the application. The period of getting staff onboard is too long. They often take another job while waiting for the VA to process their applications. There is also the problem that new staff encounters with inadequate staffing. A new person needs to be assured there is enough staff to provide quality care for the veterans. Some nurses will not come to the VA because there is no incentive that would assure them of stable shift assignment with rotations of weekends and holidays off. Oftentimes shifts must be rotated to provide coverage due to the lack of staffing. Incentives or sign-on bonuses are not offered to compete with the private sector. The incentive for completed certification courses are not offered to present permanent employees. If an employee is recommended for an incentive, somehow the information becomes lost along the way. Morale is low. Staff feels as though there is no need to accommodate certification because they would not be rewarded. Recommendation, provide consideration of applicant's pay schedule at their present place of employment. Look at the possibility of offering a sign-on bonus, offer at least a step increase to look attractive to the applicant. Process the applications in a timely manner. Keep in touch with the applicant during the process to keep them informed of the status of the application. Give them a sense that we need them. Complete the application within two to three weeks after applicant's interview. After all, the background check should be completed before the interview is done. Administration should listen to nurse managers when a request for staffing is expressed, and provide that needed FFTE. The process of categorizing patients need to be reevaluated to meet the patient's needs because our veterans are requiring more than our knowledge to complete their care. Our geriatric population requires unrushed care because of their frail state. If staffing is adequate, the problem with the shift rotation and holiday rotation can be resolved. For permanent employees, receiving an incentive for completion of a certification course would boost morale and provide them with a sense of appreciation. There is a policy for special certification and is found in the reference VA Manual 5103.9, Part I, Paragraph 8, and it addresses cash rewards. Several RNs, and I was one of them, received certification for chemotherapy administration and exit access devices, which was completed in 2002, and to date, we have not received any recognition or incentive.

MS. PATILLO:

Thank you Margaret. We will now adjourn for a five-minute break and return. (Brief recess.)

MS. PATILLO:

Next up is Dwindlyn Bodrick. Are you here, Dwindlyn? Dwindlyn Bodrick? All right, then. We'll go forward, and if Dwindlyn shows up, she can go next. Next is Sharon Little from the Memphis VA Medical Center.

REPRESENTATIVE:

My name is Sharon Little. I'm an RN at the VA in Memphis. I've been an RN for 40 years, and the last 25 years I have spent at the VA in Memphis. I have learned step-down telemetry unit and ambulatory care in specialties clinics and also in med/surgeries and triage. I have three concerns that I will address, three concerns today, and I will make them brief. My first concern has to do with the financial and professional incentives. I feel the VA is not attractive to the younger workforce. They are not interested in the fringe benefit package that our VA seems to attract younger nurses with. They are more mobile and less interested in a long-term commitment and loyalty is not rewarded. In 1966, when I first applied at the VA in Memphis to work, there was a waiting list that I had to sign up for to work at the VA. It took me six months for my name to make it to top of that list and of course, at that time, I had already found another job. So it was many years later before I applied again to work at the VA, and I sent my application in and they called me the next day and wanted me to go to work for them the next day. I feel that my first recommendation would be that Congress approve a budget capable of funding the services that the VA provides to our veterans and that they no longer pass underfunded legislation. We must be competitive with the private sector hospitals and we must provide for employees appreciation. We must provide a positive reinforcement to our nursing staff and we must challenge the ways things have always been done. Consider the employees' needs as well as the employer's needs. And we need to hire a nurse recruiter at the VA Memphis. We have been without a nurse recruiter for years. One of our nursing secretaries serves in that role. We must value our human capital and we must -- I think we need to create possibly a brand new grant program where they possibly can pay for nurses to go to school and then they are committed to work for us when they graduate for a number of years. My second concern was that RN decisions related to nursing practice and the delivery of care. In our hospital, that is nonexistent because we don't have enough RNs to -- they are overworked and cannot participate in committees and work studies and research. They cannot be spared from the bedside. Therefore, they do not have the opportunities for advancement within nursing. Recommendations are to improve the meaningful nurses participation would be to increase the staffing of beside which we all know is a problem, and there is a need for excellent and professional workforce. Be open-minded and listen when they do make suggestions and treat nurses with respect and do not talk down to them. Become proactive and not reactive. If we had been proactive years ago, we wouldn't be in this position today. My third concern and the central issue, is for pay and advancement, and locality pay and peer review. We are handicapped by not being competitive with the private sector. There are not enough steps in the pay grades to avoid topping out, and we have many nurses with many years of experience who have topped out in a Grade 2. We have no further -- there is no opportunity for them to have pay increases even though they stayed with the VA. We need to increase the grade levels within the steps within those

