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The VA's Vacancy Crisis

How years of political inaction and ideological attacks thrust the VA into the worst vacancy crisis in American government — and how to fix it.

By Suzanne Gordon & Jasper Craven

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Letter from the VHPI Executive Director

When we commissioned "The VA's Vacancy Crisis" report last year, no one predicted that a pandemic would sweep across the globe. COVID-19 has exposed what many of us at the Veterans Healthcare Policy Institute (VHPI) have long-suspected: America's private healthcare system is fragile and the Veterans Health Administration (VHA), with all its flaws, is a system worth improving, emulating, and reproducing for all Americans.

Although the department's staffing crisis first gained national exposure with the Phoenix wait list scandal in 2014, problems at the VA had been brewing since the 2003 Invasion of Iraq. Going to war was debated, planned, and executed. Caring for the war-wounded was not.

If there's a villain in this story, it's the individuals who hobbled the system and then profited off that dysfunction. And the heroes of this story – unrecognized for too long – are now getting the coverage they deserve in their noble fight against COVID-19. Frontline healthcare workers at the VA are staying on the job to care for veterans. They're also blowing the whistle on leaders who have failed to meet their responsibility to prepare, protect veterans, or give health care workers the tools they need.

The heroes include the veterans who support each other as peer specialists, VA employees and volunteers, or by using their own informal networks, VA tools and telehealth resources. The heroes are the private sector healthcare workers. Many of the private healthcare systems they work for were built to make a profit – not handle a pandemic. Many faced their own staff shortages, lack of personal protective equipment, and other on-the-job dangers and trials long before this pandemic. But many do not have a worker representative, like VA employees do, to protect them as well as help them tell their stories without fear of reprisal.

The coronavirus crisis is teaching us that we will all suffer if the VA collapses under the weight of outsourcing and understaffing. It's not too late to restore veterans' healthcare for all America's veterans. We must continually monitor and pressure the politicians who created the crisis and reform the agency in a way that makes it more – not less – able to deal with today's, as well as emerging, healthcare needs.

Brett W. Copeland
VHPI Executive Director

Letter from the Authors

In our research and reporting on veterans' healthcare, we have been struck by an important paradox: The Veterans Health Administration (VHA), the nation's largest, and only publicly-funded, fully-integrated healthcare system, continues to outperform the private sector despite years of Congressional neglect.

Studies[1] continue[2] to document[3] that the VHA's coordinated care is equal – and often far superior – to healthcare delivered in our fragmented, profit-driven, private healthcare system. Not only have we carefully examined these studies, we've also interviewed hundreds of veterans who give witness to the myriad ways in which the VHA has literally saved their lives. The department's world-class care, research, and teaching, however, are under threat. In interviews, scores of VHA staff have described the many challenges that make it more and more difficult for them to care for some of the nation's most complex patients. They told us about short staffing, anemic budgets, poor – and even punitive – management practices, and, sometimes, even downright hostility from high level administrators, the media, and Congress. (We would like to note that we reached out to the VA several times for comment on these issues and to respond to multiple questions. The VA did not reply to any of our inquiries.)

Now, as the nation grapples with the coronavirus pandemic, the VA, as we have written, has used its unique position to respond in a coordinated fashion. Yet staff are hampered by the most challenging conditions they've ever experienced. Not only must these staffers continue to provide high quality primary and mental healthcare care to the nation's veterans, but they must also serve civilians as part of the VHA's fourth mission as backup to the private system. To borrow a battlefield analogy, the situation is as if soldiers were sent into battle without the proper equipment and with one hand tied behind their backs.

Our goal with this report is to encourage lawmakers and advocates to constructively address the conditions that make it so hard for VA staff to fulfill all four of the VHA's missions. It is now time for the country to devote considerable energy and power to fulfill its moral obligation to improve and strengthen the system rather than outsourcing care to a private sector system that will face almost insurmountable challenges when this crisis is over.

Suzanne Gordon
VHPI Senior Policy Analyst

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VHPI Fellow

Introduction

On a wet and dreary afternoon in mid-February, Mick Cole and a half-dozen other members of the Veterans for Peace-backed "Save Our VA[4]" campaign climbed the steps of the Capitol to meet with U.S. Rep. Mark Takano, the Democratic Chair of the House Committee on Veterans Affairs. They were there to laud the care they've received from the Veterans Health Administration (VHA) and warn that massive staffing shortages were putting their health at risk.

From 1965 to 1969, Cole flew missions over Vietnam as an airborne voice intercept operator in the Air Force. Having learned Vietnamese, Cole's job was to monitor the communication of the North Vietnamese air force and provide real-time intelligence to American pilots. Because of his combat duties, Cole eventually lost hearing in one ear. He also had several prostate operations, likely related to Agent Orange exposure.

Yet his most debilitating problem is Post Traumatic Stress Disorder (PTSD), a condition made worse by his unique military role, in which he experienced the battle from both sides. "When I was monitoring the Vietnamese pilots and one of them got shot down, I could hear the anguish in their voices," he recently recalled. "They were just like us."

After he left the Air Force, Cole spent years self-medicating with alcohol. "Finally, 15 years ago someone convinced me to go to the VA," he told Takano. "If it weren't for my weekly therapy groups, I wouldn't be here today."

But now, Cole continued, the Department of Veterans Affairs (VA) staffing crisis, in which tens of thousands of positions are unfilled, is compromising the high-quality care he has received for years. His local VA system, in upstate New York near the Finger Lakes, is now sagging under 118 vacancies.

"My psychiatrist left to go into private practice and hasn't been permanently replaced," he said. "So every time I have to go get checked up on, I have to tell my story to someone new; it is very painful to relive that trauma over and over again." Cole added that the psychologist who runs his weekly group therapy sessions is overburdened and struggles to schedule timely individual appointments with veterans in crisis.

After meeting with Takano, Cole and his fellow veterans sat with a young legislative staffer in the office of Rep. Elaine Luria (D-VA), another member of the House Veterans Affairs Committee. When Luria's aide asked Cole how the vacancy crisis had personally impacted him, he hesitated, explaining that it was hard to tell the same story over and over again. "It's very,

very…" he began, choking up. A second later, Cole broke down, and wept quietly, before apologizing. "I am sorry," he said. "I am so sorry."

Given the current coronavirus crisis – and the VA's mandated "fourth mission[5]" as the backup civilian health system in emergencies – Cole is now even more worried. "What will happen if nurses and doctors at the VA are infected or quarantined?" he asked. "How is an understaffed VA going to handle all of this?"

Extent of the Crisis

The Department is now reeling under roughly 50,000 vacancies – a number larger than the Departments of State, Labor, Education, and Housing and Urban Development combined[6]. These shortages make it difficult to deliver timely care to veterans under normal circumstances. Given the current pandemic, shortages may compromise the VHA's ability to take care of an influx of veteran patients who need to be hospitalized because of COVID-19.

