

I. EXECUTIVE SUMMARY

A. Background

The Department of Veterans Affairs (VA) was established March 15, 1989, with Cabinet rank, succeeding the Veterans Administration and assuming responsibility for providing federal benefits to veterans and their dependents. Headed by the Secretary of Veterans Affairs, VA is the second largest of the 14 Cabinet departments and operates nationwide programs of health care, assistance services and national cemeteries. The present veteran population is estimated at 26.2 million, as of July 1, 1995. Nearly 80 of every 100 living veterans served during defined periods of armed hostilities. Altogether, almost one-third of the nation's population --approximately 70 million persons who are veterans, dependents and survivors of deceased veterans -- are potentially eligible for VA benefits and services.

Perhaps the most visible of all VA benefits and services is VA's health-care system. From 54 hospitals in 1930, the VA health care system has grown to include 173 medical centers, with at least one in each of the 48 contiguous states, Puerto Rico and the District of Columbia; more than 391 outpatient, community and outreach clinics; 131 nursing home care units and 39 domiciliaries. VA health care facilities provide a broad spectrum of medical surgical and rehabilitative care.

The VA recognizes that the nature of health care and the health care industry are rapidly changing. As such, there is a need to periodically review and assess the state of the VA's ability to carry out its medical mission. In addition, the VA felt it prudent to identify the lessons learned by other peer health care organizations which have recently experienced and reacted to changes in their operations. In order to avoid the mistakes of others and to capitalize on their successes, prior to the implementation of the "Prescription for Change" document issued by the VA's Undersecretary for Health Services, Dr. Kenneth Kizer, the VA established the requirement for a study of the best human resources practices of peer health care providers. This task was subsequently awarded to the consulting team of Rainbow Technology Incorporated (RTI) of Silver Spring, Maryland and Management Analysis, Incorporated (MAI) of Vienna, Virginia.

The primary purpose of this study was to provide the Department of Veterans Affairs, specifically, the Veterans Health Administration (VHA) with review of their current Human Resources Management (HRM) policies and practices. The review had the goals of identifying the "most effective" HRM practices for direct delivery health care organizations, identifying current VA and Federal HRM practices that are an impediment to VA transforming itself into an organization of the future, and developing recommendations about those "best practices" which should be considered by the VHA. Further more, the Study Team was tasked to investigate the role of HR in Business Process reengineering of the Medical Center; the role of HR in Strategic Planning

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processes of the Medical Center; the forms of compensation and benefits offered to Title 38 comparable positions; and the impacts non-Federal providers experienced in establishing outpatient services centers.

The study design originally included the on-site review of five Veterans Administration Medical Centers (VAMC) around the United States, the Human Resource Departments of four national headquarters offices of large health care providers, and two hospitals or medical centers of each of the four peer organizations. Over the course of the study, the RTI team conducted two-three day on-site interviews with the VAMC facilities, one to two day visits with the four national headquarters of peer organizations, and conducted on-site interviews at seven of the eight peer facilities. Phone interview were conducted with the management of the eighth peer facility, but there were multiple scheduling conflicts which did not allow for a full two-day visit. The peer organizations included Intermountain Health Care, Salt Lake City, UT; Kaiser-Permanente Northern California Region, Oakland, CA; Daughters of Charity National Health Systems, St. Louis, MO; and two large, city-owned hospital organizations.

B. Major Findings

The major finding was that the VAMCs were, in many ways, very similar to their peer health care providers. The peer groups were struggling with the issues of strategic planning, recruitment and retention, compensation, employee satisfaction, and labor relations. The methods by which the peers could respond to these challenges were influenced by the degree to which they were free from governmental controls. The three organizations with the most creative approaches to compensation, performance management (including **incentivization**), job satisfaction, and labor relations were those non-municipally sponsored organizations. However, despite Federal and City regulations, the VAMCs and the city-owned hospital corporation's hospitals have excellent human resource management programs which should be publicized to the industry.

