National Partnership Council Meeting Minutes
4/9/24 – 4/11/24 (Atlanta, GA)

NPC Agenda:

Agenda NPC
Quarterly Meeting -

NPC Members:

Alma Lee - AFGE (Not present)
Denise Biaggi-Ayer - LMR (Co-Chair)
Mary-Jean Burke - AFGE (acting Co-Chair)
Bill Wetmore - AFGE
Irma Westmoreland - NNOC/NNU
Joe Henry - NNOC/NNU
Jeffrey Shapiro - NFFE
Link Miles – NFFE
Claudia Moore - NAGE
Mark Bailey - NAGE (virtual)
David Palmer - SEIU (Not Present)
Doris Gruntmeir - OGC (Not present)
Terri Beer - NCA
Abner Concepcion - VBA
Linda Parker-Cooks - AFGE/VBA
Mary Anastas - VCS
Robert Sheena - VBA
Christine Polnak - SEIU
George Cannizzaro - NCA
Gia Chemsian - OGC
Sarah Porter - OIT (Not present)
Michael Salazar - OIT (Not present)
James Zeveski - VHA
David Perry - VHA
Ava Pichon - VHA
Simon Ravona - OIT
Ryan Fulcher - LMR

April 9, 2024

Meeting began at 9:15 a.m. ET at the Atlanta VBA Regional office in Decatur, GA.

Denise Biaggi-Ayer, Executive Director LMR (Co-Chair Management) and MJ Burke acting as Union Co-Chair in Alma Lee's absence. Denise and MJ welcomed everyone.

Access Sprints – VHA

- Hilary Peabody, Deputy Under Secretary for Health, VHA
- Dr. Jennifer Strawn, Executive Director, Office of Nursing Services

Access Sprints are part of overall strategy and multiple initiatives. 3 waves, primary care, specialty care, and mental health. 3 key enablers: improving team-based health care delivery, policy waivers, receptions. Outcomes: three key measures across each wave: 1. New patient appointments and across all sprint waves saw an 11% increase in new patient appointments. Bill - asked if all of these are unique, new patient appointments.

Hilary – Although it's possible that a patient could change hospitals and would show as a new patient, that would be an anomaly.

Bill – Do you expect to continue seeing these kinds of increases?

Jennifer – There is sustainment we believe in these increases.

Hilary – 2nd measure of patients waiting greater than 20 days for primary care. As new patients came in the door, fewer patients waiting a long time to get an appointment. Wait time measures and meeting those standards.

MJ – Asked about naming conventions for consults as it relates to staffing. There is a great variation in GI, cardiology, and PACT Act. Better understanding of CPT codes and telehealth.

Hilary – Agree we need education and standardization in those areas.

MJ – Want to be sure people are not driving toward a measure but toward the process that we want.

Jennifer – I agree we need more standardization; that is one of the focuses that we're working on for Access and to almost anything, Staffing Methodology, Telehealth work.

Hilary – New patients waiting for community care did decrease. Some veterans were just no longer wait time eligible because we got them in, and some just waited to see their provider in VA rather than go to the community. Access Sprint Outcomes Slide.

Bill – What is the difference between virtual care and telehealth?

Jennifer - It's the same.

Irma – There are a lot of places where Panel sizes are over. We're not adding providers at the rate that we're losing them. Using virtual care and telehealth but having the patient see the whole team is why they come to the pact team. Lower feasibility means you're not going to do it, is that accurate? The way these appointments are stacked, they can't keep up with their alerts and they end up staying late.

Bill – Do we have fewer providers across the enterprise? Do we have fewer? Are we losing providers faster than we are hiring them?

Jennifer – I was looking at data yesterday, we do have more than last year though there will always be a shortage of primary care providers, not just in VA but nationally and internationally.

Jennifer – Clinical Team Inefficiencies (CTI) Workgroups – we're convening and monitoring with other teams. Looking at best practices, looking at developing change management communications, tracking and reporting. Jeff mentioned he was not happy unions were not in these workgroups and were not able to provide feedback.

MJ – CPT codes, how book ability is measured, if I get those back.

Angela – Administrative burden on clinical staff, they feel stretched. Over 600 suggestions came from the field. Consult update request/view: a job aid was offered. Education on how to turn off informational alerts was provided. Additional Signer without action required. Medication renewals for pharmacy service.

5 priority options: foster a culture of continuous access improvements, refine access performance management infrastructure, streamline enterprise-wide access data monitoring activities, reduce administrative burdens.

Hilary – We're happy to take questions but have to get off for another call.
Reference of how there are Chief Medical Officers in all VISNs and now they have Chief Nursing Officers as well.

