**NPC Agenda:**

 

**NPC Members:**

Alma Lee- AFGE Bill Wetmore- AFGE

Burke Mary-Jean- AFGE Irma Westmoreland- NNOC/NNU

John Stead-Mendez- NNOC/NNU Jeffrey Shapiro-NFFE (Not present)

Kevin Mitchell- NFFE Claudia Moore-NAGE

Mark Bailey- NAGE David Palmer-SEIU (Not present)

Denise Biaggi-Ayer- LMR David Perry-VHA

Doris Gruntmeir -OGC (Not present) Terri Beer-NCA

Michael Stephens-VBA Christine Polnak- SEIU

Linda Parker-Cooks-AFGE/VBA James Leahy-VCS

Robert Sheena-VBA George Cannizzaro-NCA Gia Chemsian-OGC Sarah Porter-OIT (Not present)

Michael Salazar-OIT James Zeveski-VHA

Link Miles-NFFE (participating on behalf of Jeff Shapiro)

**October 4, 2022**

Meeting began at 10:00 a.m. ET

Denise Biaggi-Ayer, Executive Director LMR (Co-Chair Management) and Alma Lee, President, NVAC Council #53, (Co-Chair Union).

Denise and Alma welcomed everyone. Meeting was a hybrid of in-person and virtual, with in-person attendees meeting at 811 Vermont Avenue, Washington DC. Technical issues arose initially that were addressed.

**PACT Implementation Plan - VBA**

* Joshua Jacobs, Acting Under Secretary for Benefits, Veterans Benefits Administration

Joshua – The partnership we have is critical and I want to thank you for everything that you do. We are going to cover PACT Act. This is a massive bill and is a big, big deal with a lot of moving parts and to do this right, what I’m going to do is talk through the details on our implementation plan. I think what we try to do is demonstrate how important it is and be more transparent. One of the main takeaways here is that until now, the law didn’t allow us to take care of Veterans like we should. We are going to have more opportunities to utilize technologies and make decisions more timely, so we can help more veterans with more efficiency. We need to communicate internally more and externally. If you turn on the radio or tv you see commercials for Camp Lejeune. If Veterans are involved in these lawsuits, their compensation may be offset by what they receive from the courts. On January 1st we will start processing the first claim so we need to be ready to serve as many veterans as possible. The PACT act is more than a benefits bill, we’re going to continue building on that momentum of establishing presumptive benefits and improve outcomes and increased access. From research to hiring. For the majority of veterans, the media has largely been focused on healthcare, but for the 6 million plus veterans who may receive benefits, this is largely a benefits bill. Internally we’re working through the established governance structure to bring all the pieces of VA together to work in cohesive ways. We’re looking and working on potential conflicts collaboratively. With increased demand we also rely on VHA and can’t assume they will be able to meet that increased demand so we work on a data drive basis to ensure if a VAMC may not have the bandwidth, and we may have to use a vendor for that additional capacity. Slide 4, overarching goals helping us with planning and execution. First putting veterans at the center. We’re working with the veterans experience office to better design solutions that are meaningful. We have to work with our partners. Second key is collaboration, this is my second time with VA and I know we’re not always as open and collaborative as we desire to be, but if we’re going to get things done we have to be transparent; it’s critical to tackle issues and make improvement. Finally, building on collaboration is transparency and build trust. We’ve at times had a deficit in this and trust. All of our external partners are part of these conversations.

What we’re doing here is making sure we’re ready for Jan 1, we can’t deliver a great vet experience unless we have a great employee experience. We’re looking at AES for issues and opportunities and make sure we’re delivering. I’m also mindful AES is a point in time so we need more information and have opportunities to be better. Bill just walked in and he is going to pull information about where we have strong labor management relations at the local level, where we have trust, and my hunch is that where we have trust, veterans and survivors have a better experience.

We’re tracking over 1300 discreet line items in our plan. There are a lot of moving parts and pieces. Slide 7 one element of our implementation plan, if you look at hiring, we hired more than 93% of employees of 2000 that we had authorized. It’s going to be critical to bring on more people. We’ve hired more than 6600 full-time equivalent (FTE) employees with an average hire time of 49 days, which only happens through collaboration. We had our first Rating Veteran Service Representative (RVSR) cohort which graduated in July. We’re looking to see if we can contract out some work but also bringing more people on and not taking people away from the production line. We have to hire a lot of people and we want to hire with everyone’s input, like labor, to ensure we can do that quickly and effectively. Our ability to hire and train them quickly enough is what keeps me up at night.

One thing I do want to double down on is how we engage in providing information to employees and getting ideas for improvements. We do town halls, digital media, FAQs, but as I travel there is a wealth of information and expertise and trying to figure out how to unpack that is important. If we go to slide 8, we have a process strategy. We have implemented policy guidance that will enable us to process elements of PACT Act smoothly. We have presumptive conditions going back over the course of several years, the President said go ahead and get that done as quickly as possible.

All conditions can be effective August 2027. We do that through communication through Veteran Service Organizations (VSOs), labor partners, we need to get the word out. We have this up on our website to make sure people know to file now. We’re holding claims that have a PACT Act issue to January 1, we’re going to be ready to do this. We have to report and monitor what we’re working through. Slide 9 gets into details on policies for the station. Slide 10 technology will help with accuracy and help with the veteran experience. We have a pilot in Pittsburgh with a tool that allows staff to look at millions of records to determine whether we need to order an exam or go right to a rating. We can take the process from several months, to several days. We have to scale this up, but we hope the tech stuff do more and more for an increasing number of veterans. Automation was launched in Boise. We’re working with staff to see where there are opportunities for improvement.

Slide 12: we are working to do more with national archives to scan. Slide 13: we scan about 1,000 personnel files per day, we are expected to be done by March 2023. This will help employees from having to track down files. Slide 14: we talk about the veteran experience, that they are the center of decision making. We’re looking at production numbers but also quality and the veterans experience and what we need to get from qualitative surveys but also quantitative. We’re going to be empowering veterans and the tools they need. We need you and your local unions, the local community to let them know what the law provides. We have to deliver more benefits more quickly. Third we need all VA implementation. If veterans are getting their healthcare at VHA, that’s an opportunity to share that information. Slide 15: this needs to be understood by all of our employees, by partners outside of the organization, we’re doing town halls internally, externally with VSOs, we’re looking at paid media and digital media. Slide 16: I know we haven’t always met the mark strengthening training. Slide 17: communication strategy, we have internal/external media, if you have questions, please let us know, if you have questions, we know others will. Slide 18: the backlog, we can’t get away from it but it doesn’t tell the full story. The backlog of inventory is a little under 25%, when I was at VA last time, that’s where the backlog was at, until the pandemic hit. That 25% is probably a good metric in terms of telling us how we’re doing as in indicator.

Bill Wetmore– I have a concern with contracting out the training. I was an Attorney at BVA and we never contracted out because being trained by someone who does the work is crucial and it seems it would be here as well. I think people will have specific questions. It seems there would be a longer period of adjustment when they come back. It’s different to talk from experience than from materials.

Joshua – I share that concern. The current situation is untenable. We cannot limit the number of people we bring onboard, and we have to look at all approaches. I share that concern but we’re looking at how to ensure the trainers have that experience. I think there will be retired VA employees facilitating, or current, but it’s an area I share your concerns. We have to make sure the quality isn’t impacted by the vendors.

Bill – Automation, you’ve got AI that reads the documents, is that true?

Josh – It’s called OCR, optical care

Bill – How does it do with doctors handwritten notes?

Linda – The RVSR would go back and look at the pages. If its handwritten, it would require the RVSR to review that document. It’s not perfect but shortens the time for the employee.

Josh – Right, it pulls the information and puts it in one spot for the employee to go back.

Bill – I understand that a lot of people don’t read everything, they can miss a benefit that the veteran does deserve.

Linda – We’re hoping the data from the pilot will show us how well the tech is working.

Josh – We’re actively working with these four ROs and going through their verification/validation to ensure we’re not skipping over a critical piece. We’re making real time updates and working through that.

MJ – Side comment, I had the opportunity to talk about the widowers and caregivers struggling to get this legislation passed, the crosswalk is the AES, the strength of the workforce and connecting the dots. I feel the widow or caregivers as part of a vignette prior to taking the training would be good. The families feel we turned a blind eye for so many years. Maybe they could go down to Saint Louis and talk about who they were.

Joshua - I think that’s a great idea. Trying to ramp up our communication and engagement, I like the idea. We can follow up on how we can do that.

Joshua – How do you communicate with your members?