The key finding about human resource management policies and programs among high performance organizations are that they are employee-centered and patient-focused, linked to the strategic plan, and designed to assist the employee to grow with and, if appropriate, beyond the organization. The peer organizations and the Study Team discussed hundreds of programs and policies representing a broad spectrum of methodologies for making their facilities "employers of choice," including easily available training programs, incentive-based compensation, cafeteria-style benefit plans, developmental vs. demeaning-style performance appraisals, strong labor management partnerships, and frequent assessments of employee attitudes by management.

The appendices of this report include all of the interview summaries, discussions of physician compensation methodologies, and the collected forms, hand-outs, and other exhibits given to the

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team during their visits. The information is provided to supplement the findings and recommendation chapters. In addition, the Study Team has provided a number of recent and relevant articles on human resources and compensation topics.

C. Recommendations

The RTI team has presented a wide variety of recommendations designed to assist the VAMCs in meeting the challenges of today's and tomorrow's health care industry. The recommendations are categorized and broadly framed in order to stimulate discussion. The items selected are those which the RTI team has assessed as being the most potentially useful, practical, and implementable by VAMCs. Some of these recommendations can be implemented by a VAMC Director immediately. A second category of recommendations are those which may only require the signature of the Undersecretary in order to be utilized by the Directors. There are also several recommendations which, if approved for consideration, would require changes in current legislation in order to implement. These recommendations are provided in Chapter six of this study.

The bulk of the "best practices" highlighted in this study relate to achieving improved internal relations within the hospital setting. The primary non-compensation concerns expressed by staff interviewed at both VAMC and the non-Federal health care providers related to employee perceptions that managers were not understanding their fears about job instabilities, the desire for upward mobility, and an interest in self improvement in order to provide better patient care. The management of these institutions who were interviewed likewise expressed concerns that the employees did not appreciate the reductions in resources with which they had to manage the hospital. While communications through "partnering" processes are being improved, the majority of recommendations cited can assist VAMCs to enhance the work experience, maintain the highest possible quality of care standards, and respond to each others anxieties in a humanistic, yet fiscally-responsible manner.

VII. CONCLUSIONS

The VAMCs are in a state of flux at this time; although the Study Team attempted to visit a representative sample, there is no one typical or model center to hold up as the example to follow. While all of the VAMCs visited have dedicated employees and many innovative programs, each was struggling with some aspect of change. The problems faced by the VAMCs were mirrored in the non-Federal health care provider organizations:

- Shifting patient populations,
- Changed patient profiles,
- Increased competition,
- Changes in technology, and
- Requirements for:
 - ◆ increased off-site access,
 - ◆ higher patient to staff ratios,
 - ◆ performance-based budgets, and
 - ◆ increased productivity.

-- Like many of the non-Federal providers who were reviewed for this study, the VAMC system is comprised of hospitals in different phases of their organizational lives. There are VAMCs which are recruiting staff due to increases in projected patient populations and those which are continuing to downsize as their patient base moves to the sunbelt. There are VAMCs which are converting to the new Product/Service Line organizational structure and those who are not planning to move in that direction for a long time. There are VAMCs which are beginning to contract out various functions and services, including outpatient primary care and surgical unit coverage, and those which are actively marketing their excess in-house capacity in support services to other agencies.

There is no one typical employee population among the VAMCs. There are VAMCs with very diverse employee demographics and there are those which appear to have more homogeneous employee profiles. There are VAMCs with only one or two collective bargaining units represented, but which have less positive employee relations than VAMCs with up to seven unions represented. These are VAMCs with stable employee populations (i.e., low turnover, long tenure) and those with relatively new employee populations where the seasoned staff have left through early retirement incentives and other buy-out options. Finally, there are VAMCs which have nurtured their employee teams with training and development, and there are those which appear to have eliminated many supervisory positions without helping their newly empowered, self-directed, integrated work “teams” learn these critical skills and behaviors.

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The key to making use of any “best practices” from peer groups is to recognize that “one size never fits all.” Just as in the VAMC system, there were variations in people and processes between the facilities within each non-Federal provider system. The message from VAMC leaders interviewed was that their goal for this study was an increase in the number of approved human resource policies from which they could select those which were applicable to the organizational status and maturity of their hospital. These VAMC directors and chiefs recognize that there are both similarities and differences between each other and between the VAMCs and the non-Federal Providers. They are envious of the perceived autonomy by which their non-Federal provider counterparts manage their hospitals. Continued decentralization of both the responsibility and the authority to carry out their missions includes, in their minds, the ability to pick and choose which of the best HR practices to implement at their site.

