National Partnership Council Meeting Minutes
01/30/24 – 02/01/24
Washington, DC

NPC Agenda:

AGENDA-NPC
Quarterly Meeting - Ja

NPC Members:
Denise Biaggi-Ayer- LMR (Co-Chair)
Mary-Jean Burke- AFGE (acting Co-Chair)
Bill Wetmore- AFGE
Linda Parker-Cooks-AFGE/VBA
Irma Westmoreland- NNOC/NNU (not present)
Joseph Henry – NNOC/NNU
Jeffrey Shapiro-NFFE
Link Miles-NFFE
Claudia Moore-NAGE (attending virtually)
Mark Bailey- NAGE (attending virtually)
Christine Polnak SEIU
Terri Beer-NCA
George Cannizzaro-NCA
Michael Stephens-VBA
Robert Sheena-VBA
David Perry - VHA
James Zeveski-VHA
James Leahy-VCS
Simon Ravona – OI&T
Gia Chemsian-OGC

Mildred Manning-Joy – NNOC/NNU (attending for Irma)
Jason Griesbaum (OI&T observer)

January 30, 2024

Migration of Personal (work) Home Drives to OneDrive

- Brandon Gonzales, Gary Thompson, Tomasz Marszalek, Jason Miller – OI&T

Microsoft OneDrive offers 1 terabyte of personal storage for work documents and is accessible from any GFE device. Everyone with a va.gov account already has an account. When you get new GFE, you won't need to transfer files; they will already be there.

Migration will be from the home drive (which might be the u-drive, p-drive, or something else) to OneDrive. No data loss after the migration – everything that's currently in your home drive will be moved. This will take place either over a weekend or overnight. Right now, this is voluntary

by site. Communication has been sent to all area OI&T offices. About 30% of all sites have already migrated. Estimated completion date is January 2026.

Jim L– Do we have to put in a ticket to get this done? Is there not a set schedule for all program offices? VSC employees are centralized to St. Louis but are placed in facilities. We're going facility by facility, so your staff will be migrated when the facility they're placed in migrates. You can get with me off-line and I can get things moving with your IT.

Jeff – Do employees have to do anything, or does the migration happen automatically? It's automatic. If they do nothing, it will eventually migrate anyway. *Will you send something to the field so employees will know when the migration is happening?* Yes, communication from local IT is part of the process. They will know the process, the dates, and if there's anything they need to do to prepare. *If an employee has been out for an extended period of time and has to reset their OI&T account, or if you leave the VA and come back later, will you still have access to OneDrive?* For employees leaving VA, OneDrive will alert the manager that an employee has left and the manager will be able to save the files on their behalf. For employees on extended leave, their files will be recoverable when they return. *Are they saved forever, or is there a date where they won't be recoverable?* If they are saved by the manager, they will be there permanently. If the manger doesn't save any of them, they will still be available for up to a year.

Proposed Updates to the Designated Access Standards Regulation for Telehealth, Drive

- Dr. Mark Hausman, Executive Director for Access Transformation, Office of IVC

Update on three rule changes, one of which is related to telehealth appointments. When clinically appropriate, VA is going to aim to include telehealth appointments as counting toward meeting access standards. Currently, they do not.

Rule two has to do with drive time. Veterans that need primary or mental health care are community care eligible if they live outside of a 30-minute drive time. Specialty care is a 60-minute drive time. The proposed change is they will only be eligible if there is a provider in the community closer or at the same distance than VA. Sometimes, we're sending them into the community but they're driving further than they would if they came to VA.

The third is related to established patients in the middle of a care episode. For example, a Veteran receiving chemotherapy. We've been asking when it's appropriate to assess community care options for these Veterans. Interrupting care is not to their advantage.

We'll be engaging in the two-step process for making these rules changes, which includes a period for public comment.

MJ – We know we're good at integrated care. If the biggest driver of community care is emergency medicine, what are we doing in terms of case management to prevent the need for emergency care? It's like we're allowing local markets to decide what kind of cases we keep and what kinds we get rid of. There needs to be an overarching clinical strategy. What we're interested in is making sure we're making the most of the resources we have. For example, we know there are unused clinic slots today. There are all sorts of reasons for that, but we want to be able to make these available to Veterans.

MJ – Are we moving from best medical interest to established patient? We're looking at when in the process we begin the assessment. Does it make sense to assess and offer community care with every single appointment? We don't think it does. It sends the message that we don't want to care for them, and it could create a worse clinical outcome. Best medical interest is one of the 6 statutory criteria for community care; we can't change that without Congress changing the law, so that's not going away.

MJ – The system that feeds the portal isn't populating it. Is the nurse supposed to call around and find out how long it takes to get an injection in the community so they can ask the Veteran if they want it here or there? We know when the VA appointment can happen, but we don't have that information from the community. WellHive [WellHive] allows schedulers to schedule Veterans into the community more easily. It makes appointment grids visible to our VA schedulers. This makes it easier and faster to schedule veterans in the community. *But it's not populated, this is what I'm hearing. You want the nurse to populate it.* It's taking time, we're building it out in a phased way. Hopefully a year from now, there will be well-populated information.

Jim L – Telehealth will improve access data, is that correct? Yes, and the why behind this is telehealth has come a long way. We view telehealth as a bona fide means of providing care to Veterans. Not every Veteran need is appropriate for telehealth, but we should get credit for the ones that are. *Canteen serves in VAMCs and clinics. Between telehealth and telework, we've seen a reduction in traffic through the canteen. My concern is how to plan for this. I'd love to have a deeper conversation with you offline about the impact on the canteen.* Happy to have that discussion with you.