grade levels. Qual standards are too general and leave too much open for interpretation and intent. Advancement is more difficult for the bedside nurse as they cannot be spared from the bedside to participate in research or committees. Nurse managers are not adequately trained in the right proficiencies. A lot of times they don't even address the nine Dimensions. Sometimes they will address one or two. If you don't address the nine Dimensions, there is no way you are going to promote the nurses. The peer-reviewed participants are not always knowledgeable about the duties of the area of nursing that they are reviewing. If you are not familiar with the nurse's job responsibilities, there's no way that you can adequately judge. The recommendation I have is for the pay scale to be more competitive with private sector, along with adding additional steps to grade and rewarding loyalty to our nurses. Leave nothing to intimation and be very clear. Improve staffing to allow bedside nurses the opportunity to participate on committees and in research, and train nurse managers to right deficiencies. And teach them that they should be clean and neat and come to work on time. Be sure the Nurse Professional Standard Boards are knowledgeable about the nurses they are rewarding. Everyone cannot know all, but make sure the people being awarded have a fair chance at advancement and are not being penalized because someone does not understand their job functions. We need to provide for timely proficiencies, which seems to be a problem within our hospital. If you're not up for promotion, it will not hold you back. If you are up for promotion, then it can become a big problem. I would like to thank you for this opportunity.

MS. PATILLO:

Any questions? Thank you very much, Sharon. Is Dwindlyn here? Okay, good.
Dwindlyn Bodrick from Atlanta VA Medical Center.

REPRESENTATIVE:

My name is Dwindlyn Bodrick, and I'm at Atlanta VA. And first of all, I want to give thanks. This is an honor and privilege for this opportunity to have my voice heard. Basically, my concerns -- I'm a nurse assistant and I've been employed at the Atlanta VA for six years. My concerns are basically, you know, I love my job, and working hands-on with the patients. I prefer that, and I work as a nurse assistant at a nursing home. And I am now working with a SNAP team, which that called the Nursing -- Strategic is Nursing Application Plan, which is a float team throughout the hospital. So I float from different floors, floor to floor. So my concern is like the short staffing, and not being able to give proper care to my Veterans. And I'm a veteran myself. And staffing to me is a big concern in that we have a lot -- at our institution, we have a lot of agencies that come in and they are not really well-trained as to what goes on here. And we need to have, you know, hire more people. Because we are not able to give quality care. You talk about quality care, you are talking about being able to give that kind of care which is more than just a statement. And I'm not able to give it when I have got 10 or 15 patients that I have to take care of. You are talking about orientation for newer members. There is no orientation as to what is going on. I mean, the new members come in and they just are put right straight to work because of the short staffing. There is no such thing as orientation, except maybe the two weeks that they come in and go through the basics of maybe whether they are CPR, or I mean, the computers and policies and stuff like that.