The recommendations in this study are designed as general concepts rather than off-the-shelf, ready to implement human resource policies. The VHA, its new Human Resources Advisory Council, and the VAMCs will need to tailor these recommendations eventually approved for use to a more generalized format for adoption and subsequent adaptation by the VAMCs on an as-appropriate basis. Due to differences in corporate culture, Federal regulations, the politics at various organizational levels, and external expectations, the appropriateness of the recommendations will not be the same for each facility. One of the challenges will be to negotiate implementation of the selected HR practices within each VAMC facility, given that the parties may include stakeholders such as management, physicians, line staff, union representatives, patients, families of patients, and external parties such as the Disabled American Veterans, Paralyzed Veterans of America, elected representatives, and the affiliated medical schools.

The bulk of the “best HR practices” highlighted in this report relate to achieving better internal relations. While compensation and benefits continue to be a major concern, most of the staff acknowledged that the VA system has had its abilities to change salaries restricted by an external force of regulations. The next most often discussed group of problems addressed by these recommendations are related to the employees’ perceptions of the VAMC management’s understanding of their fears, the desire for stability without stagnation, and an interest in self improvement for the sake of the patients. The best of the practices and programs discussed by either non-Federal or VAMC contacts were those which suggested a “holistic” approach to the recruitment, placement, training, development, and promotion of the hospital employee at any level of the organization. In the words of one HR Vice President interviewed, “our employees understand that we can’t guarantee them a job for life, but we will make an effort to make them marketable for life.” The Vice President’s strategic plan called for all employees to be given the maximum room and support to grow in their jobs through training, cross training, job rotation, participation in and leadership of organizational committees, and interactions with the Senior Leadership Team throughout their stay with the hospital.

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Another concern that was heard at the VAMCs has been about restructuring and consolidation. The VAMCs have recently converted to the new Veterans Integrated Services Network (VISN), structure which is now resulting in the consolidation of services at a primary point within each VISN. Several of the related recommendations are based on the similar experiences of the non-Federal providers. They too have all gone to a “regionalized” services approach, and have stressed the positive aspects to those staff from whom these functions have been withdrawn. The consolidations have been helpful in reducing redundant efforts, consolidating services and warehouses or storage requirements, made data and training more consistent, and improved the quantity and quality of services to small facilities. A major selling point used by the non-Federal providers has been that this process allows the hospital which lost their HR or Food or Procurement Services departments to focus their remaining available staff on the quality care of patients. This same approach was recommended for dealing with concerns about the movement to Product Line structures. The goal of these changes is to make more resources available for mission specific activities.

The major finding of the peer comparisons has been that the VAMC system has more in common with the outside world than it may believe. There are already some excellent HR programs existing in the VAMC system which need to be shared more widely. Similarly, the VAMCs have the ability to implement many of the programs now running at the non-Federal hospitals.

Lastly, the Study Team would like to thank all of the participants for their candor and hospitality. This type of study, its goals, and its design were new to everyone interviewed. Despite some early delays in obtaining the final list of participants, the site visits went very well and the information gathered has been instructive. The coordination of initial contacts with the participants and the guidance provided throughout the process by Mr. Thomas J. Price of the VHA's Management and Administrative Support Branch has been invaluable to the success of this effort.

VI. RECOMMENDATIONS

These recommendations include specific practices designed to identify the “most effective” HRM practice, consider the “best practices” to adopt, and recognize current VA practices that will impede progress. They are also intended to broaden management initiative designs to improve an organizations culture along the lines envisioned by Dr. Kenneth W. Kizer “Prescription for Change”. These recommendations are discussed in a series of sentences below, moving from the specific to a much broader management.