Since so many veterans suffer from chronic problems due to their military service, they are at high risk of hospitalization and death from COVID-19. If staff caring for these veterans become sick themselves, die, or are quarantined, crippling staffing shortages could turn catastrophic, particularly as private sector hospitals increasingly look to the VA to fulfill its fourth mission (Its other three missions are delivering clinical care, teaching, and research.) The VA has estimated that 40% of staff[7] may be sidelined because of the pandemic.

Massive as this number appears, it fails to capture the extent of the Department's staffing problem. That's because this metric only includes positions that have not been filled after an employee has left a job. Excluded are the many new positions needed to address emerging needs and demand.

An obvious new burden is to administer and coordinate the massive outsourcing of care resulting from the 2018 VA MISSION Act. The MISSION Act has diverted many staff from delivering or supporting clinical care to coordinating care[8] with private sector providers.

President Donald J. Trump has also issued and implemented a number of unfunded executive orders, including one which mandates the VA contact and provide mental health services[9] to every newly discharged service member. These challenges are compounded by the fact that roughly 40%[10] of the Department's workforce is approaching retirement, and the number of veterans over 75 – a population more reliant on VA services – is expected to jump 46% by 2028.

Although staffing problems at the VA predate Trump, his administration has exacerbated them. Since coming into office, Trump has undermined recruiting and retention efforts by cracking down on labor protections and gutting employee benefits. VA leaders have installed, promoted, and protected incompetent administrators who have violated labor agreements, leveled threats against employees, and instituted punitive management practices. The resulting hostile work environment has driven many dedicated staff out of the agency entirely and discouraged potential recruits from filling their positions. These developments, combined with one of the most aggressive federal privatization agendas[11] in American history, have placed the future of VA in jeopardy[12].

Mental Health Vacancies

Amidst an ongoing and deep mental health crisis among veterans – and repeated pronouncements from lawmakers and the VA secretary that suicide prevention is the number one clinical priority – the most common vacancy positions are for psychiatrists. In New Mexico's VA system, chronic mental health shortages led to four-month wait-times for new patients[13]. Facing similar issues in Rhode Island, mental health counselors were ordered to double their number[14] of weekly visits to meet demand.

"They kept pushing the numbers, the numbers, the numbers," said Ted Blickwedel, a Marine Corps veteran and former VA counselor who was caught up in the order. "We had counselors taking leave, burning out, facing suicidal thoughts, or obtaining their own therapists."

When you zoom in on the types of vacant positions, the picture becomes even more troubling. The top clinical vacancy is for psychiatrists, with 61% of VA facilities reporting severe shortages for the role. (Other clinical positions facing severe shortages include psychologists, primary care doctors, gastroenterologists, and nurses.) There's also an acute need for more human resources staff and medical staff officers, whose jobs are to recruit, vet, and credential new staff. In 2015, the Government Accountability Office found that multiple medical centers struggled to recruit and retain nurses because of massive shortages in human resources staff. Things have only gotten worse, with the process now often taking months to complete.

"It has been very difficult to keep up with the patient load and deal with all the added paperwork and assessments we now have to do," observed a mental health clinician in another VA system. "We know that veterans with a high risk for suicide do better as long as they are followed by the VA. But it takes a lot of effort to do that. If we were fully staffed, no one would complain, but staffing is so low that it is really hard to follow people and assess for suicidality."

Program and Facility Closures

Not only is the quality of care suffering under this vacancy crisis, but, in some cases, whole programs are shuttering. The Brooklyn VA's ear, nose, and throat clinic has closed[15], as has an outpatient clinic in Buffalo[16]. PTSD support groups at the West Los Angeles VA hospital have been shut down[17]. In March 2019, the VA closed a clinic in Kokomo, Indiana[18], less than a year after it opened, despite praise from veterans who said it was increasing access to care. The Trump administration sought to quietly shut down services across the upper-Midwest, including a 29-bed nursing home[19] in Miles City, Montana. This effort was halted largely because of U.S. Sen. Jon Tester (D-MT), the powerful ranking Democratic member of the Senate Committee on Veterans Affairs.

In 2017, Laura Grande, the director of clinical neuropsychology for the VA Boston Healthcare System, scolded a mental health staffer for recommending a Vietnam veteran struggling with alcoholism, night terrors, and other PTSD symptoms be admitted for comprehensive treatment. Grande did this because, as she acknowledged in an internal email, there were not enough "providers or resources to provide individual treatment for all the Veterans that request/needed it." Nearly three years later, things have not improved. According to federal data, the Boston system is grappling with 620 vacancies, including 14 psychologists.

According to internal agency documents, efforts to increase capacity at the North Texas VA Health System, the second-largest in the country, were quashed last year despite internal projections that the patient population is set to increase by 12% in the next decade. Even a small veterans woodshop program in northern New Jersey became a casualty of this belt-tightening[20].

Elimination of the Interim Staffing Program

One of the Trump administration's most disturbing moves was to shutter the VA's Interim Staffing Program (ISP). This critical national service provided physicians, nurse practitioners, and physician assistants when staff retired or went on leave. The program, launched in 2013, reduced the use of costly private sector temp agencies. As an added benefit, the VA's providers were familiar with the system and with veterans' specific healthcare concerns.

According to an analysis by the VHA's Category Management Office, relying on private sector temp agencies created "headaches and inefficiencies," including "delayed services" and "erratic quality control." ISP cost just $2 million in administrative costs in FY 2018 and yielded $11 million in care.

Trump's first VA secretary, David Shulkin, was poised to double the program's size and open it up to new positions, including psychologists. Yet Shulkin was ousted after pushing back[21] on Trump's privatization agenda and was never able to move his plan forward. Last May, the

program's 76 providers were told that it would end. Replacing ISP is a new, more expensive telehealth initiative in which providers treat patients virtually.

In December, 31 former ISP staff sent a letter to Shulkin's replacement, VA Secretary Robert Wilkie, protesting the dissolution of the program and raising concerns over the quality of telehealthcare. Almost all who had left the VA said they would come back if the program were reinstituted.

ISP providers were supported by testimonials from chiefs of primary care services across the country. "When we used the ISP program in the past, we had great face-to-face patient care that not only we appreciated but the veterans really embraced," one wrote in an email provided to VHPI. Wilkie never responded to the letter.

The Trump Administration's "Big Lie"

Wilkie and other top VA leaders contend the VA has never been stronger. Most recently, they point to the White House's historically high VA 2019 budget and 2020 budget requests[22] as evidence that Trump is the most pro-veteran president in American history.

One VA administrator described this as "the Big Lie," which ignores many facts, including that the administration is slyly initiating hiring freezes (euphemistically referred to internally as "pauses") and funneling thousands of patients and billions of dollars into a private sector system largely unprepared[23] to handle veterans' complex problems[24].

Wilkie has admitted that the VA is dealing with millions of more appointments now than in the recent past. He also candidly revealed to the House Committee on Veterans Affairs that, "I would not be honest with you if I told you that my focus would be filling [departmental] vacancies." This posture potentially violates U.S. codes[25] mandating the VA secretary to "maintain the bed and treatment capacities of all Department medical facilities."