But as for floor training and what goes on and the procedures and just basic working, there is none, because we are so short-staffed that they need to get right on the floor, right then and there. And -- I'm real nervous but I'm just real honored. My thinking is not so much as, you know, you talk about the salary and you talk about -- the biggest thing with me is the unity in terms of the common welfare of the whole, the big picture here. You know, instead of the bickering of who gets this, it should be a team effort here for our veterans right now, from the registered nurse to my end. It is not -- because I could be the registered nurse or I could be the LPN, and it is -- all of us have a role here, from the housekeeper to the whatever, and our common goal here is for the patient. And yes, we do need an increase in pay. But that's not my biggest thing. My biggest thing is that we need extra staffing so we can give the quality care and so we can lead the way in that quality care. I mean, we are the VA, man. Let's have that unity. You know what I'm talking about? "Well, I should be a 6," and, "Well, I should have got that bonus," you know. That's all fine and dandy. But I'm happy with what I do. That's my reward. And I can only speak for myself, you know what I mean? But what I'm saying, it's just that I have been in the healthcare field all my life. I worked as a respiratory therapist, I worked in helping to develop disabled adults. Help to me is something I love doing from the heart. And you have got to love this profession. You have got to It is not just something want to do it. you look at it just because I'm getting paid 60 to \$80,000 a year to be doing it. You have got to want to do it. Florence Nightingale would roll over in her grave with some of the stuff we are just now bickering over. It is about, to me: Do you really care? You know, I have had ten or twelve patients that, man, you just want to get to. Some of them need to be fed, they are ready to go to bed, and they need care. But you just don't have the staff to do it. You got people that have bedsores and all like that, and it's just because you just don't have the staff to be able to give them what they need. You talk about retention. Like someone else said, we are our own best advertising. If we are happy in our work environment, then it shows, and people can tell. But, are we happy? We are not happy because we are too busy bickering about who is getting this and who is doing that. It should be about unity. That's what it is all about. You know what I mean? Talking about work allowance, or clothing allowance, fine. We need those things. But what about our veterans? Today's VA? The new millennium? The year 2000, all this new, modern technology and we cannot come together. I'm a nurse assistant, man, and all I want is to handle the patient. I want the extra time to spend with the patient. Not just run in and run back out, without an extra second to spend with them. Hopefully, I'm going to be that veteran one day. Are the nurses going to have to time to listen to me, or just push a pill down my throat? I don't know. Thank you. That is just basically all I have to say.

MS. CONVERSO:

I was just wondering if you are familiar -- because I really enjoyed your testimony -- but I was wondering if you have ever have been involved with, or do you think it would be helpful, I have seen some team-building activities over time to address the unity that you speak of. Do you think those would be helpful, if you have enough staff, some team-building exercises so you did feel more cohesive?

REPRESENTATIVE:

Yes, if you have the staffing. But if you are short-staffed, it is just not going to work. Because with the computers in play now, you have got to be able to give the medicine, the RN has got to be able to give the medicine at a certain time. Because the computer is going to ask you why didn't you give it. It is just a stress factor. You know at our hospital, well, my hospital, you have to -- you get the patient ready at a certain time, so you got -- they are worried about whether they get the meds, and I'm worried about whether my patients are ready for the appointments. So everything is just so stressful, but if you have got, you know, X amount of people on your team, then it is not as stressed. See, the classroom setting is ideal. But in the real world, you have got to have the people. And they utilize the agencies when they could just hire X amount of people to do the job. We spend so much money on agencies to come in and do the job, where we could just go ahead and hire the personnel already.

MR. COX:

I get nervous at times, too, trust me. When I speak before crowds, and some of these folks know that. I wanted to ask you, you said you were now part of a float team. Could you tell me more about that, please?

REPRESENTATIVE:

What that is, I work Monday through Friday, and I float from surgical floor to the med floor. Also, I do escorting, transporting patients or medicines, I mean, blood or whatever. I'm on kind of a float team. Really, it is two jobs in one, and my manager don't want to give me recognition for that part too, because I'm trying to get a 6 on that, but she don't know how to write it up.

MR. COX:

In other words, do you show up at a central point and then you are told they need you on this unit, or that unit?