A. Human Resource Management Structure and Practice

Develop a “business partners” human resource management model which shifts greater responsibility for management of human resource functions and associated issues to the manager to which employees report. Under the business partners model, human resources professionals would assume a consulting role in which they provide support and expertise in meeting the manager’s human resource management goals. The business partnership should be based on a service agreement which specifies attainment of strategic and performance goals. One non-federal healthcare organization projects that transition to a business partners model along with service center work systems would enable a shift in mix of professional to clerical human resources employees from the current mix of two clerical employees to every one professional employee to a mix of one clerical employee to two professional employees, without a net increase in professional employees.

Develop work systems, such as regional or national service centers, for high volume transactional human resource processes (e.g., employee record maintenance and inquiries, payroll/benefits, **staffing/recruiting,workers** compensation,etc.) which maximize economies of scale in labor productivity and information processing. State of the art information and communications technology should be utilized to realize maximum benefits. The business case developed by a large non-federal healthcare organization for a regional human resources service center, projected the greatest savings to come from reductions in middle management FTEs. These middle managers should be considered for transition to consulting roles necessary to support the business partners model recommendedabove. However, the visited organizations’experience in implementing service centers indicates that a gradual shift from facility based human resource services to a regional service center is recommended to minimize breakdowns in essential services.

Encourage staff input into the Strategic Planning Process to increase wider corporate buy-in.

Continue consolidation of staff services across Networks to allow smaller hospitals to concentrate on patient care.

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Continue to evaluate services for outsourcing to increase positions (FTE) available for patient care activities.

Comply with the Vice President's governmental reform initiatives through the adoption of additional pilot programs in "Broad Banding" of job titles, consolidated information systems and increased internal communications, and job skills retraining efforts.

Follow up the decentralization of departmental budget management with increased training and financial management information reports for the service chiefs and other responsible parties.

B. Human Resource Planning and Evaluation

Establish HR Advisory Councils at the Central Office and VISN levels. The purpose of the Advisory Councils would be to inform HR executives of human resources issues and needs within their areas of responsibility and to serve as a forum for HR planning and policy deployment. Advisory Councils should also be established as appropriate at the local VAMC level as a means for managers and employees to provide customer input to local HR management.

Develop long-range staffing requirements based on changing treatment modes (in versus outpatient), changing patient types (mental health and geriatrics), changing facilities (consolidations and several access points), and the availability of competent replacement staff which will be necessary due to attrition and increased performance requirements.

C. Recruitment and Selection

Develop competency based HR systems for employee selection, development, promotion, and termination. Identify behaviorally based competency measures which support the mission, vision, values, and goals of the VHA. Use these competency measures to assess the performance and developmental requirements of prospective and current employees.

Increase the information about VAMCs available to potential employees through increased utilization of the Internet/World Wide Web.

Establish a set of Core Values which are reviewed with job candidates and then converted to required behavioral attributes for successful job performance.

Encourage the use of validated competency - testing in areas outside of Nursing.

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Recruit for Network-based positions which can be shifted from facility to facility as workload shifts.

Provide affiliated faculty/physicians the option to have 100% of their compensation and benefits be through the Medical School, and then pay a fixed hourly rate, to the school for the physicians' VAMC work hours.

Model a direct hire program through the "Exempted Appointments" authority granted to the FAA. This pilot program allows the FAA to bypass the OPM civil service register, for many title 5 positions.

Promote hiring opportunities through wide area vacancy announcements throughout the VISN and to local healthcare agencies.

Increase the VAMC level investment in the recruitment and training of volunteers.

Participate in State sponsored "Welfare to Work" programs to supplement part-time, and seasonal or temporary, staffing requirements.

Grant VAMCs increased flexibility to terminate probationary status new hires within the first 30 days of employment.

D. Work System and Job Design

Develop process action teams to analyze all human resources procedures from the hiring management/employee/customer viewpoint.

Train staff to identify data element to collect about work processes which can be used to develop criteria for new employee success. Utilize local Industrial Psychologists to create or validate pre-employment competency or attribute tests for improved selection actions.

Train patient contact staff in the skills necessary to become self directed patient care teams. Shared leadership and self-direction of activities are not inherently easy for staff who have only worked in a hierarchical supervisory structure.

Establish, or more broadly advertise, a small grants program in each VISN to support employee-developed pilot programs for process engineering efforts. Employees to develop, implement, and brief the results of these programs.