In a CNBC story[26] that appeared earlier this year, Wilkie contradicted the number of vacancies reported by his own department. Specifically, he disingenuously suggested that the vacancy rate within the VHA was only 3,000 publicly posted positions on the federal jobs website.

In early February 2020, representatives of major veterans service organizations met with Richard Stone, the VHA's Executive-in-Charge, to question him about the vacancy issue. (Stone's title masks the fact that he is serving in an acting capacity, which means that the highest position in the VHA has been unfilled for three years.)

"When we asked him why they aren't filling the 55,000 vacancies, he disputed the number, insisting that it was incorrect," recalled Rick Weidman, Executive Director of Government and Policy Affairs for the Vietnam Veterans of America (VVA). "So I pushed back and asked him to give me the correct number, and he said they didn't really know. It would be reprehensible if they weren't filling vacancies. It's even more so if they don't even know how many vacancies they actually have."

The VA's Office of the Inspector General (OIG) has issued a half-dozen reports cataloging the rough extent of the vacancy problem in recent years, the last two took on newfound urgency and warned of "severe occupational staffing shortages"[27] across the country. The OIG's most recent vacancy report[28], which was released last September and included analysis from 140 facilities, found 96% of departmental clinics reported at least one significant shortage; 39% reported at least 20.

VA's Leadership Crisis

While vacancies at the clinical-level are delaying and complicating care, VA facilities throughout the country, and at the department's central office in Washington, are also contending with dangerous leadership vacuums.

Last year, the VA's OIG found that 14% of current medical center directors were in an acting or interim role, and that it takes an average of 249 days to transition between permanent medical center directors.

Dozens[29] of top VA officials have resigned or retired since 2016. They include Scott Blackburn, former Chief Information Officer tasked with modernizing the department's electronic health records system; Christopher Vojta, former principal deputy undersecretary for health; Dr. Amy Fahrenkopf, the top official overseeing private care programs; Dr. Harold Kudler, the Chief Consultant for Mental Health Services; Meg Kabat, former National Director of the Caregiver Program; and Kayla Williams, Director of the Office of Women's Health.

Megan McCarthy,[30] who served for four years as the National Deputy Director of Suicide Prevention, left in 2020 to become Vice President of Project 2020 at the American Foundation for Suicide Prevention. Kacie Kelly[31], who served as the National Director for Public-Private Partnerships in the Office for Suicide Prevention, has moved to The Bush Institute. In the Office of Public Health[32], the positions of Chief Consultant for Occupational and Post-Deployment Health and Associate Chief Officer for Program Coordination are also vacant.

A recently departed VA official who served in both the Obama and Trump administrations, who requested anonymity due to ongoing government work, said the high turnover at the central office in Washington meant they had to get new senior leaders up to speed on initiatives every month or two. Due to this and other bureaucratic issues, progress moved forward at a snail's pace.

According to a retired VA Central office official, having acting staff or none at all, "shows the hollowness of the VA system." They continued:

> *The VA still doesn't have an Under Secretary for Health. There's nobody in authority at the top. As a result, people at the local level think, 'Why should I listen to them, they're just temporary or acting?' There are plenty of people in senior VA leadership, in central office and in the field, who still rely on a confirmed Under Secretary and who are still waiting for that star to rise in the East. They believe that until that position is confirmed*

> *and there are key leaders confirmed up and down the hierarchy, there will be no stability on which to base future policy and practice.*
>
> *The VA is not doing anything with any punch. It's afraid to set its own policy, to imagine its own future because that's not something a bureaucracy does until someone is appointed.*

Multiple current and former VA officials said this is Trump ideology in action: ensure the government doesn't work and destroy the "deep state."

A Case Study of the Brain Drain

Kayla Williams[33]' tenure as the director of the Center of Women Veterans provides a vivid example of how agency attacks can push top talent out the door.

Williams served for five years in the U.S. Army. During a 2003 deployment to Iraq as an Arabic linguist in a Military Intelligence company in the 101st Airborne Division, Williams met her husband, Staff Sergeant Brian McGough[34], also in the 101st. It was on this deployment that McGough suffered life-threatening injuries when an Improvised Explosive Device hit a bus he was traveling on.

Williams has written poignantly[35] about her service and marriage with McGough. In 2013, she received the White House Woman Veteran Champion of Change Award. In May 2016, she was appointed as VA's Director of the Center for Women Veterans with a mandate that included increasing access and utilization for female veterans to the department. Today, while women make up roughly 10% of the veteran population (and growing), they represent only 7.5% of the VHA population. In an interview, she explained the importance of the VA for women veterans:

> *The VA provides high quality, culturally competent care. VA has the highest rates of breast and cervical cancer screenings of any healthcare system in the country. Moreover, most providers in the private sector don't even know what Military Sexual Trauma is, much less know what kinds of treatments are evidence-based to provide mental healthcare for it. The VA, on the other hand, understands women's specific military experiences and risks and is able to give women veterans the support and services they need - at lower cost.*

Under Williams's leadership, the Center launched numerous initiatives to educate staff and patients about the needs of female veterans and make them feel welcome. One of the things she says she is most proud of is the creation of a pioneering digital communications outreach

program that sent out emails, newsletters, news roundups, health research roundups, and more to female veterans.

The Center also launched VA initiatives highlighting women veteran artists and athletes. Images of women veterans were displayed, she says, at VA facilities across the country. A nationwide VA "baby shower" the Center spearheaded under her watch, provided essential items for 2,500 new veteran mothers at dozens of the nation's VA medical centers.

These accomplishments seemed to hold little weight with the Trump administration. This was made crystal clear during a media kerfuffle over outside efforts to change the VA's mission statement to be inclusive of women. Groups like Iraq and Afghanistan Veterans of America (IAVA) wanted to change the VA motto, which is a quote from President Lincoln's second inaugural address, to use more gender-inclusive language.

The VA had already begun informally using an updated version, but the White House opposed any change. Williams advised either formalizing and announcing an update or not responding to IAVA's request, but, she says, followed "a direct order by the chief of staff to send a letter" announcing that VA would not be making a change. When IAVA went to the media[36] with their concerns, VA Press Secretary Curt Cashour told[37] reporters that Williams had not followed proper procedure.

"If you have the press secretary of the organization you are working for lying to the media about you, it is not a good sign," Williams said. Soon after, she left the VA and is now working at the Center for New American Security.

History of the Vacancy Crisis

The VA has long faced difficulties recruiting and retaining staff. Some of these problems are due to forces beyond the VA's control and plague private sector healthcare systems as well. They include critical shortages of primary care[38] and mental health professionals[39] and challenges enticing staff to practice in rural areas[40], where over a quarter[41] of the nation's veterans live. It's also challenging to staff systems where there are annual influxes of snowbird veterans moving South or West during the winter months.

Congress' Funding Failures

Other problems are due to Congress' failure to fully fund the VHA. These long-standing problems were exacerbated as the wars in the Middle East ramped up with little requisite planning on the VA's end.