Bill – How much of the VHA budget is fenced for community care? How much is spent compared to care in the VA? How much does it cost per patient as opposed to VA treating them? The overall balance of care in 2023 was about 58% in VA, 42% purchased from the community. The community care portion is growing year over year. Overall, VA care has grown, so we still provided more care in 2023 than we ever have before.

2024 All Employee Survey

- Kassie Ford, AES National Program Manager, NCOD

Typically, we wait until the survey has been finalized and then send you notification. There was a request to review the information with you ahead of time, which is what we're doing with this briefing. We've typically administered the survey in June; this year, it will be in May. This allows facility leadership to include AES improvements in their performance self-assessments.

Some changes to occupational series and demographics. Added two core items related to DEI. Removed three items and added five new items to Servant Leadership Index. Added five new modules targeted to specific administrations, occupational series, etc. Removing the COVID-19 module.

Jim L– Is the total number of questions staying the same? It used to be frustratingly long and it's much better now. There are a couple of additions required by Executive Order. Based on which

modules apply to your position, you may see an increase. I think nurses will see 7 or 8 new questions this year. We understand we can't just add and add and add. We have removed some questions.

Mark – What types of major changes has the Department made to improve conditions of employment and things that employees point out through the survey? [Katerine] We have a couple of AES questions that track whether employees have seen results from last year's survey and whether changes have been made. These scores have been incrementally but steadily increasing every year.

Bill – Do you have an idea of what makes a good manager; what part does servant leadership play in making a good manager. [Katerine] Yes, higher servant leadership scores are associated with higher levels of employee job satisfaction.

Jeff – Have we looked at long-term AES data to see what kind of progression the AES has been making and whether it's successful for the agency? [Katerine] We've gotten rid of other employee satisfaction related surveys and now only use the AES. Employee engagement has improved since we started pushing action planning. This is not happening across the federal government or at all other large agencies, but it is at VA. *Is it a significant increase? Where can we see a major change in the system? We talk about mindfulness now. Does mindfulness really have an effect?* Some of this is stuff we don't track. We track things like whether employees plan to stay in their jobs or want to leave the agency, and employees' connection to the mission. *Are all of the VISNs improving? Can we look at the ones where employees are happy and figure out why?* This work is conducted by SAIL, not NCOD. We provide the data and summarize it. We know that places where employees are happy, patients are happy. But this is not the work of NCOD. Denise will follow up with SAIL Governance.

7422 Discussion

- Gia Chemsian, OGC; and David Perry, WMC

Jeff- NFFE wanted this on the agenda because the MOU nullified by Wilkie still hasn't been brought back. The MOU set up a process for declaring something 7422.

Denise – It is called MOU, but it's not a negotiated agreement. It's a decision document. It talked about creating training and a process, but it doesn't *include* the training or process. Training was jointly developed. It opened some aspects that would otherwise be excluded by 7422 to the grievance process. For example, if the agency violated its own policy, you could grieve. The document wasn't signed by everyone – it wasn't signed by AFGE. The parties followed it anyway, but AFGE never fully supported it.

Bill – The problem is we understood management would share the request for a determination with us and give us time to respond. That's not happening.

Denise – That doesn't have anything to do with the decision document. When it was signed, LMR controlled the 7422 process. LMR has been out of the process for many, many years. We don't see the requests and we don't comment or concur. If there's a policy with a potential 7422

impact, we may have to request a determination from VHA. Bill asked me why the unions aren't getting copies of the requests from the facilities. VHA generally sends those copies to the union, so I don't know why that isn't happening – this is Michelle Dominski, so maybe you need to talk to her.

David will look into the process and make sure the union is notified and given a copy.

Jeff – Why hasn't the Secretary reinstated the MOU?

Denise – No one has asked him to.

Gia – The recission document says the MOU infringes on 7422. We call it an MOU, but negotiating over it would infringe on 7422.

Jeff – Yes, it's an MOU, but we're not bargaining the intent of a management right. We're bargaining the procedures the agency would follow before you declare 7422. Before this, those would just stack up on the Under Secretary's desk.

MJ – I was fairly certain that policy 5023 did have a procedure for facilities to follow.

Denise – It says it goes through LMR.

MJ – But it's still there?

Denise – Yes.

MJ – We should be following policy. The Statute says the Secretary, and he delegated to the Under Secretary. I have never understood why the agency would be against employees or the union trying to follow its own regulations. What is the resistance to that point?

Jeff – That is the reason the process was set up. To eliminate the number of complaints coming up from the locals where local management falls back on 7422.

MJ – Let's have a conversation about why there is resistance from the agency regarding not following our own procedures.

Jeff – We did have a process and we saw that once it was in place, the number of decisions that were sent up diminished significantly. Work was able to be conducted at the local level.

Bill – The number of 7422 cases has been 3-5 a year for many years, and there's been no change, even when we had this decision document. We had reservations with it and we didn't sign it. The only thing that really changed was the results of the requests – more were found not to be 7422. The only thing AFGE is concerned about is getting a copy of the request and an ability to respond before a decision is made.

MJ – Why can't we grieve a failure to follow VA policy?

Denise – There's legislation out there regarding that.

Bill – It's only for compensation.

Denise – When this document was written, this was one of the concerns the union had. When LMR received requests for 7422 determinations, if we determined we'd violated our own regulations, we'd send it back to the local level and point that out and tell them to resolve it. Which was great, but the unions weren't seeing that happen and didn't know it was.

MJ – People come into my office and ask "why am I getting paid less than this person?" You have to ask if there's a retention allowance, an issue of effective date, etc. But managers just say "it's 7422" and it's knee jerk. Only the Secretary can say that.

Denise – Remember that the procedures created were a recommendation but not a requirement.

Gia – To address MJ's comments, I don't think there are 7422 decisions that address violations of law by arguing it's covered by 7422.