Linda – Social media definitely, Facebook, most people are not reading emails,

Joshua – We’re looking at quick 1 or 2-minute videos, white board, that kind of thing through social media. If it’s okay, we would like to follow up and look at sharing with your membership as well if you think that is appropriate. My takeaways area communications and then two, hiring, getting people onboard quickly. I’ll probably be following up on some of those hiring initiatives.

Presentation ended at 11:15am

**Executive Order 14074, Advancing Effective, Accountable Policing and Criminal Justice Practices to Enhance Public Trust and Public Safety - HR&A/OSP, VHA**

* Dr. James Ward, Executive Director/Chief of Police, Office of Operations, Security and Preparedness
* Troy M. Brown VHA Security Officer

Dr. Ward - I have some information that I want to share. I’m not sure how familiar you are with the law enforcement training center. Suicide prevention and awareness training. At the law enforcement training center, we have monthly training on this topic that we send to all of our officers. It is set for August each year that the training will be made annually to VA police. It’s more engaging and interactive.

Another training 8 weeks for all new Law Enforcement Training Center (LETC) officers. That will be rolled out in FY23, and the first pulse course started yesterday. We have met with SMEs and it meets or exceeds the CITC standards.

We developed a training toolkit for the VAMCs. The toolkit provides a checklist for agencies that can provide support in the community. It has 4 training modules. The toolkit has not yet been adopted by VHA and we’re ensuring they have the approved SOP for this training, so that is a big piece of what we’re doing for suicide and crisis training.

Anti-bias training has always been a part of our training but with the EO we bolstered that training and will include more anti-bias training for new officers. For incumbent officers we’ll do monthly training, so they get it as well.

Mark B – Will police be looking into making sure officers that are facing a situation where they have to intervene for suicide at facility, that they’re getting appropriate counseling after they respond to these types of events?

Dr. Ward – Absolutely, the beauty of being a VA police officer is that we have resources right here where we work. Yes, it is done, and it’s covered in the training and we encourage our officers to receive mental health services they are seeking. We often internalize what we see and do, but we are, in the training, emphasizing the need to do that.

Jim Leahy – We have a partnership with VCS where we provide food at the Little Rock campus and VCS will have the honor to provide food to our officers.

Dr. Ward – We’re trying to build a college like atmosphere where everything the officer needs is right here and thank you for your partnership, sir.

MJ – a follow up to what Mark said and more exploration for potentially using real life scenarios, I’d say 80% are code orange like parking. But relating to the EO, where we could make more improvement are these interactions when the veteran comes first into the EDs for substance abuse and talking about how to get police officers good at it. It’s kind of unique to VHA and I think we need more of that. The other thing is that the latest statistics I saw, 80% of police officers are service connected and if they filed at the same rate as the veteran population, we’d have very high mental health issues. In occupational health they get a little sensitive, I think there needs to be more cooperation between Occupational Health and your office because they can really get off balance there.

Dr. Ward – LETC, when we do that verbal escalation and all that is a big part of what we do in training. The training aspect will build upon that. We want to make sure we’re doing everything we can to give police officers the tools, to make sure the veterans are taken care of. You mentioned the mental health aspect of it, we also address some of those things too…we do as much as possible to get into the 8-week, 400-hour course, but also make additional training resources available too.

MJ – In my reparational function, for fitness for duty, I’ll bet 85% of what I deal with deals with police officers, I don’t know what to do with that, but I think there’s more to be worked out with Occupational Health. I see a disproportionate number of police officers and occupational health.

Dr. Ward – My wife is a captain with AR state police. I have that support at home. One of the problems I see in law enforcement is that police don’t verbalize those issues, so one thing we try to do is make sure we do in training is make sure they are raising their issues. It’s a problem throughout law enforcement.

John Stead-Mendez – We have seen VA police enforce the union contract. We had VA police mobilized to take down union flyers at Augusta. The other instance is that we’ve seen VA Police used for interpersonal conflict with employees. We have seen at Hines where there is theft accusations and the police are then used to weaponize that.

Dr. Ward – I have not seen the first issue you raised. I would suggest you reach out to Troy Brown for that situation. Any time police need to be called, they should be called. But using them to weaponize is wholly inappropriate.

Chris – Wanted to share that most police officers are veterans.

Dr. Ward – Yes and almost 90% of trainers are as well. We need to do a good job of ensuring police officers are receiving any mental health help they wish to receive.

Presentation ended at 11:45

**VHA PACT Act Implementation Updates, VHA**

* Lisa Pape, Senior Advisor, Office of the Deputy Under Secretary for Health

Lisa - PACT Act is a huge expansion and crosses through so many components of VA, including BVA and VBA. Military environment exposure includes nuclear, chemical, and physical that are part of the military environment. Whether something is toxic depends on the substance. Signing of the Pact Act authorized one of the largest expansions in history and puts more veterans into VA care. Section 103 is enacted through a phased approach to three new categories of veterans. If you were assigned to any of these locations or deployed, you would be eligible. Veterans in Category 1 and 2 will be eligible beginning on the dates outlined here. I think this was done to ensure VA can handle the phase-in beginning in 2024 and going to 2030. For category 3, they become eligible in 2032 which included Enduring Freedom, New Dawn, all of these listed. Beginning Saturday October 1, Gulf War era veterans who served in active duty may be eligible.

The eligibility is pretty complicated and if you’re not sure if you fit into one of the categories, you should apply because you may not be eligible today, but you may be for one of the phased groups. Vietnam era veterans can now enroll. PACT Act establishes 20 conditions related to toxic exposure. Veterans can also apply with VBA for these presumption issues, which means it is presumed that your service is tied to the issue. We’re working towards a November 2022 implementation for toxic exposure screening since we were given 90 days and we have 9 million veterans. If veterans do believe they were exposed, they are asked potential questions that could only take 5 minutes, but at the end we have to provide print material and resources to the veterans who report this. There are a couple of other sections of the PACT Act that strengthen our ability to provide services. We are required to do a multiagency workgroup to develop a 5-year strategic plan to make sure we all align. One thing not about toxic exposure is that we have been authorized 31 new medical facilities. We hope most leases will be awarded by FY25. If its new construction, it’s 2-3 years depending on sizing and complexity. We have resources for veterans, stakeholders, providers…. there is a VA.gov PACT site, health care application, VBA claim information and the phone number that provides a registry for airborne hazards but is not for health care.

MJ – I don’t think VA has policy on this…. but when providers put in work code. So, if a veteran is service connected for agent orange, does that mean I’m treating him for agent orange, in this broad sense about 35 toxic exposures, I think it would be wise to create policy, so we are trained to know what that means in terms of exposures.

Lisa – This is a really helpful comment. You’re right, I’m a clinical social worker but I know we need to educate providers, so they know what this means.

MJ – The only reason we’re familiar with it is it stops the EAR reports when we visit. We don’t have positive training requirements for that.

Irma – Are we going to get a copy of these slides? Are the leases for VA to provide services or for contracting out?

Lindsay – That may be something we have to take back.

Lisa – So we can share space with DoD which we can do now. But we will take that back and get a clear answer.

Irma – I don’t want us out here contracting out all this with the additional funding for space.

Lisa – Thank you for letting me come here today.

Presentation ended 1:35pm

**VHA Updates**

* Dr. Shereef Elnahal, Under Secretary for Health

David Perry – introduced Dr. Elnahal

Dr. Elnahal – David graciously read my bio and I always consider my relationship with unions to be extremely important. I don’t think I could have accomplished anything without a strong and productive relationship. I have experience finding common ground and my goal is to at the very least, foster a system that respects labor as a critical partner. That’s my commitment during my time here and I only think we’ll be better for it. It’s great to come here and see you all online. I’m going to ask Denise if you could put up the slides, please.

It’s important to share the most important priorities but also talk about the assets to go forward. All of you in this room and online are part of that. I’ll go through each of these and start. This is a picture of me going to the Orlando VAMC for a creative arts festival. They have a recreation therapy team in Orlando, I saw art, performance art and it was really just incredible. People go above and beyond in our system.