"When we go to war, we know how we are going to organize our footprint in theater and use the Department of Defense's (DOD) medical assets," said Terri Tanielian, Senior Behavioral Scientists at the RAND Corporation, who has spent years researching veterans' healthcare. "We stop wargaming for the VA. We never plan far ahead. We went into these wars without thinking about the need to increase capacity for an impending influx of veterans."

There were efforts to boost the VA budget to account for the massive military buildup, but they faced stiff opposition from the right. Leading this charge was the late Sen. John McCain (R-AZ). Over the course of the First Gulf War and in the early stages of the war in Iraq, McCain repeatedly voted against necessary VA budget supplements[42] and floated the idea of department privatization as early as 2008. As a result, groups like Disabled American Veterans (DAV) and Iraq and Afghanistan Veterans of America (IAVA) gave the maverick senator poor scores[43] on their legislative report cards.

McCain also opposed VA legislation sponsored by Sen. Bernie Sanders (I-VT) – S. 1982[44] – which was crafted with the input of VA leaders and all the major veterans service organizations. Sanders' bill would have infused the VHA with $24 billion for hiring and infrastructure improvements. It would have created an education and peer support program for military family members and caregivers with mental health disorders, expanded veteran dental care, enhanced care related to sexual trauma, and boosted offerings in complementary and alternative medicine. The legislation did not pass either chamber.

Not only did McCain vote against it, but his opposition in the Senate encouraged other Republicans to vote it down. Republicans insisted that this allocation would "bust the budget."[45] Adamant opponents of the bill included Sens. Mitch McConnell (R-KY) and Jeff Sessions (R-AL). They gave impassioned speeches[46] from the floor, assuring the public that the nation's veterans would not want this kind of taxpayer money devoted to their care.

All of this Republican hand-wringing over new spending ignored the context in which the VA was operating. The department was not only treating a new generation of post-9/11 veterans but had also just added three new health conditions as presumptively tied to Agent Orange exposure. This policy change, which was hailed by veterans' advocates of all stripes, allowed hundreds of thousands of Vietnam-era veterans to file benefits claims and access care.

Staffing Crisis and the Problems in Phoenix

It's under these conditions that the defining scandal of the VA emerged in 2014, at the Phoenix health system. There it was discovered that administrators were tampering with scheduling data, leaving veterans to wait months for appointments. Lawmakers, lobbyists, and the Koch-funded Concerned Veterans for America framed the scandal[47] as evidence of deep-seated incompetence and corruption inside the department. In large part, these practices represented an attempt by an understaffed system to meet demanding – and some contend, unrealistic – wait time metrics.

> When you overlay the hospitals with the most severe shortages and the longest wait times, it becomes even more apparent the VA is dealing with Phoenixes all across the country. The Atlanta VA Medical Center, for instance, has reported the highest number of severe occupational shortages in both 2018 and 2019 and currently faces wait-times of up to 41 days. Late last year, surgeries were temporarily halted in Atlanta due to, among other things, staff shortages.

The Phoenix affair spurred the enactment of the Veterans Access, Choice, and Accountability Act.[48] This law made it much easier for veterans to seek care in the private sector and ignited a deeply divisive national debate over the government's ability to deliver health care. Tucked into the law was $2.5 billion to hire more staff. Yet, according to a 2017 NPR investigation[49], only a few thousand hires were made. A major reason for this disappointing result is that the hiring money was not nearly as generous as publicly projected. It essentially replaced, not augmented, the VA's hiring budget.

What has not been reported is the VA leadership's refusal to interpret the law as Congress intended. The funding included in the law by Senator Sanders was supposed to be utilized for both facilitating the hiring process – through increased advertising, recruiting, and onboarding – and also for paying salaries of new employees for the two year funding period. This multi-year funding was designed to bridge the lag time between when these providers were initially hired

and when VA's internal accounting process - known as the Veterans Equitable Resource Allocation (VERA) - would reflect the increased demand some three years later.

In the first year of the program, there was a substantial increase in hiring. In the second year, however, facilities who hired these providers were forced to cover these new providers' salaries, rather than having those salaries paid for out of the centralized Choice funding. When lawmakers were alerted to this, they learned that the administration had interpreted the law incorrectly, believing they could only use the new funds to pay for job advertising and hiring processes, and not salaries. Despite these concerns, the VA did not change its interpretation. As a result, many facilities experienced budget shortfalls, requiring them to enact hiring freezes, even though veteran demand for these services was high. The budget shortfalls were not due to excess staff or low patient demand, but instead a broken budget process that didn't reflect veterans' desire to seek needed care.

The Phoenix incident led to the escalating outsourcing of veteran care to the private sector and ushered in an era of unprecedented VA bashing in Congress and the media. Early attempts to strengthen the VA in the Senate were quickly quashed by zealous privatizers in the House. These efforts were led by Jeff Miller[50], then the Republican Chairman of the House Committee on Veterans Affairs.

Miller, a former TV weatherman, disc jockey, real estate broker, and deputy sheriff, relentlessly lambasted the VHA, its post-Phoenix Secretary Bob McDonald, and then-Under Secretary for Health, David Shulkin, who became Trump's first VA Secretary.

Even after Phoenix died down, Miller attacked the VA for giving employees modest bonuses and spending minuscule amounts on art[51] in its facilities. In one bizarre instance, he went after Secretary McDonald for alluding to Disneyland[52] in comments about VA care delivery. Neither Miller nor the veterans' advocates who echoed his criticisms acknowledged that private sector hospitals are routinely praised for the use of art as an adjunct to healing[53] or that there is a movement in healthcare to follow the practices of Disney in the running of hospitals[54]. Once again, the VA and the private sector system were judged on different criteria. Miller was able to promote his anti-VA message so effectively because, under his leadership, the House Committee Veterans Affairs had a campaign-style press operation. The Senate Committee on Veterans Affairs did not prioritize media relations, which hampered its ability to effectively counter Miller's attacks.

With the media serving as an echo chamber for the rightwing critique of the VHA, many staff became demoralized. When co-author Suzanne Gordon interviewed VA staff in the wake of the

scandal, many frontline caregivers were dismayed at the hostility exhibited towards them. "Why do they hate us?" was a question routinely asked.

Kenneth W. Kizer, perhaps the most prominent previous VA Under Secretary for Health, wrote eloquently on this unfortunate trend in the foreword to Gordon's 2017 book "The Battle for Veterans Healthcare"[55]:

> *When the VA suffers from a shortage of primary-care physicians or psychiatrists, it is castigated for failing to fill staff vacancies. This is without regard to the fact that a national shortage of these professionals has created similar problems for many other health systems or that the government's below-market-value salaries materially confound the VA's efforts to attract medical specialists.*
>
> *Or, when a veteran becomes addicted to opioid painkillers or comes into the VA after having become addicted while on active duty, the VA caregivers are blamed for overusing these drugs without regard to the current national epidemic of opioid overuse and the fact that healthcare providers everywhere are struggling to find ways to adequately manage pain without using too many opioid drugs.*
>
> *Similarly, when the VA spends a pittance on artwork or an aquarium to help create a comforting and soothing environment in its facilities, it is attacked for wasting money, while private-sector hospitals are lauded and celebrated for spending much greater amounts to decorate their lobbies and hallways.*
>
> *Clearly, the VA's shortcomings cannot be overlooked or excused because similar problems exist in other healthcare settings, but a more balanced and constructive conversation would be less demoralizing to the thousands of VA employees who go above and beyond the call of duty to provide veterans with high-quality care.*

Weaponizing Accountability

Phoenix also ushered in a push for "accountability," with Republicans insisting that there were too many job protections for corrupt managers. As evidence, some pointed to the case of Sharon Helman, a director at Phoenix who was proposed for termination but ultimately retained her job after bringing and winning a federal suit.