REPRESENTATIVE:

Correct.

MR. COX:

How did that get developed?

REPRESENTATIVE:

What had happened is a lot of times they don't have enough nurse assistants on the floor so we kind of do the fill-in. But lately here we have been short in the Escort Department. So they are kind of like bringing the agency nurse assistants in because we are not able to

do that part in the hospital. Basically, it is determined when you report in the morning where you need to go.

MR. COX:

I'm sorry to keep going on with this, but it's intriguing to me because I have a lot of feelings about flowing and floating people without them being prepared. Did you receive additional training, people that go on the float team, are they trained and oriented to work in different areas, so that they are not going in cold?

REPRESENTATIVE:

Yes. When I became a part of that team, there is a head person that would go to the different floors with you. And we are trained to work on different floors.

MR. COX:

Thank you.

MS. PATILLO:

I think the VA is very lucky to have you.

MS. HANSELL:

Whose idea was that? Was that your head nurse's idea?

REPRESENTATIVE:

Yes. Yvonne Hutchinson.

MS. PATILLO:

Your head nurse thought about that and developed it?

REPRESENTATIVE:

Yes.

MS. PATILLO:

Thank you so much. Next, Dr. Elizabeth Humphrey from the American Association of the College of Nursing.

REPRESENTATIVE:

Hello, I'm Elizabeth Humphrey, Dean of the LSU Health Sciences Center here in New Orleans. I was asked by ASCN to, not to give their report, because they'll be giving you a full text written report at some point, but to talk a little bit about the relationship that we have with the VA and a little bit of testimony on the local area. First off, I want to commend the VA for the effort they have done on a national level and locally to really and truly develop close partnerships and integrate the academic side along with the service side in terms of care for Veterans. We have had people relationship with the VA, not only the Health Science Center, all of our deans, myself included, we sit on the Dean's Council and meet quarterly with the major heads of Departments at the VA. We are involved beyond being a major clinic affiliation, which they are for all of our different schools. The former Chief of Nursing was doctorate prepared and was qualified to sit on our growth council. And before that individual left town, for a promotion, I might add, we were working out ways for that person to sit on the Doctors Committees and to be totally integrated in that way into our educational plans. We do have plans for the current chief, however, to do that. I'm not sure she knows exactly yet. I served on the search committee for the Chief Nurse. We have graduates and we have current students enrolled in the school, particularly the RN/BSN Incentive Program, who are currently working in the VA and working in the program for being able to come back to school and getting free tuition and fees paid by the VA. We have, or we are initiating another program that perhaps they have not heard too much about but it is RN to MN option for students who are recruitable, we are going over and meeting with their staff and other people to tell the staff at the VA more about that as a possible retention program for the upward mobility. As I looked at the materials that were sent to me by the ASCN, I found that the goal of the National Committee of VA Nursing was not particularly unique. I'm talking about the part that references recruitment and retention of nurses. I have been sitting this past year on a Commission, Louisiana Health Works Commission, which was established last year by the Louisiana legislature to study not only nursing, but the health shortage of various professionals in Louisiana. We have just come up with the preliminary report which I think is being, as you say, the margins and so forth, so that it could be printed, distributed as our legislature got back in session about three days ago. distribution to them, and it will probably be available to you if that's of interest. The one conclusion that was presented in the preliminary report is that healthcare staff who give quality care, the level of quality care, some are related from satisfaction with their jobs. And that job satisfaction is a major determinant of whether a person stays in the job or even if they leave the profession, just plain old get out. The VA, through the years, has had a commitment to providing the best possible care to individuals, and to preparing for a well-educated nursing workforce. We and the other academic institutions in the area have consistently maintained a partnership with the VA for facilities teaching AD, BSN, masters and doctorate students. We have also been actively supported in our research endeavors and we have had faculty who sit on task forces or on research committees, or are planning to do VA research kinds of activities within an institution. The VA has taken a proactive stance for creating a new framework for advancement in that system including a process for granting waivers for extraordinary credentials of applicants and for upward mobility and educational processing for individuals. The enhancement of the plan to support higher degrees in nursing, the BSN, MSN, and I was happy to see faculty

