NFFE Local 1 Meeting with VA Secretary Denis McDonough

SecVA: Good afternoon, to start I'll just say a couple things and then the time is yours. First, I believe a union workforce is a strong workforce. Second, I believe a workforce with collective bargaining is a strong workforce.

NFFE Local 1: Good afternoon, Mr. Secretary. My name is Mark Smith. I'm an occupational therapist here at San Francisco VAHCS and I've been with VHA for nine years, primarily providing psychosocial rehabilitation for veterans with serious mental health conditions.

I'm also the democratically elected president of National Federation of Federal Employees Local 1, representing over 1200 dedicated, hardworking, and caring healthcare professionals. Many NFFE Local 1 members are also Veterans, like my colleagues here today: NFFE Local 1 Vice-President Timir Mehta, VA Pharmacist, USMC OIF Veteran, and John Kelley, NFFE Local 1 Steward, VA Registered Nurse, US Army (82nd Airborne) ODSt/ODSh Veteran.

Mr. Secretary, I got my first intro to VA healthcare when my grandfather was dying of lung cancer. He served 20 years in the US Army, including 36 months in combat in WW2 as a 605 (heavy machine gunner) with General Patton's Third Army. VHA took great care of him in his last days and he never had to worry about how his family was going to pay for his care- a blessing all too rare in America today. Many NFFE Local 1 members have similar stories.

So you'll understand, Mr. Secretary, that we care deeply about VA healthcare and the high quality, low cost, ***public*** health care we provide for our nation's Veterans and their families.

And you'll understand that we cannot sit back and watch our healthcare system plundered and bled dry by corporate healthcare interests who would like nothing better than for VHA to become a glorified insurance company.

And you'll understand, Mr. Secretary, why we might be confused as to why you acknowledged at the September 2022 Senate Veterans Affairs Committee hearing on *"Ensuring Veterans' Timely Access to Care in VA and the Community"* (1:10:30) that "Veterans who receive direct care in VA do better than those in private sector 'community care'", but have, so far, *not used your administrative authority to stop the bleeding*.

So to clear up any confusion, our members have just three questions for you in our short time together today.

And as my late grandfather used to say, we've had just about enough of politicians and high-level VA officials "pissing in our pockets and telling us it's raining", so we'd appreciate some straight answers.

1. Why haven't you used your administrative authority to revise former Secretary Robert Wilkie's misguided drive and wait time standards that have led to unsustainable increases in outsourced care?
Will you do this, yes or no, and, if so, when?

SecVA Response: NO, because it's not a regulatory issue. It's a statutory issue and would take an act of Congress.

Note: After the meeting with SecVA, NFFE Local 1 fact checked this claim, which appears to be untrue, at least based on public comments made elsewhere by Secretary McDonough: **VA Weighs Limiting Access to Outside Doctors to Curb Rising Costs**

VA Sept 2022 Congressionally Mandated Report on Access to Care Standards

2. Why have you not used your administrative authority to end Wilkie's ban on counting VA telehealth as access to care that you committed to "look into" in 2022? (see Senator Sanders questions to Secretary McDonough: 1:08:40)
Will you do this, yes or no, and, if so, when?

SecVA Response: We are actively looking at what we would have to do to change the regulatory basis for counting telehealth as access to care and we will make a decision based on the results of that work.

NFFE Local 1: We appreciate that, but Senator Sanders asked you about this in Sept 2022; when can we expect the results of that work/report?

SecVA Response: I can't talk about that timeline publicly with you at this point.

3. Given your statement at the start of our meeting that "a union VA workforce with collective bargaining rights is a strong VA workforce", why will you spend 23 billion dollars on non-union private sector contractors and temporary healthcare workers under the ICSP when we know from all available evidence that they will provide lower quality, less safe care at higher cost?

SecVA Response: Look, I've toured the country, talking to VA staff: one thing when I ask about community care, every facility talks about staffing limitations, and the need to move Veteran care into the community due to VA wait times, so we need the ICSP to recruit quickly, to get staff onboard and get Veterans into care.

NFFE Local 1: We agree that we need more staff. Why not spend that money on recruiting and retaining high quality, permanent, union-eligible staff by:
-providing fair, competitive compensation for all staff
-fully funding and staffing SFVA (and all VHA facilities) so workloads are safe, manageable, and allow clinical staff to provide the high quality care they came to VA to provide
-fully utilizing retention incentives such as 72/80 AWS for nurses and other schedule flexibilities

SecVA Response: We've done retention bonuses, relocation bonuses, the Critical Skills Incentives, and other pay raises through the RAISE Act, and PACT Act authority and we've prioritized hiring. We've hired 63 000 new staff across the VA. We are dealing with the same shortage of healthcare providers that everyone else is dealing with.

NFFE Local 1: First, we would push back on the framing that there is a shortage of healthcare providers. There are plenty of nurses, for example, with active licenses who are not working at the bedside, because what there is actually a shortage of are well-compensated jobs with safe supportive working environments for nurses and other clinical staff.