NPC Discussion

The next NPC meeting will be held in San Diego July 16-18th and the October meeting will be a hybrid, in Washington, DC. Discussion held regarding the value of cemetery tours. Following input from everyone, it was decided not to visit the Cemetery in San Diego, but instead to invite the locals from site locations to meet with NPC and have more time for discussions and local feedback.

Stay in VA, VHA

- Russel Pearl, Director, Workforce Recruitment and Retention;
- Jessica Pierce, Executive Portfolio Manager, Workforce Solutions
- Tiffany Chavis, Workforce Retention Consultant

Russ - The initiative is centered around the employee's experience. Conference was held last month to learn more about how to engage employees. Stations all over the country use Stay in VA. Every voice counts. The goal is to step away from performance and get to know our employees, how we can help improve their workplace. This all started in 2016 in Tomah, where there was high turnover, and an RN manager had 1-on-1 conversations. It led to improved turnover, went to Shark Tank, and it is now a practice considered best in VA. Touchpoints are 1-on-1 conversations with supervisors and employees. Not performance/disciplinary conversations at all. Touchpoints are voluntary and confidential – explicit permission must be granted by the employee for the supervisor to share. The purpose is only to nurture the relationship. Encourage the conversation take place somewhere besides the normal conference room. Employees may have requests or comments that could only occur within the touchpoint discussion. Reviewed 30-day, 90-day and Annual Touchpoints. All touchpoints are meant to address some common but also unique purposes. There are community of practice calls for additional feedback for supervisors. Finding time is often a supervisory concern but often understand touchpoints are an investment. Exit touchpoints are different from exit surveys. It' a conversation, not a survey. The return on investment is there.

Bill – Are supervisors being trained? Several types of training such as community of practice calls, we offer individual consultations, the Stay in VA conference. We negotiated exit surveys, are you saying these are not being used? I understood you to say that they can't say why they're leaving.

Russ – The difference is that surveys are pursued after the employee has left. The response rate for exit surveys is not the best. One is designed to gather information before they leave, the other is designed for after they leave.

Bill – Is it being required throughout the enterprise?

Russ – The goal was to do this organically. So facilities that want to incorporate it do so.

Bill – Was LMR advised of this?

Russ – Yes, we briefed AFGE in 2021. And the questions represent a survey if you will.

Irma – The data that is gathered, where does it go and how do we see it? I disagree that this is somehow better than the exit survey that we have; it's done by the same people. If we need to reevaluate the exit survey, then let's do that, but two different exit survey pieces. I'm appalled that we're not getting that.

Russ – My point wasn't that the content isn't really different, but the timing of them. Data, that's internal, but if the manager is hearing that same thing, that could show that it's something the supervisor may need to address.

Irma – It says the exit survey is reactive and non-conversational. It obtains pre-determined reasons of why people leave VA. If you're just having these little pockets of information in silos, it's not going to work. It really is running close to a union bypass to me.

Jeff – I agree this is bordering a ULP for bypass. After you get this data, you're going to notify and invite the union president in to understand the data?

Russ – I would have to poll local managers. But I would be happy to help support that at the local level where it can be a recommended practice.

Chris – I would like to see something in there about where information is being shared. This is kind of a slippery slope with employees going and meeting with management, but when things go awry, we have to come in and miss the opportunity to be a neutral that sometimes we have to be.
David explained there is no data kept in a system of record. The supervisor keeps the data and it is not shared.

Jeff – Requested testimonials regarding feedback.

Clinical Deployment Team Program, VHA

- Derrick Jaastad, Executive Director, VHA Office of Emergency Management

Derrick provided an overview/refresher on CDT published in 2021. These were subsequently narrowed down in size. Three different options were possible. The decision made to sunset the program was strategic. VA can still train for potential deployment quickly. Personnel will begin the transition into local facilities out of CDT positions. We understand this is a little unconventional for the notice, but we wanted to notify our labor partners as quickly as possible. Employees can still volunteer for opportunities and DEMPS is going to be the future of the program.

MJ – Was the funding for position prior to 2022 related to CARES Act, or COVID money?

Derrick – CDTs were not related to CARES or Covid money. It came out of the VISNs budgets. The governance board elected to reduce the VISN budgets so this reduced their budget and that money goes back to the VISNs.

MJ – But when someone is deployed under DEMPs, how is the activity of those practitioners being costed?

Derrick – When they're on deployment, the receiving is being picked up for travel. If it's under 4th mission, it comes from FEMA. Or it could come from HHS.

MJ – The question becomes, we have budgetary constraints and pauses, so how do we execute without a detrimental effect?

Derrick- If there's a call for support, those Directors cannot be penalized, but getting it into performance measures for line officials, is the way we do it. The CDT personnel onboard were scheduled to work 10 months for their home station. Whether there is an opportunity for a cohort for an emergency, yes, there is.