The accountability debate played out most vividly in a tense Senate floor exchange[56] in May 2014 between Sens. Sanders and Marco Rubio (R-FL).

"You are more likely to receive a bonus or promotion than you are to have been fired because of mismanagement and dereliction of duty," Rubio said on the floor. "And that is completely unacceptable."

"I do not want to see the VA politicized," Sanders shot back. "It is one thing to say — which I agree with — that if a hospital administrator is incompetent, the secretary should be able to get rid of that administrator without a whole lot of paperwork. I agree with that. It is another thing to say that if a new administration comes in — whether it's a Democratic or Republican — that somebody sitting in the secretary's office can say, 'I want to get rid of 20 or 30 or 50 hospital administrators because we have other people we want in there.'"

"I worry about that," Sanders said.

While Sanders successfully fought efforts to institute draconian accountability measures in 2014, he could not stop the Trump administration from enacting an equally problematic law that passed three years later.

The Trump Era

After Trump was sworn in, he purged most agencies of Obama-era officials and gave the boot to Secretary McDonald. But in the end, he elevated David Shulkin, another Obama-era official, to the department's top post. This move excited many veterans' advocates and Capitol Hill staffers, who, ignoring Shulkin's record on privatization[57], felt that, perhaps, the VA would move forward relatively free of politics.

This optimism was short-lived. Trump quickly became laser-focused on the VA, signing into law a dozen major bills regarding the agency in his first two years in office. Perhaps the most controversial was the VA Accountability and Whistleblower Protection Act of 2017[58].

Trump signed the law, his first major legislative achievement, that June with great fanfare. In an interview with The New York Times[59] after the bill-signing, Shulkin pledged that the law would not be abused. "The purpose of this is not to do firings," he said. "The purpose of this is to set the culture and the standards at the VA."

Yet within months, thousands of front-line employees had been proposed for termination, suspension, or demotion[60]. Senior managers were largely let off the hook[61]. The law gutted due process protection for employees and took away tools like Performance Improvement Plans, which gave struggling staff a second chance. It's worth noting here that one-third of VA employees are themselves veterans, many of whom are employed through the department's pioneering compensated work therapy program[62], which brings economic stability to veterans with a history of mental illness or homelessness.

The 2017 law established the shadowy Office of Accountability and Whistleblower Protection. While publicly projected as a tool to crack down on corrupt leaders, the office has been used to target local union leaders, often for specious reasons[63], from keeping a company car at home over the weekend to failing to meet stringent new work standards.

Last year, the VA's OIG found the office is often "alienating to the very individuals it was meant to protect.[64]" It further reported that office leaders failed to draft or implement standardized procedures, ineffectively trained VA investigators, and, on numerous occasions, retaliated against whistleblowers in the service of protecting bad actors.

In March 2020, the Project On Government Oversight[65] released a scathing report that found, among other things, the office's leader, Tomara Bonzanto, created an anxiety-ridden environment. In her first meeting, she "viciously verbally attacked" an employee who was seeking clarity on handling evidence. Bonzanto later had her deputy monitor staff for "appropriate body language." This office has taken in roughly 2,000 whistleblower complaints but, as of late 2019, produced only one recommendation for disciplining a senior VA leader.

As fired VA employees have sought to be reinstated, their cases have been held up by the Merit Systems Protection Board (MSPB), which Trump has also gutted[66]. Steve Robertson, a former legislative director of the American Legion, said this dominant ethos of punishing staff and insisting on "accountability" has wrought incredible damage to the department. Robertson said it "no longer made sense for people to prioritize VA when seeking government work. Why would someone come to work at the VA when they could work at the DOD or NIH or other agencies where there are more protections?"

A VA central office staffer expressed his trepidation with taking a leadership position. "I would never volunteer to have my life and work run up the flagpole and ruined in The New York Times over a misunderstanding or a medical issue," he said.

This approach contradicts best practices in management. "The backbone of the VA Healthcare System is its army of highly dedicated clinicians, administrators, and other healthcare workers," Kizer has written. "I know from my tenure with the VA that, if appropriately supported and led, the VA's dedicated staff will provide a level of service and care that millions of Americans can only wish they would receive from their healthcare providers."

Gutting Labor and Endangering Staff and Patients

The Trump administration has sought to gut its master agreement with the American Federation of Government Employees, AFL-CIO (AFGE) and revoked union time for virtually all clinical employees[67]. This has inhibited the labor union's role in negotiating fair treatment by leadership and closed union offices across the country. (As this anti-union work ramped up 2019, nearly 130 lawmakers[68] accused the administration of anti-union tactics.)

Patty Nash, a nurse in the hospital's intensive care unit and the local AFGE president at the VA hospital in Huntington, West Virginia, said this crackdown has made it difficult for workers to freely raise issues around quality of care. "I now have to be in here an hour or two every day after work to draft union grievances or EEO complaints," she said.

This labor crackdown has complicated the ability of front-line workers to share expertise and safety concerns as the coronavirus pandemic rips through America.[69]

M.J. Burke, who works out of the Indianapolis VA and serves on AFGE's National Veterans Affairs Council, has seen a troubling spike in staff getting sick from COVID-19. She and other union representatives say the VA hasn't listened to their demands concerning everything from Personal Protective Equipment (PPE) requests to training sessions to deal with this virus. In early April, Burke received an email informing her that a VA nurse exposed to COVID-19 continued to be scheduled on shifts.

"She continued to work, unbelievable, I know," a staffer with knowledge of the situation wrote Burke in the email. "She's sick now, called in today, these are safety violations." Indianapolis VA medical center representatives and the office that sent the quarantine-shortening email did not respond to requests for comment.

"When you're a union person, your job is to make people safe and secure," Burke told VHPI, on the edge of tears. "And I feel very hopeless. Everything's out of control. My people should be quarantined if they are exposed at a low or high level."

Punitive Management

Just as front-line employees' rights are jeopardized, other staff are increasingly demoralized – with some leaving the VA – because the Trump administration seems to have empowered middle-level managers whose punitive practices are creating a culture of fear and retaliation at hospitals across the country. These problems are not, of course, unique to the VA. Recruiting and training competent and effective managers in America's hospitals is a systemwide problem, as is evident in the ever expanding literature[70] on the failures of hospital leadership and how to remedy them[71].