All of the initiatives you listed are great, and we appreciate them, but the 63 000 new staff have not trickled down to us at SFVAHCS. We have a lot of vacancies in mental health, in social work, in primary care, in nursing, and we are understaffed in several areas and our staff are getting crushed.

We have a massive budget deficit locally due to the huge increase in community care, we are barely hiring, and the staff that we do have are being squeezed to increase productivity and bean-counted to death. All the while, our ELT is cutting benefits/incentives like the 72/80 AWS for nurses in 24 hour bedded units (hospital care/critical care/emergency department).

SecVA Response: Well, your ELT tells me you have a very low nurse turnover rate, 6%, which is great, and they were comfortable rolling back 72/80 because nurses received a large salary increase.

NFFE Local 1: That turnover rate is from *BEFORE* our ELT decided to roll back 72/80 AWS. We surveyed 160 nurses after the rollback and there was a 90% turnover intention rate, which will likely not translate into actual 90% turnover, but turnover intentions are the best predictor of actual turnover, so we should be very worried.

*At this point, the SecVA became visibly upset, raising his voice and cursing several times in his responses to NFFE Local 1, which we will not put down in writing. Members can hear more about the exchange at our Feb 21, 2024 membership meeting.

Thank you for your time, Mr. Secretary. We appreciate you taking time to meet with us face to face and to hear the concerns of frontline clinical staff.

While we don't have time today to share all of the detailed feedback we received from frontline SFVAHCS clinical staff/NFFE Members wanted to share with you, we have included their comments in printed copy for your review.

Comments from SFVAHCS clinical staff/NFFE Local 1 members

1. Facilitating ethical and clinically responsible treatment of complex mental health patients is critical. Leadership's obsession with filling grids and getting Veterans INTO care (without caring what happens to them once they are there) has created large and ever-expanding caseloads for providers in Mental Health with Veterans who are highly acute and complex and simply cannot be seen as frequently as needed or provided with the level of care appropriate to their clinical presentation (i.e., extensive case management, frequent crisis management and ad hoc contact, need for flexibility to reschedule missed appts due to general psychosocial chaos associated with medical condition). It is unsafe to see this many Veterans with such complex needs and leadership has ignored our concerns at every single meeting, town hall, and venue where clinicians could speak up. The response is, "Your grids need to be filled" and "there will be no discussion of a cap on caseloads until everyone's grids on the team are completely filled." This is reckless and will/has increased attrition, hospitalizations, suicide, overdose, and a range of other negative consequences, let alone created unprecedented burnout and moral injury among providers who are fully aware they cannot provide the level of care Veterans need and deserve with the current system.
2. More staffing. Despite all the requirements to have veterans seen in within given timeframes, there are absolutely not enough clinical or administrative staff to ensure timely appointments, leaving veterans without safe, adequate care and resulting in significant staff burnout.
3. Losing focus of patient care: spending too much money on community care (which we know CC does not provide the same care as the VA), leaner staffing models (switching to many VISN Hubs which means less local jobs resulting if less patient satisfaction) & solely focused on population health metrics (leadership is strongly focused on eQM dashboard metrics telling VA staff what type of job they are doing rather than using this as a helpful tool to identify patient care needs)
4. Our team’s Veterans Crisis Line volume has exploded, with 163 VCL call consults sent to our team in Q4 FY2019 and 408 VCL call consults sent to our team in Q3 2023. This increase has deeply undercut our ability to attend to our other duties, w/a resultant decrement in patient safety. This has absolutely crippled our team. Years of requests for additional staffing have been fruitless. Burnout and frustration with the paucity of support from local, VISN, and national leadership is causing a retention crisis of our most experienced clinicians.
5. Immediately reinstate 72/80 RN schedules so we can resume caring for our elderly family members, children, and partners along with the many other responsibilities of living in the most expensive locality in the country, while giving our veterans the best care possible when we are at work. There should also be a thorough investigation and individuals should be held appropriately accountable for the gross mismanagement of

the budget that allegedly precipitated the spontaneous revocation of our 72/80 without due process.