MJ – For example, a 72/80 employee is supposed to be treated as a full time employee, but some places aren't doing that. If it wasn't a T38 employee, I could request salary data, but I can't do that because of 7422. It may not end up being a violation of law, but it could be.

Denise – Who is saying this?

MJ – Nurse Executives. I don't even have the facts. I can't even file a 7114(b) request.

Jeff – If Wilkie was able to rescind it – even if it wasn't effective, as Bill says, at least it gives us a process.

Denise – The process you're talking about is the one outlined in the training. What Bill is talking about is the process WMC has continued – when a facility requests a determination, the union is given an opportunity to respond. That should still be happening even without the decision document.

Gia – This has been in place at least since I started in 2007. That process pre-dated the decision document. What are the main things in this document you think are essential?

Jeff – The main thing is before the agency declares something 7422, we should get the facts and be able to make our case. When we had the MOU, at least some stations were trying to follow it.

Gia – Many 7422 decisions start as a grievance so there's opportunity for the union to be involved and have some discussion. Are you saying that when there is no grievance, there's no opportunity for that at all?

MJ – Yes. There was a review of performance pay and it was dismal.

David – Those conversations should be happening locally with that nurse exec or manager before 7422 is even mentioned. We need to figure out a way to foster those kinds of conversations. Every example you've offered is related to compensation. Is that the main issue?

MJ – People should be paid correctly.

David – I'm in total agreement.

Bill – AFGE won a compensation case for millions of dollars. Agency counsel wanted to settle, but the employees wanted the full amount so we litigated. The employees ended up getting nothing because the agency declared it 7422. They weren't getting paid properly under the law. We're struggling to see how the agency can take this position. We have support from Congress, even Republicans, on a bill to reduce 7422's coverage.

David – I can't speak to every 7422 decision, but I still agree with you in principle. Our intent is to do the right thing. Does that always happen? No. We'll see what the legislation bears out.

Mark – The concern from NAGE is we're back to where we started in about 2008 where local officials are declaring 7422 but they're not getting an actual declaration. They won't give the local union any information on why it's 7422. There were no timely decisions being issued. Now training is not being conducted and many HR people do not know what 7422 is.

Jeff – Is the Secretary looking at reinstating this? Is it on his radar?

Denise – I don't think he's been asked to.

Jeff – Can we formally ask him?

Denise – The unions will have to ask him.

Jeff – But can the NPC do that?

Denise – That's an internal conversation the union has to have.

NPC Discussion

VA Voices

Denise – I've given you a copy of the VA Voices recommendation. Gia has some comments to make.

Gia – I think the word "major" in the first paragraph is odd. "Larger" might be better. And in the last paragraph, we reference "BUEs" and "management" but don't say anything about non-management, non-BUEs. "All employees" might be better.

Denise – I think the language in the first paragraph is from the strategic plan, or something like that, but I'll confirm.

Gia – In the second paragraph, the capitalization isn't necessary.

Denise – I think we pulled that out of the VA Voices document as well. David, once we sign this, should I send it directly to Dr. Elnahal?

David – VA Voices is VA-wide, so I'm not sure he would be the right person to send it out. Maybe the Chief of Staff or Dep Sec.

Next NPC Meeting

Denise – The next meeting will be in the Atlanta regional office. You should have the invite already. If you have agenda items, let us know. If you want a tour, let us know.

George – Georgia National Cemetery is about an hour north of Atlanta.

Denise – We will also do a tour of the VBA and possible a VHA site. We haven't started planning the following meeting, but we're looking at west coast locations where NFFE has representation. We'll try San Francisco in July. Then we're in DC for a hybrid meeting because it's Halloween.

Possible Recommendation: Designated Access Standards

MJ – I'd like to make a recommendation with Dr. Hausman. My desire is that all program offices in VHA work together on publicizing a clinical strategy. Teaching RDUs that relate to care.

Denise – Why is this for Dr. Hausman? He talked about the proposed regulations.

MJ – The issue is how do we maintain viability for VHA into the future. Community care access metric came up in relation to the codification of these proposals. The reason we don't have money is because it's all going into community care. We're not viable into the future. IVC says "we just work on access" you have community care expenditures in emergency care, you start an initiative on case management coordination outside of IVC, you have a different office working on telehealth access. They're not working together. We need to give all of these program offices our suggestions.

Denise – Draft this and send it to me.

David – There's a lot of coordination that occurs. IVC has one aspect of it. PCS and Clinical Services are involved. We spend three days a week going through these updates with the Secretary. A briefing from the CFO could be beneficial.

MJ – In my mind, the IVC has people like Rima Nelson and Dr. Lapuz who talk to the field, and we're not seeing that. We are not seeing the entire picture of what VHA is doing to try to right the ship.

David – The Chief Operating Officer position we're creating is supposed to oversee all of those pieces.

MJ – Maybe this should be a topic for the next NPC and then we can see if we need a recommendation.

David – All of the senior leaders are eager to brief this council. It's probably not going to be just one person.

Strategic Infrastructure Update

- Al Montoya, Deputy Assistant Under Secretary for Health for Operations

Academic Infrastructure Partnerships: Maximizing PACT Act money and resources to lease space through our partners.

We've just about completed design of the new HVAC system for Miami. We're taking a more hands-on approach to addressing local issues. Next week, I'll be in Oklahoma City because they've had a lot of burst pipes. We're going to see what we can do for them. In Atlanta, they'd closed a walkway and some stairways, but there wasn't a plan to repair or replace them. We worked with them to come up with a plan to get them back in use.