At the VA, punitive practices are sometimes enforced by the VA Police, a largely unchecked force with lots of power and a history of abuse[72] on VA campuses, including against veterans. At the VA in Milwaukee, Wisconsin, human resources staff summoned police to pressure union leaders to move forward with an arbitration on a case. At the VA in Pittsburgh, Pennsylvania, a union official was handcuffed and later charged for obstructing governmental operations after demanding to know why police were interrogating one of his fellow union members.

Last year, the VA's OIG documented cases where qualified applicants backed out because there is now "little recourse for staff to defend themselves from allegations." One medical director told the VA watchdog of the anguish he experienced after the media portrayed him as responsible for a veteran death even as a subsequent investigation cleared him.

While the most recent departmental employee survey[73] suggested improving morale, there were still many warning signs. Just 41% of employees felt strong feelings of trust and confidence in their supervisors. Only 24% felt deeply that their senior leaders maintained high standards of honesty and integrity. Many feel that local or regional leaders have abandoned them.

Case Study: Northern California and Memphis

Some mental health professionals have described stories of departmental managers who have created a hostile work environment.

In Northern California, psychologists told us that managers were very unsupportive. For example, they arbitrarily changed alternative work schedules, which allow staff to supplement low VA salaries or accommodate child care responsibilities. This flexibility is greatly valued inside the department. Indeed, when the Government Accountability Project[74] surveyed exiting VA staffers in 2017, they found a majority were generally satisfied with their jobs. Half said that

more benefits – like alternative schedules or tuition assistance – would have encouraged them to stay.

Staff sought to halt this move in meetings, but with no luck. "There was simply no justification for it," one psychologist said. "It turned everybody's lives upside down. People had taken other jobs, or were teaching, or this interrupted child care arrangements. For me, it was the last straw."

Although the managers in question were either moved or resigned, this mental health professional commented that, "What we experienced is a VA wide problem...People who want to privatize and close down the VA are making some inroads. They are succeeding through all sorts of draconian demands that are under the guise of improving care that are doing nothing but making it harder to provide care. It's going to be harder and harder to sustain the VA system."

In Memphis, five psychologists and psychiatrists told VHPI that poor management from their Chief of Mental Health Services have led staff to leave the VA.

Mental health professionals explained that the work environment became toxic. Vacancies were not filled and staff were increasingly overburdened. Mental health professionals could no longer hold lunch-hour meetings to strategize about staffing shortages and coordinate care. "Patients were coming up to me and telling me to look out for myself," one psychiatrist said. "It was as if I were dying, they would tell me how glad they were to have had time with me." Leaving the VA, this psychiatrist said, "was the hardest decision I have ever made. I enjoyed working with veterans so much."

According to Kathleen Pachomski, president of AFGE Local 3930 and a retired VA nurse, there was a special investigation done recently whereby the psychologists in mental health made a complaint to the VHA's Veterans Integrated Service Networks (VISN) 9 director, Cynthia Breyfogle, and VA central office. "They sent some folks in from the VISN to do an investigation. It's a mess," Pachomski concluded, adding that the system's training program as well as programs and efforts to wean veterans from opioids are suffering as a result. Despite a continuing stream of complaints and staff departures, internal investigations continue to support the administrator.

Sources told VHPI that more than 20 licensed independent providers, including at least 12 psychiatrists and eight psychologists have left the VA. They said there has been a reduction in inpatient psychiatric beds – from 32 to 16 – and overwhelmed providers in the mental health clinic. Responding to the coronavirus crisis has exacerbated this already difficult situation.

VA's Sluggish Hiring Processes

When VA hospital leaders work diligently to attract talent and shrink their vacancies, they must contend with the department's arcane and complex hiring process, which can take months to navigate.

The VA workforce is covered by multiple statues and different collective bargaining laws that vary according to professions. What people get paid in the VHA is also extremely complicated because three different personnel systems cover the workforce – Title 5, Title 38 and Title 38 Hybrid Employees.

Under Title 5, pay for non-clinical staff as well as a shrinking number of VHA support staff, like housekeepers, police and maintenance workers, is still under the traditional federal GS wage grades systems that are primarily set by Congress and federal regulation. VHA clinical staff are covered either by the Hybrid Title 38 or the full Title 38 legislation. Hybrid Title 38 governs the compensation of a large group of VA health care staff, including psychologists, social workers, and other mental health and medical personnel (other than psychiatrists). Compensation is based on the GS system but gives management more discretion over GS levels for hiring, promotion, and retention pay. In contrast, psychiatrists and other physicians, as well as dentists, registered nurses, physician assistants, podiatrists, optometrists, chiropractors, and dental assistants are covered solely by Title 38, which gives local medical center directors broad discretion over most aspects of compensation. With regard to Title 38 compensation, Congress has enacted subsequent legislation aimed at pay for individual professions.

For example, in 2004, Congress passed Public Law 108-445[75], which amended Title 38, to "simplify and improve pay provisions for physicians and dentists and to authorize alternate work schedules and executive pay for nurses." Unions that represent VHA employees, like AFGE, have contended that the way VA leaders have implemented this law, which Congress enacted to make physician and dentist pay more competitive with local markets, has violated its intent.

They have submitted a variety of recommendations, notably in 2013[76] and 2015[77], to Congress about how to improve recruitment and retention processes within the agency. The union has also raised concern with Congress about the fairness and adequacy of pay for positions within each of the three personnel systems. The union has also attempted to address these problems through collective bargaining. AFGE representatives contend that the VA has interpreted Title 38 collective bargaining laws in ways that preclude any bargaining over any aspect of compensation, which AFGE argues is also contrary to Congressional intent.

Competing with the Private Sector

The pay rate for VA employees is further complicated by the fact that the VA is often unable to compete effectively with the private sector. By law, no federal employee can make more than $400,000 –- the salary of the President of the United States. A VA facility chief of staff noted that an interventional radiologist or cardiothoracic surgeon could easily earn more than $500,000 in the private sector. According to the VA's OIG, VA hospital directors make roughly 25% less than their private sector counterparts, yet many hold greater responsibilities.

Although working at the VA offers many rewards unavailable in the private sector – like the opportunity to work with and give back to veterans, avoid the hassles of dealing with insurance companies, and deliver truly coordinated care – they may not always compensate for the high cost of living in many urban areas. To cite one particularly stark example, the Palo Alto VA Health Care System is grappling with a whopping 984 vacancies, in large part because potential staff are unable to afford a home in the region, which averages nearly $2.5 million[78].

At the 2019 Palo Alto annual medical staff meeting, employees were informed that the slate of services offered would soon be cut, in part to reduce the number of vacancies on the books. "They told us they are trying to figure out what to eliminate because they feel it's impossible to fill all the vacancies," said one of the meeting's attendees. "Leadership said this work will better 'align the system with national priorities,' whatever that means."

Apart from the significant salary issues, the VHA is saddled with cumbersome hiring procedures. Some critics, like unions that represent VA employees, argue that there is no reason VHA cannot be more agile in its hiring and that its processes are a result of incompetence and deliberate "foot-dragging."

Whatever the interpretation, many who have gone through the system say hiring proceeds at a snail's pace.