6. Every VA's situation/staffing and challenges are NOT the same. Over my years the VHA has centralized everything and taken away local automonmy which gums up proper decision making (see LEAF/grids changes to our schedules for one of many things). Using the AES and solving LOCAL problems makes far more sense than hiring more centralized bean-counters to distribute pressure to local staff when they have no knowledge of what the local employees deal with.
7. Mental health desperately needs to improve staffing. Unfortunately due to staffing issues, veterans are being referred to community care, and often complain about the lack of cultural understanding and expertise of veteran's issues, which in turn lead the veterans to disengage from mental health in general. My concern is I've noticed this has led to spikes in both hospitalizations and attempted suicides/completed suicides.
8. There has been an influx of staff from the private sector coming to join us here at the SFVAHCS, especially those in the Nursing Management arena. There is a great orientation for nurses in the classroom and on their respective units but very little for the Nurse Managers- I believe. It is very difficult for them to transition to the VA System as it is totally different to the private system and the daily function of a department. It may be beneficial to have an intense 6-week course/class for Nurse Managers to learn the basics of working with their assigned staff and unit.
9. Unsafe staffing ratios for Social Workers. Prior to hiring freeze, it was outdated and did not take acuity into account; now during hiring freeze it is unsafe and not sustainable, esp in SF. For Primary Care it is about 1:2000 but we cover for other clinics and programs. Now that we're in a hiring -freeze there is no relief in sight. Social Work caseload safety is not as obvious as nursing ratios but if we miss a safety assessment, it can end in elder or child abuse, suicide or a mass shooting. In SF our mental health acuity, dementia rates and homelessness rates are exceptionally high. It is taking a toll on our mental and physical health.
10. The rural CBOCs have struggled to retain employees in key positions (including healthcare providers, VA Police, and leadership). How are we working to increase retention of employees in areas where it's difficult to find replacements? It's disappointing that retention options such as EDRP are so difficult to obtain, with folks languishing on the wait list for years.
11. More staffing. Despite all the requirements to have veterans seen in within given timeframes, there are absolutely not enough clinical or administrative staff to ensure timely appointments, leaving veterans without safe, adequate care and resulting in significant staff burnout.
12. Management continues to ask for more with less. Care coordination eats up the bulk of my time and I could be much more productive with someone I could delegate tasks to so I can focus on continuing to provide direct quality care to our veterans. Mgmt is relentless with insisting clinicians be more productive but resist requests for assistance

so we can meet these expectations. The result is stressing clinicians like myself to the breaking point and being placed in a position of having to apologize to our veterans for being unable to provide them with much needed services.

13. lack of budget/sufficient staff to handle workload and patient care effectively, causing patient safety & care issues, employee burnout. The workload is not balanced with the number of employees. Many times, i have to multitask which may lead to medication error.
14. In regards to "compensation," abolish the "Aggregate Limit" for R.N.'s/CRNA's, which currently restricts this group from receiving "ALL" of their Bi-weekly Pay.
15. The ELT's language is couched in hyperbole and doublespeak much of the time. In light of our current budget shortfall they have not spoken or stood up and addressed their mistakes and the other reasons this has occurred. This is the first thing ANY leader should do. A clear and honest accounting of what led to this and then a plan to address it. They have never addressed it head on and what we are left with is a 'leadership' team that is not held to account and a growing resentment and a loss of faith from those they are 'leading'.
16. Expand Telework opportunities to decompress the clinics and campuses and allow for better utilization of space for when in-person care is truly needed.
17. AMSA/MSA staff need to be paid SIGNIFICANTLY more so that we aren't continuously losing staff. If we don't have staff to schedule patients, we don't have patients scheduled. Having well-paid MSA staff increases productivity.
18. The pay rate is in our department at SFVA is $30,000-60,000 below the surrounding VAs. Even when the hiring freeze at SFVAMC ends, the applicants for future jobs will be fewer and siphoned off to all the surrounding VAs with much much higher pay. This has an incredible impact on morale. Not only is there no hope in sight, it also feels like there is minimal recognition or respect for the work that we do. The options to promote to a higher pay grade involve leaving in-person patient care at SFVA, which seems to fuel a burgeoning healthcare bureaucracy. The work expectations increase but the pay does not for those of us who see the most live patients per day. There was talk within the VA about staff retention and addressing employee burnout, but no real action in terms of systematic changes.
19. Streamline administrative processes with a goal of relieving the clinician burden of care. Reward Leadership for achieving high provider satisfaction in the workplace, not for metrics over which they have no control (eg scheduling, the curse of my existence. Admin, not the clinician, should be fully accountable for keeping schedules full and the draconian "six week rule" does nothing but create stress and encourage non producers to call in sick. Six weeks notice for a day of AL should be a desired courtesy, embraced by staff due to respect for admin efforts, not a mandate. It's toxic.
20. Meeting productivity metrics too often reflects individual ability to "look good and play the game" instead of clinical excellence, work load and employee engagement. Scheduling challenges and admin requirements can suck valuable time away from the

Veteran (it can take several emails, filing a LEAF request every time you call in sick, change a patient appt type, open and close a clinic, start/stop a group, add/subtract a meeting. It's exhausting, sucks unmeasured time away, and it should take 1 call or email. And it should be easier for admin to get that done too. Poor process for clinical and admin undermines and makes irrelevant current productivity metric demands while negatively impacting the provision of quality patient care services and developing disengaged and burned out staff, which we know ultimately undermines performance. AND there are so many dedicated, impassioned people here. I wish you knew all of them. They are being squandered. Thank you for the question.

21. Short-staffing leading to poor veteran care and high burnout for providers who have to cover. In social work, the VA is no longer competitive for recently licensed clinicians as they have to work at least 2 years as a GS11 before they can become a GS12; we are losing social workers to other agencies that provide more competitive pay. Also very concerned about the move towards privatization.
22. reinstate 72/80 for nurses in Acute care, streamline the hiring of chief nurses, we already have too many that are making decisions for such a small hospital (too many chefs, not enough cooks), but they are focused on cutting back the benefits that the floor nurses earned