Jeff – Take a look at the Broward clinic if you want to see a boondoggle. I have Broward on my list. Central office has to do better at supporting the field. That's why we went to Atlanta and why we're going to Oklahoma City. *We're going to be building more and more of these, so if you look at the history of the problems, that can help us write better contracts in the future.* What my office is really asking is how we can support the field. Houston came to us and said they needed more space, so I pulled together a team in my office to come up with a menu of options.

We've taken a look at the current MOUs and I hope Claudia is already seeing improvement out in Coatesville. We raised the red flag about a location they were considering (Brandywine), and we're working on finding a different location now.

Philly is right behind Coatesville because Coatesville already identified a need, and Penn came back to us with a proposal. Palo Alto is looking at establishing a cancer center with Stanford. Omaha is a little different because they're already talking to the University of Nebraska. The MOU is a way to get them to start talking, but if they're already talking, there's no need for it.

MJ – What do you do vs. procurement and logistics? I think you deal with physical space but not necessarily the contracts? Contracting, engineering, VCS, logistics and redesign, bio-med – they all fall under me. On the operations side, police and Member Services fall under me. Everything infrastructure related on the VHA side also falls under me.

Jeff – When you're opening a new location, are your people coming in to help with the openings, or do you just show up when there's trouble? In the past, we left activation to local leadership, but now we're trying to standardize activation so medical center directors can focus on treating Veterans. In Tampa, they told us they were having a hard time with the Army Corps of Engineers, so we worked with them to get the certificate of occupancy for their new bed tower.

We learned from that and applied what we'd learned to Canandaigua, and it opened much more quickly.

Jim L – What's the benefit to VA in partnering with these institutions? They pay to build the facilities for us and are responsible for maintenance.

We have an IPT with DOD looking for ways to share space back and forth. I can share more information with you at the next NPC. In Pensacola, the VA clinic is right next to the Pensacola Naval hospital. We send all of our surgeries into the community but realized we could start sending them to DOD operating rooms. They've been trying to make this happen for the last ten years, but with more support from VACO, we've been able to get it done. We're going to help them reopen surgical beds and then embed our nurses to care for our Veterans there. We're looking at resource sharing agreements too. Sometimes we just need to share staff.

Mark – When you talk about sharing staff, are you just talking about other federal employees or does that include university employees too? The only way we would share staff is through a sharing agreement. We're still using our employees. In one example, our surgeons had to clean their own ORs after surgery. So we signed a sharing agreement, and now EMS cleans all of the naval ORs full time, and we get paid for it.

VISNs 6, 17, and 22 are part of a pilot to develop a local infrastructure strategy. They're seeing the highest increase of PACT Act Veterans coming into the system. VISN 6 is going to host a VA-DOD summit with our staff and the market leaders from VHA and DOD to talk about how we can support each other and share space.

Joy – I know Durham is getting a new health care center. Do you know when that's opening? There are three new ones opening in VISN 6 right now. I'll get you the specifics. Fredericksburg is going to be the biggest. We're standardizing the design of those centers so we can open them more quickly.

[Information provided on 2-8-24:

Chesapeake OPC – Hampton VAMC
Building Acceptance – 07/02/24
1st Patient Day - 01/27/2025

Fredericksburg HCC – Richmond VAMC
Building Acceptance - 08/16/2024
1st Patient Day – 02/16/2025

Wake County (Raleigh OPC) – Durham VAMC
Building Acceptance – 11/30/2024
1st Patient Day – 04/20/2025]

MJ – We've seen some PACT Act housekeeper contractors and we're hearing about problems with those people playing video games and stuff. Who is monitoring all of this? CFM and I are working closely on staffing methodology for housekeepers based on square footage. I'm not aware of any contract housekeeping groups. For every contract, there's a performance statement they have to meet. *Goodwill came in right after the PACT Act.* There are some

instances when we open a new clinic, if we can't staff it right away, we have to go with Ability One, by legislation.

David – For clarification, PACT Act did not remove Veterans preference, it just removed absolute Veterans preference. If we're in leased space, we're not going to put housekeepers in the space. We're going to use that organization's custodial services. But for VA space, we use VA employees. And yes, we're working on staffing models for all positions.

Chris – Staffing methodology doesn't mean anything when your buildings are so old. If ceiling tiles need to be replaced, that should be FMS, which is an even bigger problem right now than EMS. But I have not had contracted housekeeping in any of our facilities.

MJ – Any movement on centralizing Police Service? We're still having the conversation. Troy Brown and his team are working to support police service staying in VHA. I'm supportive of that because it gives more control to facilities.

What would you like to see for next quarter?

MJ – Are you familiar with a software program called Flock? It reads license plates. I'm aware of it, but I can have someone come in and brief on it.

Chris – There is a new process when there's a complaint against a police officer. It goes into a system and immediately triggers an investigation, usually by another facility. That can take a long time. What if it's criminal in nature? I'll look into this and get back to you.

January 31, 2024

NPC Survey Discussion

- Ryan Fulcher, LMR

Results of the LMF survey conducted agency-wide in 2023. Survey was emailed to facility and VISN directors and union presidents. 588 people were sent the survey and 199 responded. Pretty even split between management and the union. *Request for more detailed data by administration.* We have it, and it can be provided. Most have an LMF or engage in some sort of partnership activities. Most said their L-M relationship was fair to very good, with the majority saying it's very good. Most meet monthly for an hour and believe that's adequate. *Jeff – prior to Trump, most NFFE LMFs were monthly and lasted half a day. Joy – ours was an hour, but it was shared with AFGE, and it wasn't enough time.* This is what the data is telling us. I'm not advocating for anything specific, but when we put training together, we should be letting folks know what is working at the majority of sites.