ONS Pay Code Review

- Lauren Kuiper-Rocha, Executive Director, HR Center of Expertise
- Meggan Babcock, Director, Employee/Labor Relations, Performance Management & Worklife

Lauren – We identified misalignment of nurse assignment codes. We further identified issues around utilization of assignment codes. Bottom line, we're doing process improvement work and found some hiccups in assignment codes and locality pay schedules and problematic uses of assignment codes. We have two buckets, one is non-pay impacting and where there is a misalignment, they will correct that in a way that won't impact pay at all. In the other bucket, it's more of a quality assurance type exercise. We uncovered errors in the employment record where employees are on assignment codes not compliant with the policy. It will require looking at the personnel record. Changes where there is no pay impact will be made first. Automation in HR Smart may mitigate these historical issues. Regular and recurring reviews will occur.

Lauren – We have a set of business rules that define the assignment codes.

MJ – I think people got greedy. Educate me on who is responsible for making determinations.

Lauren – Field operations determination. The policy standpoint is something that VHACO determines. Ensuring the correct codes are assigned is field operations. The VISN CCOE is validated by Lauren's team, facilities don't have influence over whether there is a job match.

Link – I've had this explained to me as a recruitment/retention tool.

Lauren – You've had experience, where maybe two critical care nurses are both with different codes because one may be under a recruitment/retention incentive?

Link – Yes.

MJ – There is a lot of movement of the nurses.
Bill – What is the moment in which the person is owed the additional pay?

Leah – A nurse can change codes every time their schedule is changing. There are a lot of nuances. There is a formal reassignment vs. a detail. It takes 41 hours.

MJ – Can we have a list of top erroneous assignment codes, that would be helpful.

Lauren – I can provide the list of definitions. We can discuss the trend analysis as we go through.

SAIL Governance

- Dr. Joe Francis, Executive Director, Analytics and Performance Integration
- Ron Freyberg, Director, Center for Strategic Analytics and Reporting
- Matthew Quarrick, Supervisory Program Analyst, Analytics and Performance Integration

Ron – SAIL is a balanced score card model. Analyzing and digging deeper into data to analyze performance. SAIL can identify high performing facilities. A key advantage of SAIL has been related to its learning environment. Score cards are published on VA's website. Quality measures. No access restrictions for SAIL and to view SAIL report. SAIL is divided into quality and efficiency. There are many domains that fall within each and with measures within each of those. They are updated on an annual basis. VAC3 – this is an external measure value to compare facilities in the community. Visualization and presenting data easily is something we focus on as well. SAIL used to be tied to executive performance. SAIL Governance Group, the committee is comprised of facility leadership and technical experts that understand measurements and statistics. The group meets monthly, for one hour.

Jeff – Are unions on the group?

Dr. Francis – That suggestion is not something I'm opposed to and from what I understand that is something we're looking at. It is a chartered process. Ron and I do a show and tell for the four corners, the Senate, House. We would be happy to be a recurring item on the NPC agenda.

Jeff – The union would want some kind of initial training so we can figure out the graphs. That would be something we would appreciate.

Dr. Francis – We would love to see 400,000 VA employees access SAIL. In terms of basic training, we have some short videos of reports, and we need people to make suggestions from the front line. We would love to have you be a spokesperson for this and you can start right now. I can't speak right now about membership on councils.

MJ – Integrated case management is something that we could measure that, and there are things that SAIL could measure that aren't being measured now.

Dr. Francis – Our concern is that if we focus on something new, we can't focus on something else. There are some things that we cannot get from the numbers as well. Numeric, qualitative and on the ground observation are the three.

Irma – My husband can't come to the VA because coming for a primary care appointment costs a lot of money. We lose a population if they have to pay out of pocket for their own costs.

MJ – Do you do any work with the Shark Tank?

Dr. Francis – We interact with them quite a bit.

Bill – How many people have asked to be trained on this approach?

Dr. Francis – We max out all of our available lines when we offer this. We've gotten thousands of people trained. We will put those in the chat or Ron can forward.

Bill – Do you keep statistic on how often people use it after a year of being trained?

Dr. Francis – We track users and it's about 66K per year.

Bill – If you know what works well, but instead you want them to fix something they do poorly.

MJ – Would Dr. Francis be opposed to NPC making a recommendation. We can advocate for this notion of integrated care.

Office of Nursing Service Update

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

Continuous improvements – Qual Standard Process Overview: we have live session dates and times, and they can access recordings from prior events. The SharePoint site is full but has a search engine.

Irma – SharePoint is good but RNs don't have time to get released and absorb this information. The most important thing is the link and finding that information. One thing they asked us was for available classes when there's no peak medpass or during tour changes. Their major concerns are changes in the standards and not knowing what it is, whether they'll meet them, or whether they'll meet Nurse III at the bedside without having to leave the bedside. Nurses want to know, what are examples of what I can do to meet those standards.