development, because from my point of view it is near and dear to my heart, the ability to have the faculty to prepare future nurses. There is also a recognition in making that statement I believe that the level of preparation in education can make a difference in areas of particularly, clinical decision-making, critical thinking, and oftentimes a broader knowledge base of community health, patient education and nursing management decisions. VA employs nurses consistent with the current educational program. The graduate program provides them with educational opportunities to move forward in their careers. Each level offers distinct roles and responsibilities. Evidence indicates that differentiate nurses foster positive outcomes related to job satisfaction. Staffing costs, nursing turnover rates, adverse events, nursing roles and patient interventions. I have to sort of parenthetically say, I have been around a long time, some of you might have -- but I have been around long enough to see many of these things come and go. I was alive and a nurse at the time of the 1965 position paper, I had been -- I have seen in our own state differentiated practice studied by at least four groups over the last 20 years. To actually see somebody with perhaps national scope actually putting something down on paper and putting, you know, saying it, maybe there's hope. That's my personal parenthetical. It has taken a long time perhaps. The VA is a leader in providing quality care and in supporting nursing research and advocating nursing education. The VA is setting new standards and has been recognized for your effort to ensure quality care and patient safety. One of the things referred to there is the 2002 The Institute Of Medicine Report called "Leadership by Example", where the VA was praised as "one of the best in the nation." I think y'all need to take credit for that. And in that vein, as recently as last week, one of our students spontaneously praised the welcoming and positive atmosphere they experienced from the VA staff when they were in the facility, and were saying it was one of the best receptions they had gone in their rotations throughout various institutions within the city. This particular student when on to say, from her point of view, about the value of the learning opportunities that were there for them. I would be supportive of any program for educational advancement at any level that the VA can manage to support and I look forward. I got here late, but I do concur with a prior speaker that there probably should be another program considered with a stipend enrolled in the first nursing programs. I say that because the private hospitals all around us are doing it. They are awarding \$500 a month or \$600 a month and then students, two months per month of stipend and so forth. In the other part of that, the reason I'm supportive from our perspective is that we have several scholarships that were somehow tied into the stock market. And we don't have interest from the stock market to be able to give those scholarships. So we have a lot of students who definitely are in need of financing to support their families and to just keep their lives together while they are going to school. I know this is brief, but if you have any questions I can answer, I will be happy to. But I thank you for the time.

MS. BURNES-BOLTON:

Thank very much for your comments. Do you provide any assistance to the junior colleges in your area? We had somebody here earlier today from Delgado. I posed this question to her about what activities in the academic world were going forward in this area to make sure of this AA to MSNs, those kinds of programs. Can you give us a little bit more information on that?

REPRESENTATIVE:

Every school in the state has been mandated by the legislation to have an advancement or an upward mobility -- Articulation Plan is what it is called. And there is also a movement in the state to provide a lexicon of courses that are equivalent all the way across. This is sort of in development. Our Deans' Group, the Louisiana Council of Nursing Administrators have worked on this on many different occasions. I still, to be totally honest, I think probably it's a little bit variable in how it is applied. We work with Charity Delgado, and we had an AD program in the year 2000 and had one for 25 years. At that time, we had not as many applicants as we needed because we were a little bit more expensive than Charity Delgado. The students had gone to get their pre-nursing courses required and they wanted to go where their friends were. We felt that since we were the university in the city that had baccalaureate, master's and doctorate and they are literally located two blocks away from us, that it probably was not in our logical best interest to continue that program, where Charity Delgado would do a good job in numbers and we could put our resources into providing ours into BSN programs and ours into masters programs.