Majorities say the meetings are respectful, effective in resolving issues, that PDI is taking place, and that its been beneficial. *Request for data broken down between management and labor, who said it has been beneficial.* Will be provided. Most have a charter. Most do not have metrics for measuring success. 40% report fewer grievances since reestablishment of LMF. Most say LMF is leading to greater trust, PDI is creating better working conditions, LMF is leading to positive changes, and they can informally resolve issues at LMF. Most want training on PDI. Other requests are for training on improving the relationship and building trust. Most want in

person training, but about half said they'd be happy with virtual instructor led. Bill wants to know who said they do not need training and why? Is it because you know what to do or because you do not care.

Next step is to reach out to the sites that are doing well and learn why. Then reach out to sites that need help and/or do not have LMF and begin developing and providing training.

Talent Experience Platform/HR Smart Company Directory – Organizational Charts

- Corinn Hardy, Acting HR Smart Product Owner, Human Capital Information Services, Center for Enterprise Human Resources Information Services

Employee Self Service features are part of the TXP/HR-Smart platform. Rolled out in 2022. It allows employees to do certain things for themselves that they used to have to go through HR for. The Company Directory allows employees to view their own service card and org chart, and to search for any other VA employee and view their profile and org chart. Briefing slides provide instruction for accessing this information.

MJ – This allows employees and managers can bypass the union in submitting telework agreements. If a change to an employee's telework status occurs, you have to notify the union. [Denise] – Notice was sent to Oscar about this function, and as of now use of the self service portal is voluntary. [David] – The telework form just documents a request to go onto an agreement. Notification is a separate process. All this does is let you fill out the form electronically. *MJ – It doesn't route it to us.* David – neither does paper. If they fill out the paper form, it still doesn't go to you.

Bill – Can we see bargaining unit status in the portal? The company directory does not provide bargaining status, but the employee's individual card does. That's not searchable to anyone else. *Can we find anybody across the enterprise?* Yes. *How current is the information?* It depends on the data field. Most are immediate or that night. *Will this let me see all employees at a given facility?* – It won't give you a list. Employees can only search by individual name.

MJ – Are contractors in here? No, they are not in HRSmart. *George – Does this include temporary and term employees?* Yes. It does not include contractors or WOCs. *Jeff – Will ICPS employees show up?* No, they are contractors.

MJ - Is the plan to use this for 505 data? David – No. 505 is position inventory for HRSmart. Unencumbered positions are included. *How would you prevent the agency from hiring contractors willy nilly?* If I'm going to use a contractor, I have to map it to a vacant, funded position number on an org chart. I have to provide the position number to the contracting office. I can't hire a contractor until I can prove I have the money to fund it. *Jeff – You bring in the contractor and they can convert to a permanent employee?* No. They have to compete. I can only use a contractor for up to a year. *Mark – If facilities are contracting out, does that have to be reported to VACO?* No. It can be approved by the MCD and their VISN.

Denise – Let me remind you, the Integrated Critical Staffing Program (ICPS) is intended to fill a short term need. A nurse leaves, and you hire a contractor while you're recruiting for and filling

that vacancy. *MJ – We're hearing we have to be FTE neutral. Then we're hearing they're abolishing positions.* David – If I just abolish those positions, I can't use contract work at all. I have to have a vacant and funded position in order to use them.

OI&T Employee Experience

- Nathan Tierney, Deputy Chief Information Officer and Chief People Officer, Office of People Science

One AES area for improvement is workgroup and employee recognition. We're focusing on service awards, special contribution (tripled the budget for SCIs) and performance awards (doubled award amounts), and QSIs (tripled the number in two years).

Another area of concern is SES motivation and ethics. They are required to have AES action plans. We do a two-year SES integration program. Wrote engagement metrics into performance plans.

Implementing SSRs. Conducting an SSR impact survey to determine whether it has an impact on recruitment, satisfaction, and staffing. We think it will.

Because of the budget, we're not expecting to be able to increase FTE very much in 2024 or 2025. Hiring including backfill has to be justified for most positions. Regained some HR authority from WMC.

Joe – Can you talk about funds going to AI & CyberSecurity? An Executive Order requires me to allocate some of my FTE to AI and Cyber.

Bill – What grade are the people who create and maintain websites? I'll have to get back to you on that. *One of the reasons I get contacted by OI&T employees is because they lose access to programs they need in order to do their jobs. Is this a widespread problem?* Not that I know of, but when you hear about things like this, please let me know. I do know people have had a problem losing Adobe Pro, but we found 80% of people who have it aren't using it.

MJ – Are there just two AI projects? Wellhive and one other? OI&T is only involved from an architecture, strategy, and oversight perspective. This administration is very interested in how to leverage AI. *I'm hearing there are problems with the Cerner contractors.* That's outside of OI&T – that's EHRM. But I do know they have a good team working on it.

Suicide Prevention

- Dr. Christopher Watson, Acting Executive Director, Veterans Crisis Line

Three tenets of suicide prevention: suicide is preventable; requires a public health approach; everyone has a role to play. Suicide is increasing in the U.S. for Veterans and non-vets, but it is decreasing for vets enrolled in VHA care. More Veteran suicides are committed by firearm than any other population.

0.26% of veteran suicides (20-25 a year) take place on a VA campus. Half of those are in a parking lot or garage. Chartered a workgroup in May 2023 to review polices and practices, and to make recommendations to senior leaders. The workgroup promotes placing signs in each garage with VCL contact information and information about what to do if you're in crisis.

Lethal means safety intervention pilot: VCL responders can offer things like gun locks and pharmacy medication takeback envelopes to callers. Currently evaluating the results, but it appears to have been very positive.

Bill – Are you going to start a LMF? I met with all locals this fall and it came up. My understanding is we sometimes have to go to national first before we can go to the locals. We're figuring out the next steps on how to do that. [Denise] – I'll contact you to discuss this.