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Combine existing VAMC level organization development reengineering units with the existing management engineering units under the Human Resource Department to coordinate product line restructuring, work process analysis and redesign, and required position management activities.

Explore the results of the VAMC-East Orange (NJ) participation in the SARATOGA Benchmarking Service surveys. In most cases, participants receive free or discounted copies of the final benchmark report.

Some organizations have begun to rethink the concept of who would most benefit from increased availability of limited training resources. In many cases, high performers (who are typically more highly compensated) are given the most training opportunities and resources. In several VAMCs visited, training dollars were allocated to each Nurse Manager on a percentage basis, based on the percent of the total staff their staff represented. Training dollars were then distributed to Nurses based on the criteria of seniority, participation, authorized absences, and contribution to unit growth. However, those who may most benefit from extra or remedial training are the lower skilled, lower motivated, and most likely, lower compensated employees for which there is also often higher turnover. Physicians and nurses do need to keep their skills current, but the less skilled staff need more training in order to increase their skills and to introduce them to new change in the balance training investments (i.e., shifting more of the resources to lower skilled staff), the additional training can reduce errors, increase motivation and job satisfaction, reduce turn-over, reduce patient complaints, and result in greater overall team competencies and work ethic. The EEO Chief at one VAMC explained the lack available training resources for lower level employees to obtain additional skills that might have been the reason for recent increases in EEO complaints of “discriminatory failure to promote.”

Introduce a version of DCNHS-Seton Medical Center’s Nursing Service Shared Governance System to increase participation in the VAMC decision making process and for leader development.

Following the lead of the DCNHS-Seton Medical Center, a Nursing Executive Council of a VAMC would meet twice per month, serving as an advisory group to the Chief of Nursing Services. The Council would be comprised of representatives from each of the medical departments and from each VA facility in the area, as well as representatives from the Center’s Accreditation and Training organizational units.

The Nursing Congress of a VAMC would assemble monthly to discuss policies and procedures which impact all medical areas and facilities. Subgroups of the congress are developing standards of care **recommendations, and** suggestions for standardizing supplies and equipment across all facilities. Each of the medical departments and facilities are designated as districts; each districts

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elects a Staff Nurse representative to attend the Congress on their behalf. There could be a Physician representative in the Congress.

Nursing Practice Specialty groups of a VAMC would work on education and policy issues related to their medical specialty. These representatives focus narrowly on practices which may cross facility lines but are specific to a type of nursing.

E. Compensation and Benefits

Increase the use of training leave, but not necessarily additional tuition, for recognition of superior effort at all levels of the hospital. Training leave is considered to be a valuable resource by employees who may otherwise be eligible for free or reduced cost training.

Allow the staff to sell unused paid time off (PTO) back to the hospital for cash at the end of the year. This practice was used more widely for physicians at the private hospitals visited.

Introduce an incentive-based payment for performance component at all levels of the organization. Utilize individual incentives for physicians and a combination of individual and team incentives for nurses. Team awards can be used for other levels of the organization.

Substitute a "Market Rate" Special Pay component for the "geographic" and "Hard-to-Recruit" Special Pay rates. In the free market of competitive healthcare communities, the non-Federal "Market Rates" for physicians is based on the cost of living in the area and the need for more of each specialty in the hospitals.

Use "Tenure" Special Pay rates to finance the introduction of performance-based incentive pay over a five-year period.

Allow VAMCs to utilize commercially available, industry accepted compensation survey reports for use in determining locality pay when local hospitals will not provide the comparative data directly. The data is now often available by position, by specialty, and by region.

Provide a cafeteria-style benefits plan which provides a set amount of benefit dollars with which to purchase customized benefits.

Establish a separate compensation program for staff of remote access clinics, since the workload and types of patients served are different from the hospital operations.

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F. Performance Appraisals and Performance Management

Develop a standardized Medical School - VAMC affiliation agreement which defines specific, yet customized, employee performance measures, goals, and milestones for success.

Translate the VAMC mission into measurable behaviors, **identify** related criteria for each behavior, and then support employees as they begin to develop the behaviors on the job.