In this next picture, you’ll see a live simulation demo, they offer students and trainees across the country. This next picture is from when I went to the Long Beach VA, if it weren’t for VA, veterans like the one in the picture here wouldn’t have been able to have a full life because of the Blind Rehab Center. I also went to the Dallas VAMC, these people here are the highest performers in the facility, and I got their direct feedback in how we can all improve the system. Really an amazing visit. I went to Hawaii, it was a quick turnaround of 48 hours, I had a chance to see the Mental Health clinic. These visits were able to give me the opportunity to see and speak with the front line. These VHA priorities line up with what I was hearing. To make progress on behalf of veterans. They match with what our external stakeholders want, and what our own team has said to me about what needs to improve. These aren’t numbered for a reason. Hire faster and more competitively is something we have to do. Having people in seats and roles is fundamentally the most important thing we have to make progress on. We took a non-standardized process and made it shared service across hospitals. Handoffs increase the risk that packages get lost in the system. I think this is a mutual priority for a lot of us. I know NNU has expressed this a top priority and frankly I agree. We’re going to be having a hiring standdown, which is an opportunity for VAMCs to pick their highest priories but still need to bring these people on board, and then everyone will get together on Friday October18th, to improve relationships among VISNS, but to celebrate the number of packages that have been brought to the finish line. Leadership will be traveling to VISNs to draw attention to this.

Connect veterans to the soonest and best care. Whoever is in front of the veteran, having all the info in front of them to inform the veteran. First appointments at that facility, other facilities, telehealth appointments within that area or nationally, community care appointments. MSAs have to put three, four, five screens up to see that full slate, so we have to improve that because things will happen faster if we can do that.

PACT Act and toxic exposures. This is a once in a generation legislation. So, we have presumptive and also the phased approach of eligibility for veterans coming into the system. It’s also really important because it will allow the system to survive. Training, research and all of that relies on busy clinics and facilities and this will do that. PACT Act also offers hiring authorities. Accelerate to high reliability: I want to have psychological safety for whistleblowers because we shouldn’t have whistleblowers, because we should be listening to them up front.

Support veteran whole health: the caregivers program falls under this, we have 5K application in the last couple of days. Whole health and a full scope of care options are available, we really need to get whole health program, including ChampVA. Prevent veteran suicide: mental health care access, making sure clinics are well staffed, and community-based prevention, that can only be done with robust partnerships in the community.

Everybody should be thinking about how to utilize one of these aspects, or all of them. Retaining and investing in our people, but we have assets around us like retention authorities that we didn’t have pre-PACT Act, and training HR professionals. We have a REBOOT initiative for employees experiencing burnout. We have the initiative ecosystem. Improving out tech and workflows, we have OIT who has a service-oriented mindset, and so many other assets that we have to improve our technology to make progress on our priorities. We have to drive equity for women and LGBTQ and including historically marginalized groups. We have the office health equity and the office travel health and minority health, we have so many resources and our EEO professionals are thinking of making better environments for our employees. Modernize – facilities over 100 years old. Partnerships including with our labor partners. We’re going to have forums at the VISN level and if we’re not having that I want to hear about it. That is my goal.

Irma – I appreciate the optimism of labor management relationships. The first thing you talked about is onboarding and we’re behind that. We also need to retain the staff that we have, and we won’t do that if we don’t utilize the tools we have, such as locality pay system where we can adjust pay for RNs. We don’t utilize that in certain areas. Also, it’s going to be extremely important for the 72A programs, there are kinds of program out there that will help retain the nurses we have, and it needs to be offered. Other alternative work schedules as well need to be offered for staff. At San Diego they have a plan and are implementing 72-80 for all of the inpatient units and they’re doing it in a phased approach, so they have a plan there to do that. So, there is a success in that. Back to my facility, they won’t allow the 72-80 because they will allow nurses to be in a float pool, but to do that you have to be eligible to be in any part of the hospital. We’ve lost over 100 RNs for FY22, and we didn’t replace half of them. It’s very disheartening. I met with an RN last week and she said she can’t work this schedule. They had this nurse work 3 Saturdays in a row. I saw this morning she cleared. She had been here 4 months. Some places are still saying that since we have the emergency designation, they can go back and do whatever they want under the guise of it being an emergency. I have people leaving after 13-14 years, they don’t want to be scheduled this way. I want to see positions filled and HR move to the VISN work, but I want to see butts in the positions and retained. We can talk about that more offline.

Dr. Elnahal – We should, and I appreciate your comments.

John Stead-Mendez – To hammer home the point that Irma is making, we know we have to streamline those processes. At the outset you said in New Jersey, you worked with labor partners and created structures. Here in VA which is unique, is 7422. We see that as a negative for the Agency and veterans, not just the employees. We will call on you to sign on the VA Employee Fairness Act.

Dr. Elnahal – As those requests come to my desk, I look at every one of them. I don’t think it’s a threshold matter, an OGC opinion that is legal, should be the only threshold that we cross. When it comes to a particular providers skill not meeting the standards of care, if it comes to a safety issue and peer review issue, I may say that it is.

MJ – One issue right out of the gate, is money. Our expenses go up and up and we’re getting more veterans, so I’d like to hear your comment on the PACT Act and we see a 4% increase in budget for all these veterans coming on with the legislation. You can’t turn to HR to hire quick if there isn’t any money there. But we’re starting to see in these critical range, very alarming situations where there are no candidates, and 25-30% turnover in those situations. So, what is the union here for, people like job security and retention, but we don’t get the data we need to make educated decisions. Is it logical for all the money going for recruitment but nothing to existing employees? Skyrocketing administrative costs in VHA that labor isn’t taught and front-line employees aren’t taught about. We need metrics that we all agree on and their value.

Dr. Elnahal – As always, we have productive feedback. Regarding money and PACT Act and how that aligns with the numbers, keep in mind that is over the period of 10 years, those veterans coming online. My sense is that we have to do something about financing our hospitals that removes the disincentives to hire and invest based on the overall pot of money. I am tracking on whether we have the funds to meet our priorities. So, I appreciate you’ve also noticed that. Overall, we estimate that as a total dollar amount and budget for next FY, we do think we can cover. We have to think about how we fund our sites with these challenges. In every site and healthcare center. Your point of administrative costs is taken. There are always data limitations, but if we fix our workflows and techs up front for employees, that will reduce costs and will help us retain our employees because their daily administrative work will be easier.

MJ – I think it’s the burden of a large organization, but I know I’ve heard NFFE complain about the staffing of the PACT model, specifically the Agency understand we have to go to telework to get to rural veterans, but I feel where the agency is too aggressive is with grade standardization, when we have health connect.

Dr. Elnahal – Thank you

Irma – On the PACT teams our providers are overwhelmed, cutting their hours by 2 is not going to help them in any way, for providers with hundreds of alerts coming in a few hours before the end of their shift. Providers are saying they cannot continue here. An RN cannot handle three providers alerts in a day. That goes back to hiring and retaining people.

Dr. Elnahal – That’s a helpful flag.

Christine – This generation cares about money in hand, not retirement. It’s about the here and now and so we have to roll differently from what we’ve done in the past.

**RAISE Act, VHA**

* David Perry, Chief Officer, Workforce Management and Consulting

David – I think we provided in mid-September the number for RAISE Act, so we’re in sustainment mode. We will not continue to brief and we consider implementation completed at this time.

MJ – It’s a cultural problem, if you implement 95-98% of Nurse execs and 4s and then wait 3 months for the 5% for the rest, that doesn’t equate to the messaging their getting now. Of course, you have turnover issues, when you immediately implement for the managers but not for everyone else. You’re not going to be the market pay leader if there’s a value problem that people see right through immediately. I’m adding these comments for a dialogue.

David – The RAISE act didn’t raise the parameters for what we have to do with the schedules. Looking at what got processed, about 80% were at the grade 2 and 3 levels and not focused on the 4s and 5s. We had a particular distribution at the lower grades. Grade 1-3 was at 5%. Nurse 4s saw a 6%. To your point, for us to change the criteria that we applied, we would have to have regulation and legislative change, I know that’s not a great answer but, I think we had a lot of staff presuming that it would lead to an overall increase and that may have been a missed opportunity for us.

MJ – I don’t even get the data. You gotta really think about what you guys are doing if you’re creating service contracts. I have employees that leave and come back in 6 weeks to get the perk. I think we need to have some shared power here and we don’t.

David – We publish that data so we can share where to get that data, they’re not getting kept internally only.

**DEMO My HR – Talent Experience Platform (TXP)**

* Center for Enterprise HR Information Services (CEHRIS) and IBM

James Struckmeyer – We are here to give a current status demo of TXP, the user experience being crucial. We’ve had a relationship with IBM and have been able to overcome many challenges efficiently.

Rob Fox IBM – HR Smart is where we capture all employee records. We support other agencies as well. We have a personalized homepage that brings other systems to one page. Our goal is to provide a better experience for all users of all HR systems across VA. You’re going to see the very first part of this. We’re excited and proud of the work we’ve done.