MS. CONVERSO:

You spoke of differentiated practice. I assume that was in support of that?

REPRESENTATIVE:

Yes.

MS. CONVERSO:

I have heard different explanations of that recently. But was the support in favor of a differentiated practice from AD to BSN? Is that --

REPRESENTATIVE:

I think, well, again, I want to say that I'm not necessarily the ASCN because I haven't talked to them, but my feeling is that each degree or level of education that somebody has, somebody should be expected to do certain things. By virtue of the -- if I say you have a diploma in nursing, then I should be able to expect you to have competency or be able to do certain things. If you say you have a associate degree, I should expect many things, many are the same but different. Baccalaureate, you should be able to expect something different. Master's, doctorate, the whole line. And that -- I think the practice should match -- I firmly believe that an RN title solely, period, does nothing to say to the hospital -- because I have a doctorate, I have a master's in nursing; perhaps I should be expected to do something different than someone who has not had the opportunity to have the education level that I do. But if I am -- if I sign things as an RN, I'm held to whatever the base standard is, and you know, you should be able to expect more of me. That's my own belief. And that's what I mean by differentiate.

MS. CONVERSO:

Is there ever a point in time in a staff nurse's role where experience levels the playing field from an AD to a BSN?

REPRESENTATIVE:

If they have the same kind of competency, I don't know why there is not more than one way to get to a level of competency.

MS. PATILLO:

Thank you very much. Next is Janice Stewart from Dublin, Georgia.

REPRESENTATIVE:

Good afternoon, I'm Janice Stewart. I'm an LPN working at the VA Medical Center in Dublin, Georgia for 18 years. I would like to thank the committee for giving me this opportunity to address issues and concerns of the VA nurses. I like working with the veterans because these are the individuals that have made it possible for me to be employed for 18 years. These are individuals who have made it possible for us to have a democratic environment to live in. These individuals are our yesterdays and our future for today and tomorrow. These veterans requires different levels of skills of care of nurse assistants, licensed practical nurses and registered nurses. All are equally important for the different skills. But mostly they are needed for the quality care provided to our veterans. Inadequate pay for nurses adversely affects retention and recruitment of VA nurses. This results in chronic insufficient nursing staff on the floor, increased workloads, stress, and inability for staff to complete required computer documentation. This results in mandated overtime. In itself, as a licensed practical nurse, LPNs primary to the nurse was mandated to work 16 hours on 3-25-03 and 16 hours on 3-26-03. This causes unsafe nursing practice. Also, an LPN's primary duty stations at Ward 19B worked 7:30 a.m. to 12 midnight. On 3-24-03 she returned and was informed by her nurse manager that she would be mandated to work 3:00 p.m. to 12 midnight. This nurse reported to the AFG representative that she was ill, tired, under extreme stress, and felt she would be unsafe to perform her nursing duties. AFG was responsible for obtaining the LPN to work in the place for the mandated LPN. We are requesting for the Commission to recommend that mandated overtime be rescinded and all overtime be voluntary. If a nurse prefers to work voluntary overtime there would be no disciplinary action against the nurse. Insufficient pay based upon 1999 Nursing Qualification Standards, which is not supposed to become effective until 2005, is preventing nurses from achieving higher levels of grade in pay. An associate degree registered nurse cannot obtain their BSN. These new qualification standards prevent RNs from being promoted to Nurse 2s. RNs with ADN are leaving the VA for the private sector due to their inability to be promoted. A current example is an RN whose primary duty station was Ward 17N, she has been employed at the VA for 25 years. She has never been