A Broken Hiring Process Meets an Inadequate Budget

Despite attempts in recent years to reform the hiring process for clinical staff, it still involves multiple offices and entities that work in a linear rather than parallel fashion. It is not uncommon for the VHA to lose well-qualified, eager candidates who simply become tired of waiting and shift to the private sector. While the actual cause of a delay varies by facility, administrators often struggle to balance competing staffing needs in an environment racked by budgetary uncertainty. Often, VA facilities won't begin the hiring process when an employee announces their departure, but rather after they leave.

Rajiv Jain, an oncologist and former Chief of Staff at the Pittsburgh VA who most recently served as former Assistant Deputy Undersecretary for Health for Patient Care Services, said that even if a search is launched to replace an employee as soon as he or she announces her planned departure, the department often becomes blocked by the prohibition against "double encumbering" – or temporarily paying two people to do the same job. This is out-of-sync with practices in the private sector and can lead to a steep learning curve for new staff, as they aren't able to shadow the people they are replacing.

Another significant hurdle is getting permission to fill a vacancy. When it is clear that an already existing position will be vacated, there is no automatic greenlight or authority for filling it, says Russell Lemle, a VHPI senior policy analyst who retired as Psychology Director of the San Francisco VA Health Care System last year.

Department chiefs must first go to a facility review committee – usually composed of the system director, chief of staff, associate director, chief nurse, head of HR, and representative of finance. These administrators manage the budget and will decide if there is money to fill a vacancy or create a new position. "Requests are submitted every week, especially in a large VHA facility, and the request may not be reviewed for weeks or months," Lemle said.

If there is a budget shortfall and multiple vacancies exist, departmental heads must compete for prioritization of their requests. Hiring a neuro-surgeon or interventional cardiologist may take precedence over hiring a primary care physician or social worker.

This can lead to a perception that the senior management at a facility values certain professionals more than others, say nurses over doctors, specialty care over primary care, or mental health over specialty care. One VA psychiatrist, for example, argued that VHA medical center directors often fail to appreciate the value of mental and behavioral health services:

> *Health care administrators at the VA are drawn from the American population. So directors have no trouble talking about radiologists, or surgeons or anesthesiologists but psychiatrists? Their attitude may be, "I don't know about those people." If medical center directors have a limited pot of money, many don't consider mental health professionals to be critical. They would rather spend the money on a surgeon or radiologist.*

Human Resources Obstacles

Even if the pot of money was significantly expanded, other obstacles stand in the way of speedy action to fill vacancies or add new positions, chiefly that the offices which play a critical role in hiring have faced severe shortages for at least a decade.

Human resources staff and medical staff officers are tasked with recruiting, vetting, and credentialing new staff in an expedited manner. In 2015, the Government Accountability Office found that multiple medical centers struggled to recruit and retain nurses because of massive shortages in human resources staff. (According to the OIG, the top non-clinical vacancy job across the department is for human resource management. Current VA staffing data shows there are over 2,000 HR shortages across the department.)

If overburdened HR staff can be quickly assigned to a case, they must navigate a complex world of rules and regulations. First they must look to the government preferential hiring[79] rules for veterans[80], which, while laudable, add a complex layer to the start of the process.

If a job search is to be extended beyond known candidates, a listing is posted on USAJobs.gov, which also adds delays. All applications must be read and rated. Search committee members have to meet to confer on who are the top candidates. Those finalists have to be interviewed at a mutually convenient time for the committee members. At that point, Lemle said, "things slow down rather than speed up."

In a laudable effort to ensure fairness in the process, all candidates must be asked the same questions and interviewed in the same manner. Candidates who live nearby cannot be given the advantage of an in-person interview, while a candidate who lives hundreds of miles away is interviewed by phone, or via V-Tel, the VA's video system. "All this can take time – maybe from six weeks to four months – because people on the hiring committees are busy and HR staff overloaded," Lemle said.

Once all the finalists are interviewed and an individual is identified, HR is notified, and then the chosen candidate must be vetted, including a security review. The candidate must have a physical exam, and if he is a male, must have registered for the Selective Service by age 26.

Then comes another hoop. The Medical Staff Office must make sure all candidates for clinical positions have the right qualifications, hold a current unrestricted license, have no malpractice cases against them, and face no extended gaps in providing clinical care. Written professional references must be sent to the VA and then reviewed. Because of short-staffing, all of this takes an inordinately long time, sometimes as long as three months.

If a candidate gets through all these hurdles, there are several more to go. Prior experience has to be reviewed in order to determine a starting salary. The decision to hire has to be approved by the medical center director. If his or her answer is yes, a candidate is put in line to be given a start date, which could be weeks away. Then comes an onboarding process that includes an orientation and new employee training.

"You could wait another six weeks for a start date if there are a lot of hires, and HR has a lot of paperwork to onboard," Lemle said. "It was incredibly frustrating. In the interim, existing staff had to cover the gaps by adding to their already heavy workloads."

Budget Shortfalls and VA Hiring

When questions about VA privatization and the internal staffing crisis arise, Trump allies proudly boast that, on the president's watch, the VA budget has hit historic highs. There is plenty of money to spend on hiring and care, they insist. What this claim fails to mention is that a major driver of Trump's VA spending is on private sector care, which now makes up nearly 20% of total[81] healthcare spending.

As a result, VA hospitals are still being starved. Rather than having plenty of money for recruiting and retaining staff, two senior VA administrators have told VHPI that 14 out of 18 of the VHA's integrated service networks are virtually out of money. They, as well as other sources, also point out that the 2019 budget did not provide funds for Cost-of-Living Adjustment (COLA) increases for staff and/or cover the cost of each medical centers' increased contribution to the Federal Retirement Plan.

"Maybe someone up there is sitting on a pot of money but no one knows," one administrator said. "Some people think they are sitting on the money to cover the costs of community care, which is costing who knows what." A senior Senate aide confirmed that there are "instances where VA folks are being told to tighten their belts because a lot of money is going out into the community."

So far, the VA has refused to brief lawmakers on the initial costs of community care through the MISSION Act. This is part of a trend of VA-Capitol Hill intransigence, especially towards the Democratic-controlled House, whose staff last year were blocked from overseeing the rollout of the VA MISSION Act[82] at departmental hospitals across the country.

Yet even as the department sinks untold amounts of money into administering the parts of MISSION that benefit corporate actors, some are concerned that the parts of the bill that were most sought after by membership-based veterans organizations are being neglected.

These additions would help expand one of the VA's signature accomplishments of integrating mental health and primary care. One of the MISSION Act's mandates promised to amplify an Obama-era program to support peer specialists – veterans who have themselves overcome mental health or substance abuse problems and are specifically trained to work in mental health. Section 506 of the MISSION Act mandated the hiring of 60 peer specialists to work in 30 sites in primary care centers around the country.