Doruk Akan IBM – Ultimately, we want to have a unified experience. When we look at VA, we see a fractured experience, half the time someone doesn’t know where to go. So the TXP is a single pane of glass. We want to be able to integrate across all systems and make them so there’s a comfortable innovative way to deal with human capital and HR. We’re not recreating the systems. We want a unified experience of hire to retire, from end to end. This will help for the end user but also for HR as well, which can improve delivery and then back to the end user.

DEMO PROVIDED

Included; Quick links to TSP, myPay, etc., Employee resources page with links to forms for FEHB, personal action items, important calendars and compensation information.

Personal action items include things that were previously in HR Smart, such as personal info, disability info, update their telework agreement from the dashboard, emergency contact information, disability status info. What previously may have been a difficult or confusing process is simpler. Also contact HR personnel.

Manager dashboard: managers self-service and recruitment data if they have positions directly reporting to them. Assisting with visualizations for data. Direct reports info is all in one place. USA Staffing insight, that layer of visibility is available to employees and managers.

Doruk: Release 1 went live August 29th for 20,000 employees in VHA. Overall, very good feedback so far.

Irma – When looking at data, can we pull out that data to show how long positions have been vacant?

Doruk: The data is drawn from USA Staffing but it’s a test demo so the data may be a bit goofy, but yes, that data can come out and be pulled.

Irma – The screen with the direct reports, what were the fields you could get?

Doruk – Shows the fields.

Irma – I look at the day of within grade increases for nurses, could you show when their proficiencies are due, or when their evaluations are due? Maybe their seniority data?

Doruk – We want to be able to get that data. Some from HR Smart yes, and maybe we could get it from other systems. The short answer is yes, as long as we can identify the data from the source.

Irma – Maybe offering a widget service where you can choose what you get to look at.

Terri - Does this system supplement Manager Self Service and if so, how does this data work with MSS?

Doruk – We’ve found a way to make it work without too much difficult integration, but we do have MSS integrated into the system and we’re looking at ways to make that better.

Terri - So as a follow up - does that mean we are going to be working in two systems for a while with entering the same data?

Doruk – So yes, right now with the pilot we do have two systems, but in the end state, we’ll have one. For the end user, it’s as if they’re using one system.

Michael Salazar: Both Manager Dashboard and Employee Resources - is there a self-service Admin. Toolbox for Fact Sheets e.g. Leave Administration, FMLA etc.?

Doruk: We can load some of those things.

Meeting ended at 4pm

**October 5, 2022**

**Office of Nursing Service Updates, VHA**

* Karen Ott Director for Policy, Legislation and Professional Standards, Office of Nursing Service

Karen – It has been several months since we presented our strategic plan, so I put these up front to remind you. We’re getting very close to partnering with you for the changes in the 5 VA handbooks. We have two new additions to ONS. The pathway to excellence is an important program we continue to work on. I know the elimination of the boards is important and I’m hoping that issue will become more distant the next time we brief you as we make progress.

Expansion of nurse residents. We’ve asked for centralized funding through a legislative proposal to greatly expand nurse residence programs, for those that have been hired for less than 1 year.

Milestones: RAISE Act, we’ve been briefing a lot on that. There was a miscommunication regarding nurse raises, we’ve been giving briefs on why nurses may not be seeing a raise in pay when they thought they would. We’re providing info as we get it. It helps nurses understand what the Act does and does not do.

Standards of practice: our national standards will not likely be approved until FY24. It will take longer than we thought. I’ll be happy to report more on that at the next NPC. The Secretary and Under Secretary for Heath have talked about need to hire 45,000 nurses and we’ll continue to work to make that happen.

Strategy: we have groups working on these pillars. Optimizing our practice is still a big goal. Strengthening our model and infrastructure. Strengthening the nursing pipeline is something we’re always working. We have to invest in a centrally funded pipeline of residents. I’m part of a workgroup to do that. Reimagining lifelong learning and career development and establish nursing in leading. A leading culture and looking at the private sector for examples is something we are also doing as well, including nurse work life balance.

NPSB elimination we began revising handbooks back in March, we’re in October and we understand our labor partners will meet after 10/21 and we anticipate LMR and labor will meet after that date. It looks like we’re not very far but we are further than it appears. We’re looking at changes and getting close to the end as OGC continues their review. PACT Act has sidelined them a bit but they are continuing to look. Slide 19: This is where we are with each Handbook. After publication is when we will be able to eliminate the NPSB and implement training. After OGC we will go to labor and continue working so we’re ready to move forward quickly, we hope by the beginning of the year.

Irma – You’re saying that labor partners policy review changes, all unions have said they are against no waivers, you marched right on in the policy for no waivers, when we get to that time, it is the wrong way for the facility to go.

Karen – You haven’t seen the policy. I can’t say that it’s in there.

Irma – Do you have an actual date when this might start? I disagree with the policy on no waiver, but nurses do want to know when this is starting. I have employees that can’t get out of nurse 1. Doing away with boards I have concerns over supervisors promoting the people they want only. I could walk on water and never be promoted. The only appeal is the Chief Nurse, so I have a concern about that. I think there has to be a process where they go outside of that facility. Strengthening the workforce by 45,000 nurses, it looked like you have 45,000 RNs, is that additional?

Karen – Yes

Irma – Is that just RNs or staff?

Karen – RNs

Irma – I’m concerned that we’ve taken FTE from the bedside for all these evidence-based practice nurses or other admin with 20 patients but 3 RNs, so I think you gotta think about that and be careful in how we staff. I’m really disappointed in the residency program and where that’s going. It looks like a bunch in FL, one in GA, then the NP in Dublin, there’s nothing in Augusta. There are more facilities than we’ve got here, so we’re not producing that benefit to those units. Is this some kind of pilot for the rest of the units, or is it only at those facilities?

Karen – The ultimate goal is a residency program in every VA facility. If not possible for the small facilities, there would be one in the VISN nearby, but that has to be worked out.

Irma – National practice standards are delayed until 2024. Will it be delayed beyond that?

Karen – It has to go through lawmaking and that does take time. There’s approval here as well, so it seems like a long time but it’s just the steps we have to make this work.

Irma – MISSION Act I thought would give you a bump.

Karen – It will.

MJ – Data for people that are leaving. If you need 45,000 folks, I don’t think it’s in our interest to give new employees better conditions of employment than the people that have been here for 15 years. Rather than surveying exiting employees but existing employees to keep them here. That goes with the nurse residency thing, I think we need more seat at the table, what we’re getting is hire quick and hire fast, making special deals with people that may be arbitrary and capricious, I get there aren’t a lot of people out there to get, but I don’t think what we’ve been doing the past 9 months is strategic. We could start litigation on some of this stuff about minorities not getting the same hourly rate but why do that, let’s try to solve and look at what we’re dealing with here.

Kevin – I agree with your frustration, I know when the wheels don’t turn, we have to be patient. I agree with MJ and Irma. Our issue is especially that 45,000 is a huge number and there are so many barriers at the facility level. NFFE represents urban and rural areas. The 5% raise that went to the small minority of nurses and didn’t get to the 1,2 and 3s, that was a disappointment, and we have to stay competitive. We’re missing the boat where market surveys aren’t happening at all. Are they on the same page as us?

Karen – I think the Under Secretary for Health has pledged that if the network directors will not recommend a raise in the pay. The entire cap gets raised and then the pay schedules with the higher pay cap at the end, that’s how the pay surveys work but you still don’t see what you thought you would get. Eventually the steps will come with more pay as the pay scales increase.

Kevin – HR process. We can’t compete with private sector…its slug of hire. If a facility has a nurse recruiter they’re lucky. We can’t describe the VETPRO process, it’s taking months to get personnel onboard. If we’re not competitive when they need to change jobs, we’re shooting ourselves in the foot. There has to be something done if we’re bringing on 45,000 to make that process work. Elimination of the boards will help, but we’re losing most applicants between tentative offer and final offer because it takes so long. I heard we’re getting rid of tentative offers but haven’t seen that materialize.

Denise – What is the delay between the tentative offer and final?

Kevin – That HR is backed up. A critical and this was even a non-nursing one we had a clinical social worker position tell me.

David – You’re right and I appreciate that. If occupational health can only schedule 3 a day, that creates logjams. Where we do have shortages in HR, we are addressing those as well. We have STAR, a massive hiring effort. It’s not a quick win but will help. We’re looking at surge events for those that have received an offer will get an EOD and scheduled to come onboard. Start looking for more communications over the next 30 days. We are looking at a single offer letter as well. It doesn’t feel like a lot is happening now, but a lot is in the queue that we’re close to getting out. Lump sum retention incentives is something we’re now looking at with PACT Act. Retention is the best place to focus. The 45,000 is an estimate over the next 5 years so I wanted to provide context.