promoted above a Nurse 1 level. The nurse usually functions as an RN staff nurse. In this position, she is solely responsible for the staff and the care of the bedrooms on the ward. All nurse assistants at Carl Vincent VA Medical Center, even though employed for over 20 or 30 years, have been at GS-4 level with no promotion when all other Veterans Administration nurse assistants are at a GS-5 level. On behalf of these employees, I ask the Commission to recommend a promotion for these employees for the quality of work they have always provided for our veterans. Currently the highest level of qualifying want form is Level 6. A level qualification standards has been approved and I'm requesting that the Commission recommend that the Level 7 be enacted as soon as possible. On behalf of the LPNs, I'm asking the Commission for the GS-7 to be put in force across the board. On behalf of all the nurses of the VA, we are begging your permission to recommend that the Commission have a national, nation-wide education budget with nationwide funding to inhibit the practice of favoritism that prevents the registered nurse with an ADN from obtaining a BSN and the LPN from obtaining an ADN, and nurse assistants from obtaining an LPN. We also request that staffing be appropriate in order to allow the employees to attend school. There was a five-year gap in our upward mobility. The law changed to include the LPN and respiratory therapist, physical therapist and ambulatory care. We ask for people on the staff to receive Saturday premium pay. We ask the Commission to recommend this law be changed to include nurse assistants, environmental medicine employees, and nutrition and food service workers, and all other workers who work on Saturdays to receive the Saturday premium pay. These employees sacrifice their weekends like the above-stated staff and nurses, and leave their family to provide service to our veterans. It is easier to staff the nursing personnel on Sunday due to Sunday premium than it is on Saturday without Saturday premium. I would like to thank the Commission again for allowing me the opportunity to address my concerns and issues. May God continue to bless each of you.

MS. PATILLO:

Thank you very much. We have come to the end of a long day, and, Commission members, do you have anything you need to say as parting comments?

MS. HANSELL:

I can't tell you how impressed I am with your level of commitment and enthusiasm. Thank you.

MS. PATILLO:

I want to also maybe summarize perhaps the three things I have picked up. And I already mapped out this acronym, BBBN, balancing the budget on the backs of nurses -- inequity. So we have some very good information there. I want to also remind you that I'm very touched by the fact that there are some nurses wandering around in the units not knowing who to go to, with no one to talk to. That really saddens me. There is a problem with practice and management. Theory and reality. We need to put these two together if we are going to make anything work. Also, somebody made mention about the respect, that nurses are the most respected profession in the nation. But who respects us? The

public. The public and families know what we can do. So I think we should have a partnership with our patients who love us and know they cannot do without us, and have them, mobilize them to support us. And the other thing is that I want nurses to be seen, and VA nurses are probably some of the most talented, some of the most expert people that I know personally. What happens is that I just think that we are invisible. If you read the performance report that the VA sends to Congress every year, I read that as my personal orientation to this Commission, and I said, where is nursing? The report is this thick. The place I found nursing was under nursing home, said it twice, and that was the only reference to nurses. I thought something was wrong with this picture. So I think we have to be able to verbalize all the good things we are doing and not be seen as just a bunch of whiners, because that's not what we are. But we just want some respect. Which cannot be mandated, by the way, it has to be earned. But we have to be able to articulate our value, not only to each other and to the directors, and to the nurse executives, but to our patients, and have all of us work together so we can give better care to our nations' veterans. Thank you so much, and we really appreciate your presence, your staying with us to the bitter end, and your flexibility and your written testimonies. So feel free, if you have afterthoughts, talk to us via our Web site. Say, "By the way, I thought about this, I put these things together and I have further insight." We look for your insight. Thank you. Drive carefully, and be careful going home. (The hearing was concluded.)

REPORTER'S CERTIFICATE

I hereby certify that the foregoing transcript is a true and correct copy of the proceedings, and was reported and transcribed by me and under my supervision, to the best of my abilities. I further certify that I am not a party to the foregoing proceedings, nor am I interested in the outcome of said proceedings. Further, I certify that I am not related to or associated with any members of the panel, or the Veterans Administration in general, and that the foregoing is rendered without prejudice to any parties involved.

CATHY RENEE' POWELL
Certified Shorthand Reporter