Increase the use of peer reviews, 360 degree appraisals, and balanced scorecards for more robust assessments of competency.

G. Training

Provide additional non-medical training in the areas of:

- team-building
- leadership development (not just supervisory skills)
- cultural awareness and diversity appreciation
- avoidance of sexual harassment
- basic life skills
 - work ethics
 - money management
 - English as a second language
- anger/violence/stress reduction
- pre-retirement planning
- etc.

Provide chiefs and other mid-level managers with training on how to read financial information necessary to carry out decentralized responsibilities.

Provide “Labor Relations” type training, such as how to establish internal “partnering relationships,” in order to resolve issues at the lowest possible organizational level.

Reward cross-trained staff with non-cash recognition for becoming more flexible, and therefore, more useful to the hospital.

Link professional skills training and education benefit expenditures to the strategic business plan. The funds allocated for training should be spent first on courses identified in the business plan as required to meet current or near-term regulatory, medical, safety, or administrative requirements.

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Funding of other courses should be secondary. Distribute a list of courses and workshops annually based on requirements for the next year's strategic plan, and categorize the courses by priority:

- Level I - VAMC lacks resources in this area or training is a new legal requirement - Funding Likely
- Level II - VAMC has a future need for resources in this area - Funding Probable
- Level III - VAMC has a non-critical need for resources in this area - Funding Possible
- Level IV - Individual staff member needs training in this area for future advancement - Funding Less Likely

Expand the New Employee Orientations to a minimum of three full days, and provide a signature sheet to verify receipt by the new employee of the current policy statements.

H. Job Satisfaction

Utilize town hall meetings, grand rounds, brown bag lunches, focus groups, and/or "Coffee with the Director" sessions to increase contact between the Senior Leadership Team and the staff and to control rumors.

Solicit recommendations from staff on the "Topic of the Week" via anonymous e-mail, comment card, or phone message machine.

Provide patients and staff comment cards, conduct phone surveys, and send follow-up letters to solicit comments from customers about services received and employee attitudes observed. Provide each patient care team with specific feed back.

I. Labor Relations

Link the "paid" time that bargaining unit officials are given per week for "official business" to the ratio of members to eligibles within each represented facility. Officials with a larger percentage of eligible employees in the local as members would receive slightly more "official business" time than those officials with a smaller member to eligible ratio.

Use the partnering process to promote joint labor-management sponsored celebrations and other "fun" or "healthy" events during the year.

Encourage bargaining units to provide input to the creation of new "Broad-Banded" job descriptions for multi-functional, cross-trained staff. Present these blended job descriptions to OPM

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for acceptance in pilot programs targeting the retention of hardworking employees who may otherwise be downsized due to consolidations and the elimination of duplicate functions.

J. Exit Interviews and Reductions in Force

Use some type of exit interview form (short or long) for each employee who separates voluntarily and track the responses for analysis purposes. Utilize the data to support the strategic Planning Process and as a diagnostic tool to identify reoccurring complaints in specific areas.

Develop out placement resource centers 'on an in-house basis, or via contract, to assist employees in positions identified for elimination. Utilize existing local, Federal-funded Joint Training Program Act, retraining program resources in the community to supplement hospital job funding services and resources.

Develop the capability to provide responsive and focused human resource management support for large scale changes within the VHA, such as facility start-up, **reconfiguration,** or closure. As demographic, economic, political, and technological forces drive the need for transformational change in healthcare delivery systems, the workforce will continue to experience dramatic changes such as job redesign, the need to acquire new skills, career dislocation, loss of employment, and relocations. The ability of individuals to adapt to these major changes is a critical factor in the organization's successful adaptation to change. The organizational changes needed at any one time will vary from location to location. A closure will occur at one location while another location is reconfiguring its facilities. A facility closure will require special support for employee assistance and career transition. Rather than leaving it up to the local facilities to provide such support on its own each time the need arises, a coordinated standardized approach would maximize effectiveness and facilitate continuous improvement of the support capability by building on lessons learned from previous efforts. HR support capabilities should include: career transition counseling and out placement; "broad-brush" EAP; early retirement and buy-out planning; financial counseling; labor relations planning; work systems transition planning.