MJ - But don't you have expedited appointment authority pending the credentialing and 5019 process? It seemed like during that initial covid stand up we had huge, expedited appointments.

David – I don’t have credentialing. We do have authorities under COVID that we continue to use as well.

Christine – Karen, for NAs and LPNs, right now retention bonuses are great, but we have NAs that are being brough on as GS-5. We utilize band aids to keep people, but the truth is we lose people because of pay, money. The average salary table picture at a job announcement, I had an NA who is not even making that. We need to do a better job using the step system and utilizing that. Someone coming in at a GS5 step 1, that may make sense for no experience, but the GS-5s grow. Employees are coming to us as the union, we have to know what we’re saying, we will lose an employee through a conversation.

Karen – We are looking at LPN qual standards as well and proposing higher grades. I can give you more information but we’re aware of it.

Christine – Good, I think utilizing the step system as well.

John Stead-Mendez – Back to VA national standards for RNs. We have put forth a midterm proposal under Directive 1900 for which standards will be developed. It establishes a process for a workgroup for VA to develop standards, has the Under Secretary for Health established that workgroup?

Karen – Yes that has been in existence, the surge group?

John – We proposed to have NNU representatives to that.

Karen – That work began in 2021.

John – We look forward to that counter proposal.

Presentation ended at 10:55am

**NPC Discussion of Recommendations**

Irma – We need to seriously look at pay for everybody, from my perspective on the nursing side, there is too much leeway to allow directors to do nothing. Tuscaloosa recommended a 6% raise for nurses and 9% more, so 15%....in Augusta we’re looking at 2% and 4%. There is a wide, vast way to look at how people are being paid. RAISE Act gave it to the top nurses. It’s not balanced out at all. My recommendation is what can be done to look at nurses salary? There is leeway to do something, but not to do anything. Prices are going up everywhere.

Denise – What can we recommend? More specifically. We need ideas of what they can do.

Irma – Data on who got raises and what they were. You can look at facilities and where they gave small ones, provide some justification.

Christine – You can bet that employees are going to talk about what they got. When we don’t know, we can’t answer employees. But you guys don’t share information with us.

Irma – Retention bonuses only go for a year in time. So, they feel like they got a pay cut after that. What I want to address is base salary. But retention and sign on bonuses are not going to work long term. I want data on what salary increases were given by facility. So, we can look at where they haven’t given anything. I want to look at data, see the disparities and take action.

Bill – My recommendation in the chat for the Under Secretary for Benefits, that the training should not be contracted out. I understand he wants to hire faster, but we discussed today the difficulty in bringing more HR staff onboard. I think we should have people that do the work provide the training. Also, only retirees get COLAs. We have to go fight and lobby like heck to give everybody a raise. We have to get that from Congress through lobbying.

Kevin – We also have to look at succession planning. From the nursing standpoint, looking at Spokane, San Francisco, when nurses get a tentative offer, they can’t find housing and are turning down their final offers because they can’t find a place to live. They’re staying in Airbnbs.

Denise – So they’re not hiring because they don’t have the staff to back that up?

Kevin – So they don’t have the nursing staff in the CBOC, they could get a tentative offer, if they’re moving in from out of the area, they get a tentative offer and they start looking at housing, but they can’t find anything. If we’re pulling from people that already own their houses. We have to make it more attractive for people to leave their private facilities. We have to have a schedule that is competitive and have to have it so there is no pay cut.

Denise – Ryan is helping with capturing all these things. I’m going to try and pull actions from the notes, but we need a specific recommendation and we will need additional feedback. The committee will need to pretty them up maybe or make them more actionable.

MJ – They’re at a level or pretty close to formulating the 502 requirements across the spectrum related to a position that is validated to what is recruiting. We need solid budget execution for what we need. We as labor can help save costs, in order to do that I need to see what is reflected in the data that is not accurate. I feel like I need a lot more education on all these different data. In order to get to yes, we can get the money to flow here, but this is a huge project, us being educated and we are way behind the eight ball on that, regarding pay.

MJ – CERNER and connected care, I think mental health is further along, but the concern is that these call centers are not good for the veteran experience. The problem is that agency resources are being used to stand up connected care, without the view alert priority process. We need to fix the grid standardization and reduce view alerts or capture that as workload because that has exploded. I think we need a better handle on those two things.

MJ - Training requirements for the screening tool in VHA. Is there a training requirement for providers?

Denise – There is, we briefed on that with Oscar.

MJ – In CPRS, let’s say I see a patient, we never get training on the copayment on what the veteran pays. Is diabetes for agent orange service connected? Providers don’t know, we’re never trained in these service connections. So when you’re rolling out burn pit toxic exposure, what is the connection for these things on their workload? We’ve never been trained on that, as far as I know, there is no policy. The recommendation is to first create a policy on what that stuff means.

Denise – I think all that is being done.

Linda – I raised the training issue at the VBA senior leadership symposium two weeks ago. The instructor disabled the chat when I raised that, during the training, employees are not allowed to ask questions and get answers. I share that there is a concern about adequate training. They have a very small cadre. But I also pointed out that those that do the work should do the training with real live experiences. The training classes are large, you cannot ask questions. The first part is all recorded and they’re watching videos. I did point out that they needed to look at the curriculum. I do think we need a recommendation for the training size and method in which they deliver it. Before we may have had 30 students but now we have 100.

Denise – Is it via Teams?

Linda – Yes.

Denise – It can be hard to navigate the chat if you’re doing the training, but if someone is managing the chat, that helps.

Linda – Yes, but the instructors may have that, but they disable the chat. They have two people in the class but not allowing students to ask questions. You may finally get an answer from the session last week.

Michael Stevens – Yes, that was brough up last time. I’m not aware of the no questions and I’ll take that back and look into it.

Denise – Next meetings: should we look at the calendar and try to block next year? November and December weren’t possible, but if we start blocking next year.

Next NPC Meeting: January 24 – 26, 2023, 3 full days. Plan to be in person, in DC, but may be hybrid.

Following NPC Meeting: April 18 – 20, 2023,for 3 full days. Location TBD during January NPC meeting.

**All Employee Survey Data, VHA**

* Chris Orszak, Management Analyst, National Center for Organizational Development

Chris – Executive Dashboard shows all data across VA. Welcome video connects feedback and action and goals. Color palette changes for red/green colorblindness. National response rate was 71%. Most responses for AES ever. Increased 2% from last year. VA scored 5th for large agency responses.

Engaged percentage: 4 questions on a 1 to 5 scale. To fall within fully engaged.

Irma – In the burnout….no symptoms of burnout, so there is 51% of staff with burnout, correct?

Chris – Yes, correct.

Chris – Burnout trends have decreased from last year. Covid module from last year, we had down to 24 questions and this year we had 2 questions. They were related to additional stress Covid has added to professional and personal life.

Christine – When we thought it was temporary and we’re in year 3, it will be interesting to see that next year to see where we’re at.

Chris – We thought it was going to be over, vaccines were here but it’s just not going away.

Christine – Typically employees handle it and do what they need to do.

George – Even beyond or in addition to…being aware of this, this has been helpful to see and see how it impacts our lives.

Chris – It’s also great to recognize that the dates of administration of the survey can really impact the results and answers respondents give.

MJ – Burnout and leave policies…Ryan and I had a conversation about version 9 of the leave policy that we’re on right now. It makes people feel disposable. You know what I’m saying. The waxing and waning of leave policies, the agency requires people be there when infections go up.

Chris – Yea and there’s always a deeper story than just the scores.

MJ – I find the comments the more helpful and purposeful for me in what I track coming into the union office.

Chris – Diversity, equity and inclusion. This is now a core instrument. The way to read this to interpret the scores is by comparing the minority to the majority scores. Male gender is the majority in this graphic, though females responded more. Female scores for inclusivity are lower than male counterparts. Based on race, sexual orientation and veteran status, we see a lot of red unfortunately. When you’re looking at the organizational level, you can only slice so far with the 5-person response rate for confidentiality. Priorities and turnover…what to do with all the numbers. We developed a priorities question of what would you like to action plan over the course of the next year? And so, employees can respond to 10 options. For turnover intent, are you planning on leaving your job in the next year? Just culture is the intersection between accountability and psychological safety. We also have a new video from the San Francisco VAMC as well. The action planning dashboard link I will provide. From this link you can see all facilities. You can also break it down by individual workgroups. This will be accessible for all employees.