"Those of us who agreed to participate in this were surprised that there was no appropriation to cover the salaries for the peers, which would be only a few million dollars," one VA staffer said. "Some of us had to drop out, even after the VA found the money internally since it was only assured through 2021. After that, our facility would have to come up with the funding, which means competing with other needs in the hospital. So we had to pick between hiring a peer or a therapist who could treat PTSD or opiate dependence."

Solutions

While solving the VA vacancy crisis can seem daunting, the solutions are far from a mystery. The solutions we discuss here result from our research, as well as in-depth interviews with health care leaders, subject matter experts, and have also been discussed in Congressional committees and government reports.

Calculate the Budget Based on Current and Projected Need and Demand

Congress must allocate enough money to fully fund and staff the VA. This will require calculating the VA budget based on the expected future demand, not, as is currently done, on the prior year's utilization.

Staffing shortages can impact a facility's utilization. If, for example, in year one, a clinic only has enough funding to care for 100 veterans, when, in fact, many more eligible veterans want care, then in year two, the budget will be based on the needs of 100 veterans, not the hundreds more who may be waiting in the wings.

Under the MISSION Act this problem has been exacerbated. New mandates that shift patients – and funds – to the private sector regardless of patient preference, ensure lower utilization at VA facilities. When the next years' budget is calculated, utilization has therefore been reduced, which, in turn, justifies a reduced budget allocation. The spiral circles ever downward and money that could be used to expand VA staffing and improve infrastructure – like the exam rooms needed to accommodate more staff – is shifted to the private sector, ensuring even lower utilization and staffing and increased privatization. This way of calculating the VA budget guarantees that staffing shortages not only remain but worsen. Not only is there no money to hire new staff, demoralized staff, as we have seen, are driven out of the VA entirely which leads to decreased utilization and waning budget allocations.

The only way to reverse this downward spiral is to base budget calculations on a comprehensive staffing model that covers all occupations and effectively projects care needs (and veteran preference) into the future. This calculation must account for how many veterans will need care now and in the future, as well as predict the emergence of new treatments and procedures, new pharmaceuticals and their increased costs, and the possibility of new Presidential mandates that add to the workload of VA staff. According to the VA's OIG, the department already collects this data and needs to utilize it better.

Streamline the Hiring Process

Additionally, the VA should effectively implement recent Congressional directives aimed at streamlining and bolstering the department's approach to hiring. This includes offering better pay to physicians' assistants, bolstering tuition assistance, and raising relocation bonuses.

"Congress has worked really hard in the last handful of years to give VA more tools to actually recruit and retain qualified professionals to work with the agency," a senior Senate staffer told VHPI. "But we have to routinely go to the VA and see whether they are or are not using these authorities."

An example of this comes in two critical positions: medical officers and nurses. Because these two jobs have seen severe shortages since 2014, VHA was empowered to appoint individuals to these roles quickly. Yet late last year, the OIG found that despite this flexibility, the department had made little progress in hiring for these positions.

Fill Key Roles

These reforms would be made much easier if the VA had a permanent Under Secretary and Principal Deputy Under Secretary for Health and filled other key positions.

There's also leadership positions to be filled at the facility and VISN levels. With 14% of medical center directors now serving in acting or interim roles, it makes sense that some may not be working to bolster their facilities for the long-term. The department should look to stabilize leadership positions across the system through better pay and more benefits and enact new expectations that recruitment and retention are top priorities.

The VA could make this mission easier by remedying cumbersome hiring practices, in large part by conducting various parts of the process simultaneously. The policy on double encumbering could also be reconsidered and all VHA facilities should initiate recruitment well before a position is vacated.

Competitive Benefits

The VA could also offer more benefits, like paid family leave, and recategorize more employees under Title 38, which allows the department to offer them more competitive pay. In some facilities, as part of the COVID-19 response, bonuses of only 10% have been given to those employees covered by Title 5 and hybrid Title 38 while Title 38 employees, whose salaries are

higher, have been given 20% bonuses. This kind unequal treatment should be abandoned no matter what "title" the employee falls under. This is particularly disturbing during a pandemic when all employees are risking their lives to care for veterans.

Recruitment Must Be a Leadership Priority

For his part, former VA Secretary Shulkin wants the federal government to overturn the rule barring federal employees from making more than the president. "That rule never made any sense to me," Shulkin told VHPI. "The president's salary is unrelated to anything we do at VA. What does it have to do with the VA being able to hire the best doctors to take care of our nation's heroes?"

If VA increases recruitment, a top initial target should be HR staff. However, as former VA Secretary Robert McDonald told VHPI, recruitment should not be the sole responsibility of HR. "Recruitment is a leadership responsibility," he said. "You have to go out there and talk to doctors and nurses and inspire people to join you."

Rick Weidman, Executive Director for Government and Policy Affairs at the Vietnam Veterans of America, suggested that hiring could be more centralized and that the VA could directly reach out to military service members who work in healthcare to recruit them to work at the VA once they are discharged. "You may not get all of them, but you'll get a lot of them and some might be interested in working in rural areas," he said.

Veterans healthcare advocates have also suggested expanding the Uniformed Services University[83] (USU) – a federally funded program which now educates physicians, nurses and biomedical scientists to work in the military. During his tenure, McDonald said that he approached the USU and got several dedicated slots for VA. "We got maybe three," he said. "It wasn't a lot but it was a beginning,"

Congressional Leadership

Congress must treat the VA and its employees like an investment to be managed and strengthened - not as an institution to bash in order to achieve social media and punditry celebrity.

The VA's own data suggests that potential recruits are nervous to enter an agency with a bad reputation and weakened labor rights. The VA must meaningfully examine its culture, and

improve it. Leaders should better examine survey data from those leaving the department and institute new programs to mitigate regrettable losses.

Former VA Under Secretary for Health, Kenneth Kizer offered perhaps the most critical advice to both Congress and the VA leadership: Stop the VA bashing. "When you have talented and well credentialed people who are shouldering a very heavy workload, you have to create an environment that supports them," he said. "That's not rocket science."

Hiring Isn't Impossible - Coronavirus Response Proves It

Time and again, the department has shown itself capable of hiring many staff in a pinch. During his tenure, Secretary Shulkin quickened hiring processes significantly and implemented a predictive staffing program using VA data that allowed officials to anticipate shortages at the facility level, and act to stem problems. In some cases, the VA held job fairs that led to same-day hires. Most recently, as the coronavirus has ripped across the country, the VA managed to hire 3,183 new staff members[84] in over just two weeks, 981 of whom are registered nurses. These practices should be continued after the pandemic abates: VA's staffing problems should be considered an on-going emergency.

Contact VHPI

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Do you have ideas of how to improve staffing at the VHA? Have your own story about hiring challenges at your local VA? Want to tip off VHPI to other areas worth investigating? Please email your comment to Brett W. Copeland at ExecDirector@VeteransPolicy.org

About VHPI

The Veterans Healthcare Policy Institute (VHPI) is a 501(c)3 non-profit (EIN: 82-0680624) that empowers veterans and provides clear information to decision makers that leads to better healthcare outcomes for veterans. VHPI was founded by veterans and their caregivers, healthcare providers and professionals, and healthcare journalists in 2016.

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