MJ – I think the materials in the SAVE training need to be updated. It's more awareness training and I think your practices have evolved and employees should know about that. Thank you for that feedback (taking for action).

Joy – Atlanta and Jesse Brown have both had incidents in the last 30 days. What is the plan going forward? We work through the local suicide prevention coordinators to support local medical centers, but they create their own plans.

MJ – There's a disconnect between the program offices that are involved with this. Does VCL have after action responsibilities when suicide happens on campus? That is mostly handled by the local facility. We want to be there to support and help align some things the facility will need moving forward.

Mark – Does your team-work with police on this? Hiring more police could help prevent suicide. Yes, this is something we're talking about quite a bit. We need more mental health staff, more nurses, and more police.

Prevention of Workplace Violence

- Dr. Kelly Vance, Director of Education and Informatics, Workplace Violence Prevention Program, Office of Mental Health and Suicide Prevention

Joy – We've been asking for metal detectors in the emergency department at Jesse Brown for a long time. Why haven't those been provided yet? Physical security falls under police. We manage the human behavior aspects of security.

Joe – What kind of training is available to help staff de-escalate these situations? A big part of the workplace violence prevention program is to train staff at all levels of the organization. One thing we train in Prevention and Management of Disruptive Behavior (PMDB) is awareness around location of weapons. Asking about weapons should be a standard part of an intake assessment. *Do you have data on the percentage of employees who have completed the training?* As of May 2023, 73% of high-risk employees had received verbal de-escalation training, 63% received physical safety training, and 45% had completed training on restraining

violent individuals. *Can we see the training materials?* Yes, they're on the WVPP SharePoint site: https://dvagov.sharepoint.com/sites/VHAPMDB/SitePages/Home.aspx.

Joy – We have a wait list at our facility. There are a lot of facilities that are looking to hire full time PMDB trainers. What we're finding is not that we need more trainers – we're not filling the classes we do have because people sign up but can't get away from work when the training rolls around.

MJ – I'm hearing complaints from psychiatrists being called in when they're on call to help with an admission. You need people who do this full time. This does fall outside of WVPP.

The disruptive behavior reporting system is a desktop app that lets employees report any incident they think should be reported in their own words. Use is increasing every year. We received almost 71k reports from across VA last year. There has also been an increase of reports of disruptive behavior happening when we send our staff out into the community.

Joy – We have a lot of patients who come in with red flags. They might say the patient has to stop by the police station first. They don't do that. The flags are designed to function as notification to the employees. The safety they provide is awareness. You're right – they don't force the patient to do anything. But it raises the alert level for employees who know they're going to see that patient today. The facilities who are using this system the best are creating tiers for their flags – police escort should be the top tier. Lower level flags indicate different actions the staff should take when dealing with these patients. These should be discussed during daily huddles. We're also advocating for clinical staff to be given more admin time to really chart these things.

For questions, please contact: WVPPConsultation@va.gov

Introduction and Discussion of Anti-Harassment Stand Down

- Cassandra Law, Assistant Secretary for the Office of Human Resources & Administration, Operations, Security, and Preparedness

My first day in this position I sent out two memos. One was to direct OGC to review all training materials related to sexual harassment, sexual assault, and overall harassment. The second was to the workforce asking for an anti-harassment stand down. It's a pause and focused review of what it means to have a harassment-free workplace. To reinforce the zero-tolerance policy and to highlight what that means across the enterprise. The goal is to develop a plan that can be implemented after we meet our bargaining obligations.

Jeff – The biggest problems we see are not employee vs. employee, they're management vs. employee. We only do the stand down when we need to check a box because senior leaders and the media are involved. I'm committed to being proactive about this.

Jim L– Can you give us an update on the consolidation of ORMDI? [David] – We're still working on an MOU between VA and ORMDI, but it should happen sometime this year.

MJ – There are separate statutory definitions of EEO and anti-harassment. There are different processes and employees don't understand.

Mark – I'd also ask you to look into how VA investigates harassment by doing a fact finding and give employees the option of filing an EEO.

I'll look into all of these things.

Gia – I have taken MJ and Mark's concerns about clarifying processes back to my group, and we're looking into it.

February 1, 2024

HDSP-12 Personal Identity Verification (PIV) Card Transition – "Cliff Event"

- Christopher Layton, Director, HSPD-12 & Credential Management; Daniel Galik, Executive Director, Office of Identity, Credential, & Access Management

In 2017 the Federal CIO mandated all federal employees must have a USAccess version 8.1 or equivalent PIV card by June 30, 2024. GSA is managing the program. GSA has been bulk printing cards from a central location and sending them to local PIV offices. PIV offices scan and record the cards and contact employees to tell them to come in and pick them up.

Gia – Is there a reason employees can't do walk-in appointments? There are too many people for walk-ins to work.

Terri – Will there be extended hours or extra days? It's hard to get an appointment. Individual PIV offices can make those decisions if they don't think they're going to be able to get everyone in on time. I have a list of facilities that are in danger of not completing the transition by the deadline that I've sent to the VHA Chief of Staff, so they can encourage those facilities to come up with a plan for completion. In July, anyone without a new PIV will have to get with OI&T to get a username and password to log in.

Joy – When we make appointments to go in for a new PIV, we're told they don't know when they'll be able to give them to us because Washington only sends them 100 cards a month. There is the option to print locally. For the central print, the number an office can order is based on how many they usually print in a month.

Gia – Is there a website where employees can track where they are in the process? Your sponsor can track that in USAccess.

Jim – There's no standard procedures for PIV across VA. Is that something that's coming in the future? We all follow Handbook 0735 and 0710. PIV is mostly decentralized. I am working with VHA to standardize the process. It's hard because they don't report to me.