Mark – Chris, did Denise or anyone in VACO share with you concerns from a local President regarding the survey and results? I had sent out to all my local presidents, information that I received from the NAGE regarding the survey and the local Director from the Cemetery provided the information, they found comments that were provided during the survey were blank.

Chris – Yes, I believe it was the Midwest district and some of those comments were edited?

Mark – Yes.

Chris – We did look into it, we did review the messages provided. We did send the full file, after the file was sent, some comments were redacted, or part of the comment was removed. We don’t encourage any editing of course and we did not do that.

Mark – Nobody responded back to me, why didn’t you respond?

Terri – We did look into it, because the cemeteries are so small and have only 3 people in it. In the cemeteries they go to the whole district. Our district gets those from 150 cemeteries. The things that were redacted were vulgarities.

Mark – That’s not my question to Chris. I brought up an issue and they did not respond back to me.

Denise – We responded and said it was going to be discussed in the NPC, as we are doing.

Mark – I’m sorry but I’m not feeling this partnership with VA. I have major issues with how this survey is being done and the union wasn’t involved in putting the survey questions in. It’s bold and in our face that you’ll do what you want to do and how you want to do it. When someone tells me something is on the agenda, I’m thinking it’s going to be discussed.

MJ – When it comes to the write in comments, it doesn’t seem like that’s part of the survey data and I think local Presidents have a right to that data. I don’t want expletives, but I do want the comments shared and those aren’t things you can really get roll up data from.

Chris – The comments we only send to the local director and local union president.

MJ – To me operationally, there’s a problem or it seems like people don’t want to share the comments.

Chris – It is kind of a heavy lift to gather the information of all local union presidents.

MJ – I just think that should be an automatic.

Denise – How do you get those lists?

Chris – Our team puts in a lot of effort to get updated lists of all their labor POCs. It’s no hesitancy on our part to send that information.

Alma – Not sure why they’re not providing that information, the Director should have all that information.

Irma – I feel your pain of trying to get it to the right people, but I would prefer that you would call me and just ask me. We’ve got 5 national unions; I have a responsibility to provide who my officials are.

Christine – I got an email from your group asking for that.

**Veteran Facility Transformation and Healthcare Enhancement (Formerly AIR Commission), VHA**

* Alfred Montoya, Senior Advisor, Under Secretary for Health

Alfred – I’m here to provide an update on infrastructure updates across the enterprise. Driving forward with what our veterans and employees deserve. Regarding where we were…I’m a firm believer in learning from past experiences, but how do we now take the next market assessment process, which we have to do every 4 years under the Mission act. We had an evolving strategy, and we didn’t engage our external partners in the past which VACO led. We’ve flipped that coin and made it field led with VACO support. Greater involvement has really been ingrained upon me. Here we have the different workstreams, but the point is to provide updates for each of these. You all do have different representation on these workstreams. How do we prioritize different facilities in terms of access, sustainment, and so this work is really involved in that clinical restructuring? Implementation planning: how to carry out implementation in a standardized way, with a checklist, so that we can open new clinics following that. How do we come up with a business plan, how big does the clinic need to be, how many PACT teams need to be there? That’s happening in San Marcos, TX. But making sure a lot of this is field driven. Partnership development group: in the next month or so when I come back I would love to give an update on this. We need to come up with a playbook for VISN Directors and medical center staff. Whether it means using the PACT Act authority, how do we take certain partnership opportunities and then a checklist that goes alongside that? How do we now use some of the PACT Act authorities with a playbook? The playbook is due at the beginning of the year and when we have an NPC around that time, I’ll be happy to provide an overview. Rural health strategy: we took best practices in our rural networks and come up with a playbook on this. How do we take something working well in WV and incorporate it into Montana? Facility infrastructure campaign plan: there is a theme with these workstreams, how do we make it easier for the field to open new facilities and identify where so the field can get energized around new clinic openings? Quadrennial market assessment planning: this has not started yet but should have updates in the next few months. All of this needs to be transparent, coupled with data and field driven. That should make the next phase of infrastructure planning more robust and fruitful.

John – Local engagement, in mid-August some facilities got lengthy emails about ranking templates, no engagement, no discussion or any background on the subject matter. So that put us in a bad way. It smacks of pushing forward, we’re concerned about closures of facilities, surgical services in 2 dozen facilities, it doesn’t appear there are any Tampa closures but there was some in the Lake City area.

Al – When that happens again in the future, please feel free to reach out to me directly. We are not entertaining closing any facilities. Our veterans want more VA, not less, so we now have to focus on that. Last month I joined Ms. Lee at the semiannual conference and that was my message there. How do we open new facilities is what we’re looking at? We heard it loud and clear from AIR and from you. If an email does come out like that in the future, please reach out to me directly.

Irma – We want to be involved in the process, start to finish A to Z. No closure is what we want to hear, expanding. I was concerned a little at the beginning, but you pulled it out in the end.

Al – Are your members on the workstreams finding them valuable?

Christine – Concerns in VISN 4, there may be some discussion with David Palmer. But with AIR, I think employees are confused because they don’t know what is going on, but I think we have to staff the facilities that we have too.

Al – We spent 4+ years on market assessments and then there was radio silence. We have a communication plan that we’re getting ready to push forward. You know that I’m transparent in the message.

Kevin – NFFE represents urban and rural centers. Viability of rural centers where we’re not able to recruit adequately for specialty providers. We’re hemorrhaging care in the community dollars at a higher rate than what we would provide the service for here. If we don’t keep these small centers in rural areas viable, they’ll say they won’t have any other option. I would request the workgroups look at how we can make those more robust. So that we make it, rather than buy it from the community.

Al – Very good point, I know we have to have community care data, so we better understand how much is really going out the door at each facility and for how much. If we put a new clinic in North Dakota, what services are there to capture it back from the community? We have to have those numbers and get creative. The first start is the data before we start that conversation. We will have that updated data. I have a request because I’m a regular member of this crowd, are there any particular working streams or topics that you would like me to cover?

Irma – We’re going to get back to our staff and ask them.

Ended at 2:30pm

Resumed at 3:15pm

**PACT Act, OCHCO/HR&A/OSP, VHA**

* Tracy Therit, Chief Human Capital Officer
* David Perry, Chief Officer, Workforce Management and Consulting

Tracy – David and I are going to talk about the PACT Act. The workforce authorities in Title 9 are really important. We’re going to work together to go through all sections of Title 9 as it pertains to all VA employees and VHA. We’ve already implemented four sections of Title 9. We’re on track to complete by the end of this month or by the next year. Section 903 requires an enhanced system to improve hiring. There's not enough transparency, there's not enough information, so we will test this enhancement to see if it meets it.

Irma – Does time to hire start on vacate start date or announcement start date?

Tracy – We follow OPM. The date the hiring manager goes to HR, says they have the FTE, a PD, and that’s when it starts. We really do track everything

Irma – To me it’s vacate, because the 2 months in between matters. I don’t think we can say we’ve made meaningful changes until we look at the data.

Tracy – We’re going to have metrics and dashboards around these to see if it makes a difference.

David – I think, Irma, what you’re driving at is time to hire or time to fill. We’re looking at time to fill. We have something we need to get into place but that’s what we’re working towards.

Tracy – Section 905 is the hiring of housekeeping aids. You should be able to see job announcements for housekeeping aids for vets and non-vets. Prior, our pool was restricted, and we had constant turnover. We’re looking monthly, we’re seeing increases. This doesn’t remove veterans’ preference in any way.

David – That trendline is going up because we’re finally seeing it go in the right direction.

Tracy – Section 908, you remember the Choice Act, the Mission Act, the PACT Act has removed regulatory restrictions about spending for awards and bonuses. We hope that by removing this cap, we will be able to use these authorities as they should be to recognize employees.

David – I think it’s a great win for us. Especially for mission critical occupations.

Mark – It seems that when HR did away with open continuous that was a good way to deal with this. That would put them ahead of the game. They had their name and info on file. What is the difference between this and the open continuous rosters as it relates to having a roster of applicant?

Tracy – Open continuous announcements do exist. Time to hire has sometimes been a disincentive to using these processes. We don’t want the goodness of an open and continuous announcement to be tainted by a lesser timeframe.

David – There were challenges with how those were handled in USA Jobs, staffing and HR Smart with respect to the time to hire initiative. There is a way to still do open continuous announcements and not reflect on the time to hire timeline. That is something we continue to hammer in our communities of practice, so HR knows that is a viable option. It’s also in line with Hire Right, Hire Fast.

Mark – I’m not seeing it being utilized throughout VHA. When I ask the question of local HR, they say they’re not allowed to use that. I always questioned why that wasn’t being utilized.

David – It’s important that hire fast be used and it is successful. If there are specific locations that they’re not being utilized, we’re happy to go back and look at those, especially in higher volumes.

Mark – When you brough up the MSAs, I hear friends and family members are being brought in on this hire fast hire right model, despite them not being qualified.

David – It doesn’t change those dynamics of being brought on but if you have examples, please let me know.

Irma – Were additional funds given to awards and bonuses or do we take that out of exiting budget?

Tracy – For FY22 we’re stuck with what we have, but for FY23 we are looking at wiggle room for the distribution. But for what we ask in FY24 and FY25, we will have to get more.

David – You’re spot on Irma. For FY22 we have what we have. For FY23 we’ve done some projections about using COVID waiver authority, I don’t anticipate a lot of movement in FY23 outside of the administrative areas. But we will need more budget moving forward to see substantial growth.

Irma – I could see how it would be difficult for this year for sure, but how we can take advantage for the future?

Tracy – A good point is to move to 909. We have special contribution awards up to the $25,000 limit, rather than the $10,000 in the past, after SECVA went to OPM. Also, entry level talent, we have up to 25% of college grads and post-secondary students for expedited hiring.

Irma – For hiring, a bonus for hiring amount, is it that?

Tracy – No, it’s a percentage of the workforce that can be hired. This month for student loan repayments and we have relocation and retention incentives that we’re working on. Those items are pending for completion this month. We have to establish new qual standards for HR and develop a recruitment and retention plan for HR. We are working to implement special salary rates in recruitment locations that are difficult. We have authority to offer critical pay for specific positions, there are 53, we have now up to 200 up to the VP’s salary. And critical skills for up to 25%. There are specific VHA authorities in Title 9.

David – Rural recruitment strategy should be in place next year and having dedicated ways to bring some of that care back into VA. We have to build out policy for that and get staff in place. The service contract buyouts give us the ability to go after providers and buy them out to bring them into VA. And the continuing service agreement have to be put in place as well. The alignment of Title 38 for special salary rates, 904 and 906. 904 is in progress and creating new pay caps for Title 38 employees. 906 is the authority for hours and conditions of employment for employees. We have a lot of things in the hopper to get these across to the finish line.

David – We have put a lot of resources together around PACT Act, for Title 9 and everything it encompasses, including training and we should have the link in the presentation and will provide after the meeting. This is the best place to have the information available consistently for everyone. We created a resource room pushed out through Teams where any employee questions get routed to the proper SMEs. A majority of questions are around eligibility, but we do get some and we respond with a 1-day turnaround. We’ve received hundreds if not thousands, from employees across all the Administrations.

Tracy – We got some good experience writing and now implementing legislation. If there is more that we need to be doing, we welcome those thoughts and suggestions. Once you can figure out how to work collaboratively to get legislation passed, we want to build off that.

MJ – I would like to ask question about the OIG section of the 2017 legal requirement of severe and moderate requirements. We need to know what you’re trying to recruit. I don’t think we’re going to get anywhere.

Tracy – I heard the question about policy.

MJ – I don’t think you’re going to make headway until facilities are reporting severe staffing shortages of LPNs, MSAs…

David – There’s a standard methodology, an aggregation. While Dayton has certain challenges, Cincinnati may have different. Staffing mix, there are ways to counterbalance what care needs to be based on location and other drivers, the mission critical list gives us authority for direct hire authority for the occupations we determine are needed in VHA at large. Local conditions could be different. We also submit everything in tandem with OIG. There’s a lot of workforce planning in that, it’s not random or arbitrary. I can get you more detail MJ.

MJ – Maybe at the next NPC, I want to get into the weeds on that issue. We can work collaboratively on time to hire time to fill, but more transparency on where you get these numbers.

David – We can bring our national workforce planner for a brief and overview to gain a better perspective on the process on how we get to this list. In 907 we weren’t suggesting that we’re going to have closures, but if we needed to have staff focused on realignment that was built into PACT Act. That’s where that language stems from.

MJ – Waiver, what does that language do?

David – You can go over the pay caps for employees doing work for those functions. Burn pits.

MJ – 704B not A, I was being thrown by that.

Tracy – On the leave, if you can give us some ideas, we’ve been going back and forth for employees that have a lot of annual leave, with OPM, OMB and the Hill, or maybe they could get lump sum payments.

Irma – Extend the time for everybody, for all of it to 4 years.

Tracy – Can I quote you to extend the time on the books?

Irma – Yes

Christine – Yes. They want to use their leave and they just can’t. But plenty of nurses forfeit because they don’t want to hurt their coworkers.

Tracy – We are trying, it’s hard because OPM is about equity across government.

Mark – Keep in mind, employees have donated leave because they couldn’t use it and rather than lose it, they donated it. And once they hear this, they’re going to be upset.

Tracy – I donate a lot of leave at the end of the year, we’re actively having these conversations.

Presentation ended at 4:10pm

**OAWP Updates, OAWP**

* Maryanne Donaghy, Assistant Secretary for Accountability and Whistleblower Protection

Maryanne – I’m very grateful to be here. This is an important topic for us. I’ve met with some of you periodically. We’ve had a challenging past and I want to let you know what the OAWP of today is all about. I’ve been traveling nationwide, and I’ve met with a lot of your local representatives. I’ve gotten a lot of good feedback. OAWP was established in 2017. Our mission is to improve accountability in VA, and I report directly to the Secretary. The Secretary has asked OAWP to look at a systems perspective for benefits. We still do look at senior misconduct and whistleblower retaliation. There are 1,000 or so across VA, of senior leaders, but with whistleblowers it goes down to any VA supervisor, of which there are 40,000 across VA. If an employee goes to stairwell and finds cardboard in the stairwell, which is a fire hazard, the employee could reach out to us, and we refer that to the right people to investigate it.

Office functions – we do holistic work as well. We track and confirm recommendation from OAWP, OSC, GAO and OIG. Organizational structure, we have 125-130 employees. Last year, we did more than 450 cases for investigation, but this is just the beginning. The training is now required of all employees and these numbers need to be updated. In 2021, we investigated more than 1,100 cases last year. We’ve had 1,100 folks come in and give them a voice and give us an opportunity to take a look.

Denise – I receive questions, or complaints, and some of them seem like they should be directed to OAWP. Should I refer the email directly OAWP, or send the employee to you?

Maryanne – Great question. There are responsibilities in policy for reference. The only hesitancy is that the employee makes that choice. If you find yourself in a situation where you feel an employee may need to be counseled, the whistleblower navigator may be a good resource for you.

Irma – 1,100 investigations but only about 8% result in actions?

Maryanne – I did this informally; I think that’s probably about right. It’s something that I’m kind of looking more into.

Irma – I really want to make sure people feel comfortable, a place for them to use and get results. I know every allegation is going to a whole case, but I also know some allegations don’t have a place to go, it won’t fit into EEO. I would recommend you look at some of that data that you’re not presenting, like things that came to you that aren’t in your wheelhouse.

Maryanne – Awesome idea. Looking at the 1,100 and 86, helping folks understand, that’s a great idea. We’re getting a lot of questions about the number of recommendations not being taken as much as you’d expect. When you take account that there was some discipline, but not what we recommended, I’m on the tail end of that but we still have work to do. The reasons are multifaceted, and we have a plan to address or look at why our recommendations are not taken.

Christine – We know HR makes recommendations and we know it’s not their final decision. But people make decisions based on who the person is. We don’t want this to be another entity for someone to get away with bad behavior.

Maryanne – We’re also looking at ADR. We focus on accountability. Investigations can take time, but sometimes employees need a fairly quick way to get their issue addressed, stay tuned, we’re looking at incorporating an ADR process into OAWP.

Mark – I would like to know how can you survey the field to get a feel for what employees in VA are thinking about being a whistleblower, or the managers that enforce this?

Maryanne – I don’t have a quick answer for that right now, but that doesn’t mean that we’re not thinking about it. I do meet all the unions. That’s not the hardcore data that you’re talking about, but as we grow, there are valuable pieces of information that I get, when going out to the field. But the travel is a first step to that.

Mark – I agree that’s a first step, but please understand that the past is something people still hold on to. And people that blew the whistle had actions taken against them. Many employees who want to bring forth or blow the whistle don’t want to face the individual they are blowing the whistle on. So, I question the ADR process.