Office of Nursing Service Updates

- Karen Ott, Director for Policy, Legislation, and Professional Standards

Elimination of PSBs has taken about two years. It required changes to five handbooks. The policies were signed on January 29th, but have not been published yet, which means we can't start following them yet.

Main goals are to return time spent on boards to patient care and speed up time to hire. Make hiring and promotion more objective. These changes mirror the T5 and hybrid process.

Bill – How does this increase objectivity? The complaints we received were board members are biased and stay on the boards too long. I understand that there is concern with the objectivity of the supervisors as well. *What is the advantage of making it consistent with the hybrid process?* It's simpler and people are more comfortable with those procedures.

Joy – Why wasn't the union notified about training before the managers were trained? The BUEs are not being trained right now. This training is for senior leaders and HR. RNs will be some of the last to be trained.

Joe – The problem is local union leaders are getting notified about these management trainings, but national wasn't. We want to be treated as partners. I understand that.

Jeff – Our MOUs say the unions will be part of the trainings, but we haven't been allowed. [Bruce] – As I learn more about training opportunities, I'll be sharing that with all of our labor partners. *Jeff – When you roll this out to BUEs and the union officials haven't been trained yet, that puts us in a bad position.*

MJ – Nurse execs used to be responsible for proficiencies. Now it's in HR Smart and HR owns it. No one is talking to the employees, employees don't know how to submit self-assessments, documents just show up in their eOPFs that they never signed. [David] There are a lot of groups that have to be trained. Labor will be trained at the same time as BUEs. *MJ – The anniversary dates don't match the proficiency dates in HRSmart. HR is backdating proficiencies to get them into the eOPF on time.* The clean up is supposed to be done in accordance with policy. If it isn't, you can grieve – we're not instructing the field to ignore policy. *Did we get notice about the data clean up? If you're changing anniversary dates, we need notice.*

Jeff – We've had people on these committees and anniversary dates were the hardest part. [MJ] Dave's shop has to clean it up now. David – Yes, HR is responsible for getting everyone aligned to 9/30-10/1. That's part of the reason HR is being trained in the first group.

We intended to have everything start at the beginning of the last fiscal year. It didn't happen that way. There were delays in getting everyone into ePerformance. We won't have those problems this year, and I'm hoping employees will see how beneficial this system is.

Mark – If this doesn't work, will you converse with the unions so we can be part of fixing the problems and so we can answer questions when employees come to us for help? Yes.

Joy – Are we moving from nine dimensions of practice to five? Yes, the dimensions of practice and qualification standards were really out of date. *Can the union get trained separately?* Yes, I was going to suggest that.

MJ – The training doesn't seem to cover educational waivers. Are those still an option? I'm not sure how to do it in ePerformance. Yes, and it's in the policy. We will train on it.

MJ – In 2020, Handbook 5017 was changed so a local facility could decide whether they wanted to allow an SAA or SAP to reset the anniversary date for PSIs. Is that still in policy? [Meggan] SAAs and SAPs shouldn't impact anniversary date of grade. I'll look into it and get back to you.

Joy – Will APRNs get an automatic promotion to NIII after six years? Yes.

Joy – When will our nominees get invited to participate in the workstreams? As soon as possible. I will send that information to Irma.

VHA Access Sprint Update

- Dr. Ryung Suh, Chief of Staff; Dr. Lisa Arfons, Executive Director, Office of Integrated Veteran Care

[Dr. Suh] We know the care we provide is the highest quality. Our goal is to improve access to that care. We have nation-wide efforts, but the Sprint was an opportunity to allow local leaders to try things that might work in that specific location. Three Sprints, one for primary care, one for specialty care, and one for mental health. Considering policy waivers when appropriate, and incentives for leaders and employees. Reviewing results now and as we decide what to implement, we will notify you and negotiate.

[Dr. Arfons] VAMCs were asked to submit action plans and to identify impact to BUEs, and bargain locally if necessary. Most involved extended hours and changes in TODs. The first two Sprints both reduced wait times. The mental health sprint is ongoing, but there was an improvement in seeing new patients and providing same day appointments.

MJ – It seems like a lot of the same stuff we've seen before. I have a concern about the long-term sustainability of certain surgical units and inpatient beds. [Dr. Suh] My concern is the sustainability of the system as a whole. We've done a good job of growing our system in a competitive health care market by adding FTE. But the shift towards community care has continued. We're pushing to offer VA care to everyone, even if they're eligible for community care.

Jeff – We're not a for-profit organization but we're trying to mimic what a for-profit organization does. We are not concerned about the profitability of our operations. We're concerned with prudent allocation of resources so that we can provide care. *We need to know what we do well, like spinal cord, and what we don't do so well, like oncology and women's health.* We're growing the women's health program. The quality of our hospitals, objectively, is better. Patient satisfaction is objectively higher. We still have improvements to make. [Lisa] Studies show VA does a better job with treating prostate cancer than community care. Same with ED care. *If you want the best people, you have to pay them. And if you want to retain them, you need to let doctors be doctors and not make them do all their own admin.* [Dr. Suh] – We have some of the best providers. We're using our PACT Act authorities to maximize compensation.

MJ – Politically, a lot of people want VA to turn into a health insurance system and not a health care system. You have to do a better job of capturing integrated workload. [Lisa] I agree with you.

MJ – I'm concerned about policy waiver for the 93 action plans. [Lisa] We didn't waive entire policies. We waved sentences. And we probably approved less than 5% of policy waivers because they usually didn't actually need one – they just didn't understand the policy. *View alters have to be reduced.* Boston just saw a 14% reduction in view alerts because of the Access Sprint and providers report is made a huge difference.

MJ – People want to be seen face to face for mental health, but providers want to work in the community because they can do more telehealth appointments. In Tomah, they had 130 mental health vacancies last year and are down to 17. These people are coming into the facility because that's where the veterans want to be seen. They're shifting the makeup of the mental health staff and leveraging recruitment and retention incentives.