Maryanne – The ADR process will be wholly optional by the whistleblower.

Mark – Yes, I just don’t want them to prolong everything. I appreciate what you’re doing but you have a long way to go in convincing people from the way your organization started. It’s hard to convince people to be a whistleblower; they’ll share with the union or EEO, but they don’t want their name affiliated with the complaint.

Maryanne – Yes, this won’t be done with a couple of trips and it’s going to take a long time to build. If OAWP had been perfectly set up the first 3 years…it was already a significant challenge. I appreciate hearing that and being constantly reminded of it.

MJ – I’m going to show you my phone…from November of 2021, the whistleblower training in 2021, and the training needs to be updated. There were no forms, no phone numbers, I’m glad to hear that, it’s progress.

Maryanne – Thank you I appreciate that. Would you mind sending me those slides?

MJ – I did union training for union official back in 2017 and I’m glad to see that you’re improving it. The ICARE Values and how can we prevent the E in that from happening again. I applaud you.

Maryanne – Yes, we have to keep taking steps forward and getting there.

Contact information for OAWP:

 [www.va.gov/accountability/](http://www.va.gov/accountability/)

855-429-6669

Email at OAWP@va.gov

Meeting ended at 4:45pm

**October 6, 2022**

Meeting began at 10am

**PDI Subcommittee, NPC**

* Bill Wetmore, 3rd Executive Vice President, AFGE
* Don Stephen, Staff Director, LMR

Slide 3: Pre-Decisional Involvement

Don - started the briefing stating that PDI should take place for all workplace matters to the extent practicable. Communicate with the Unions before decisions are made.

Slide 4: What does the VA thinks about PDI

Slide 5: PDI: Requirements of Management

Slide 6: What does PDI involve

Irma - suggested changing the language ‘Education of the union on the subject matter” to something else, it sounds like management is educating the union which is offensive.

Don - stated the committee would take that into consideration. Jim Zeveski is working on getting the program offices to involve the unions in policy work groups prior to making the policy changes.

Jim Leahy - it is extremely important that we communicate with the unions early. We tell all our supervisors to engage the unions up front.

Slide 7: Barriers to PDI

Alma - asked if this subcommittee was going to provide training on the PDI process.

Denise - covered the taskings of the PDI subcommittee.

Gia - stated that the subcommittee should develop a communication for the field how PDI can shorten the bargaining process.

Denise - suggested the use of different language for “lack of patience”.

Irma - stated involve the unions before all the decisions are made for a true PDI experience.

Claudia - agreed with Irma, bring the unions in before the cement is poured.

Mark B - stated how can the department say the process will take longer when the department is already bargaining after the fact and policies are already in force.

MJ - stated incorporate the ICARE values into the PDI process.

Slide 8: How will both parties know when to use PDI

Slide 9: Six principles of PDI

Slide 10: Elements in a formalized Process

Denise - suggested the subcommittee provide a definition of PDI and the PDI process for the field.

Slide 11: What to ask when establishing expectations for PDI

Denise - stated that she doesn’t think we will convince anyone to participate in the use of PDI with what was covered in this presentation. We need to highlight more of the positives of PDI and not so much the barriers.

Slide 12: Group Discussion

Denise - asked Don to explain how group decision is part of the PDI process.

**Office of Women’s Health, VHA**

* Dr. Patricia Hayes, Chief Officer, Office of Women’s Health
* Randy Spahos, HR Consultant, WMC

Dr. Hayes - I’m very honored to be here to talk to you today. The Interim Final Rule allows, as of September 9, for VA to allow abortion procedures and consultations. We determined it is necessary to protect the life and safety of patients. In many states, they are creating a medical emergency for the veterans we serve. This will save veterans’ health and lives. Everyone knows about the Supreme Court ruling. Since 1996 we could not do anything and we had to go begging to non-VA sources, and ask someone at the head of a medical school to perform it but, not charge VA. The Supreme Court decision needed this change in the law.

60% of abortions are performed by medication up to the first 10 weeks of the pregnancy. We also will do this in the cases of rape or incest. 300 or 400 could be procedures. The other group, which is very small, is when serious medical developments occur within the pregnancy and something has gone seriously wrong and they can die if we don’t treat them with a procedure. We don’t anticipate these to ever be performed in the VA. We will be arranging and referring them out wherever we can, even if we have to move them to another state.

I’m not a job category, PD expert at all, but these are the types of occupations that could be involved. Secondary staff like SPD. Counseling could involve Social Workers, Chaplains, Pharmacy Techs, Radiologists primarily in the ultrasounds arena. Call centers and other ancillary staff as well. Some of these are already done but for different purposes.

Right now, we are responding to the most urgent calls for this, where we’ve had emergent emergency cases. We also know that the field will need ample time to add these. We anticipate changes in SOPs, we’ll have a new directive, a VHA notice which will proceed the Directive. We know that significant training will be needed as well. We have a very tentative agenda to work on the roadmap, how the VISNs are going to be doing this. We’re cognizant on how state laws could have a chilling effect. We also know that employees will have concerns with moral and religious beliefs.

Federal supremacy – how will VA address issues, like their state licensure being challenged. The Attorneys have very much stepped up here to protect employees. We’ve also had a lot of employees who have stepped up and raised their hands and be supported in doing this for veterans.

Randy – This will be familiar because of the vaccination process. A lot of the procedures are being performed already, but for this particular duty is related to pharmacy and dispensing medicine and so those duties will be reassigned. We do need to make sure there is continuity of care for patients. The accommodation process is familiar to us and will look very familiar to employees, but we do need to make sure it’s in that accommodation process.

Irma – Union invites for PDI?

Dr. Hayes – LMR and Ryan are working on that and you will see it soon.

Christine – Is it virtual or in person?

Dr. Hayes – It is both, with the large majority being virtual.

MJ - How many states have put forth restrictions? Additionally, has the agency thought about assisting employee providers in re-licensing in an approved state

Dr. Hayes – Most states do have limitations and restrictions in place. Part of what our Attorneys are doing is looking at keeping their job if their license is an issue. We think it will be to have a license in another state, but we’re looking at that more definitively. I can’t be official about that yet.

MJ – I’m from Indiana and all I know is we have some freaked out people. I know it’s already in place, so I don’t know exactly what happened. I talked to the committee about some of these issues and urged that we need to get some messaging out to people quickly. I was remiss about the freak out; I have to move and risk my licensure over these things. To have that type of reaction is something we have to fix urgently.

Dr. Hayes – We understand we need more messaging to providers. Every piece of guidance we send could be relied upon in terms of defense. So, every statement that goes to employees has to go to DOJ. Given that we only have 20 workdays we haven’t been able to do that, though I would of course like to do that very much. I think some providers are scrambling and risk is such a personal risk. Although we’re scrambling, we’re not requiring anybody to do anything today. And that is why we’re supporting the piece on reasonable accommodation. Also, we’re looking at opportunities to hire state providers that can no longer provide their service.

MJ – Has there been any uptick in DoD and sharing resources?

Dr. Hayes – We’re still meeting with DoD, in a lot of situations they have not done it onsite, they would send it out to the community, but that was in states where that was allowed in the states. If the state disallows abortion, the community care provider cannot do that. These 14 states are closing their doors.

Ryan - Be on the lookout from me for the sequester invitation.

Presentation ended.

**Meeting Wrap up:**

Denise – I need to send out the save the dates.

Kevin – Jeff wanted me to ask about the subcommittees. Are they still working?

Link – We’re looking for guidance today for accommodations? The COVID accommodations?

Denise – I’ll talk to Lyndsey on that, I know things are continuing to change.

MJ – I don’t want to wait so long and all these committees are mish mashed and we give presentations and don’t get results. I sense urgency. I know this is very aggressive and we’re not getting updates. Like the project management piece needs to be more granular. Maybe we should be passing back outlines on things.

Denise – I think we need to provide guidance to the subcommittees.

Irma – I would like to see a call out on the agenda, to have the committees come back to us. I think we’re missing the mark a little bit by not setting dates and times and looking for the follow up we want. People need deadlines to work. We need some kind of report out to NPC.

Denise – We maybe need to block a day or half a day for these committees.

Irma – Right, we could have spent this afternoon working on projects.

Denise – Let’s do half of the second day for the next NPC meeting date.

Irma – Maybe we can get some time in the NPC to get this done. People need to stay or go home late. We have a commitment to this.

Denise – I’ll send my due outs today or tomorrow.

Meeting ended at Noon.