Jeff – We have problems with burnout. Providers have to work at home after their tours to get their view alerts done. [Dr. Suh] Many of the access sprint initiatives surround eliminating clinical inefficiencies. [Lisa] The clinical inefficiencies workgroup is reviewing 17 pages of recommendations. There are five required view alerts and the rest are optional.

Bill – Do we have a harder time hiring doctors than the private sector does? [Dr. Suh] I'm not sure it's harder here than anywhere else, but the market overall is struggling. We are limited by how much we can pay. You can make 4 or 5 times as much in the private sector, and that's a major problem for us. We're fighting for greater flexibilities, but in the meantime, we're making use of temporary employees to continue providing care. *Bill – When I meet with my congressional representatives, I ask for more money for VA employees. But if we're not having a harder time than the private sector because of the pay, I won't make that argument. Do we have statistics I can show them?* We do have data, and I think David can provide it. [David] Yes, that's the data we use when we put forth new legislation. In Oklahoma City, a cardiologist can make $600K in the community, and we can only pay $400k, so we have to contract that out, for about $2 million. PACT has helped, but we're still limited.

Merger of Hines and Jesse Brown VAMC

- Daniel Zomcheck, Director, VISN 12

Idea is to integrate and modernize Hines and Jesse Brown under one leadership structure. Maximize care options for veterans, improve access and quality, reduce use of community care, and better engage employees. JB is on the west side and sits next to most of Chicago's larger hospitals. 1-B complexity. 14 aces, land locked, and busting at the seams. Grew FTE 7% last year, but there isn't enough space for everyone. Hines is in the west suburbs, only 10 miles away. 147-acre campus and a 1-A facility. There is room to grow and build at Hines. This is probably the only place in VA where there are two separate hospitals in one city, with separate leadership structures. JB spends about $25 million more dollars a year on community care than Hines does, even though their patient populations are about the same. It doesn't have enough space to see all the patients.

The staff talk to each other, and they make note of the differences. It's a problem when it comes to pay, if one facility does a retention incentive and the other doesn't. Performance awards are different. When a veteran committed suicide at JB last month, they had townhalls and engaged the employees. That wasn't offered to Hines employees immediately, but those employees had a lot of the same fears and concerns.

If the merger happens, it still won't be the largest or most complex health care system in VA, but it would have the most employees.

No one will lose their job. Employees also won't be forced to change duty stations. This is meant to expand care. Everything stays open.

I haven't formally proposed anything yet, and I won't be the one who makes the decision. I'd like to get feedback from you before I decide whether or not the propose it. I've met with the local unions, VSOs, and supervisors, but not the employees. One concern I've heard from the unions is employees like to have their supervisors physically around. If there's one director or one service chief, where will they be? I don't know the answer to this.

Joe – Have you discussed this with national labor partners? No, this is my first engagement at the national level. *Our concern is with reductions, transfers, transfers of assignment, floats, etc.* There is no potential for reductions. If we move or consolidate offices, it will only be after negotiating. *There was a proposal from the AIR Commission to rebuild parts of Hines and part of that recommendation was to merge the ELC. Is this driven by that?* No, I own this. Yes, it was a recommendation, and yes there are some similarities, but they also recommended some things we're not interested in.

MJ – Will you lose any beds? No bed closures, and we hope to add. *Will there be any name changes?* The VAMCs will keep their names but we will probably add something like a Chicagoland VA Health Care System. *It's a problem because of the FLRA certificates.* [Denise] – I'll look at the certs and we'll talk about this. *Are they the same locality?* Yes. *You said you'd move the administrative services, but not the people. How does that work?* The intent would be once new space is built at Hines, we'd move the services and the staff from JB to Hines and convert the admin space at JB into clinical space. That's one of the things we need to talk about. It may be through attrition.

Bill – We'd encourage you not to do townhalls or talk to the BUEs until you've completed negotiations with us. This could lead to unions petitioning to hold new elections, and this could make the employees unhappy. [Denise] – If everything being done now is pre-decisional and Dan is trying to collect information from all stakeholders, what's the problem with a townhall to allow the employees to provide their feedback? *It's not a legal issue, it's a practical issue. The rumors will increase. They already think this is definitely happening.* I understand what you're saying and apologize that you're getting lit up about this. My intent was that if they hear it from me, it will dispel rumors, and they can bring their questions to me.

Denise – I don't see a better approach. What was he supposed to do differently? *Linda – Start with the NPC, so we can talk to the locals.*

Bill – Then talk to the local union leaders. They know what the employees' concerns are.

Chris – If the goal is to bring in more patients, you are going to need more staff. That's the plan.

I'm still recruiting for both ELTs, but I am going to hold back on the Director for Jesse Brown. I feel urgency to make a decision before the acting director's term ends.

Denise – I hear what you said about the townhall. But the rumors are already out there. A townhall could be helpful. *Bill – People hear what they want to hear. The best course is to let the local union leaders tell the employees no decision has been made. Linda – Meet with the locals regularly. Chris – When we get calls from the locals, we can help explain that this is PDI.*

NPC Discussion

VCL Recommendation

Bill – We should endorse the VCL and what they're doing, especially along the lines of addressing suicide on campus. We should encourage them to expand their community connections, which they're already doing.

Chris – In VISN 2, the police are doing training with local entities (local sheriff's department, etc.) on how to get Veterans in crisis to a VA for intervention. We might want to share that as a best practice.

MJ – Our recommendation should be that asking whether magnetometers were used and whether they have 24/7 police presence is part of the after-action review. Operation SAVE should be updated to include the suicide hotline. We need more PMDB trainers.