Karen – Thank you, I need that information and you're bringing it directly from the nurses. We can work together on it.

David – Is the time the issue?

Irma – It's that it's an 8-hour thing. I told them its broken into snippets/vignettes and there needs to be notes on how to meet the standards, not just what they are. The nurses don't have their functional statements. They don't know how they're going to be judged and evaluated, that's missing.

David – My staffing specialists can't spend 8 hours in it, we have to break it down into smaller chunks.

Irma – Small vignette training is the most beneficial thing they've done. Budget cuts, will they have any impact?

David – No that will not have any impact.

Jeff – Asked about FAQs

Karen – Yes and we're trying to use this site and promote it.

Irma – I've heard in Martinsburg, they've already said in the townhall that the education waiver won't matter, they don't believe in it, and that's a hard pill for the nurses to swallow.

Karen – I'll take that back and they need to respond in the appropriate way.

Bill – Nurses are upset about them not getting 90 days and 60 days. And they're upset about not being able to move around because their school wasn't accredited.

Karen – I'll take back the 90-day and 60-day response. Could you email that to me Bill?

Bill – Sure.

MJ – Certification on 30 days.

David – Will circle back on that.

Jeff – Standdown day to capture everyone at the end. There will be stragglers and have administrative time to do that.

Karen – ePeformance on May 1st and will be available.

Irma – One thing about that...all these pieces need to happen and it's not happening. Nurses need to know that there is a process for nurses to get the info they need on performance, but they don't know how to get it.

April 10, 2024

Georgia National Cemetery departure at 8:30 a.m. EST

- Todd Newkirk, Director, Georgia and Marietta National Cemeteries

Discussion around challenges, successes and projects at Georgia National Cemetery.

Atlanta VBA Regional Office Management and Union leadership

- Angela Seelhammer, Assistant Director
- Patrick Zondervan, Assistant Director

- Michael Foreman, AFGE President, Local 517

Discussion on local forum, cooperation and communication leading to successful partnership.
They meet monthly with AFGE/NFFE, however they do not have to wait for an LMF meeting to meet. They have an open-door policy. They have a Charter and rotate the Chair.
They continued the conversations during the previous Administration. They have had a relationship for a long time. With the LMF they simply expanded the number of people included in the conversations.
They are focusing on training and attrition. There are too many people leaving, and the PACT Act has many more Veterans coming into the VA. They want to know why employees are leaving the VA. The union brings information about why employees are leaving. The LMF then is able to address concerns expressed by employees to the union. Employees were concerned about meeting quotas. That was addressed as well through the development of a pilot.
The LMF has helped eliminate grievances and litigation, they talk and resolve issues.
Issues resolved through LMF-dress code, starting time for employee change, lactation rooms.
Michael meets with Division chiefs weekly.
Asked if there is training available for LMFs.

Atlanta VHA VA Medical Center Management and Union Leadership

- Lovetta O. Ford, Acting Director with her leadership team
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- Roosevelt Davis, President, NFFE Local 2102
- Dana Horton, Director, NNOC NNU Local 508
- Karen Carstens and Glenda Chestnut, Presidents, AFGE Locals 0518 and 2778

Discussion on local issues and challenges, including Veterans Crisis Line (VCL) challenges for staff.

April 11, 2024

Meeting began at 9 a.m. EST
Mr. Davis discussed partnership with Ms. Ford, he meets with her every two weeks. He works directly with service line chiefs and has a true partnership.
AFGE VCL reps talked about issues with overtime and lack of rotations. Also issue with lack of access to org charts.
NNU concerned about safety in the VAMC after incident in January. Suggesting need for metal detectors.
AFGE reps VAMC also having issues with org charts.

Infrastructure Partnerships, VHA

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

Al called from the Portland VAMC and mentioned the housekeepers are on 4/10s and the nurses have 72/80 which has helped with retention. There are critical infrastructure failures the field faces every day. We expect the number of challenges to rise in 2024 because it is such a focus. There is a power outage every 1-2 days. Same with HVAC systems. What is not shown in infrastructure is the impact on the Veteran. We're asking for projected cancellations if the facility has not done anything. A strictly weather closure may not be included, but a weather-infrastructure issue would be.

Irma asked about leased clinics and whether it's tracked.

Al – We do include that because of the impact it does have on veterans.

Irma – Can the clinic numbers and hospital numbers be included and whether it's related to a leased vs. owned property. The concern was also that we don't want to have over inflated numbers.

Al – I don't know if we can differentiate between leased vs. owned. These may be under inflated because we don't always have things come in. At the next NPC meeting I am happy to give you a snapshot of 2024 numbers. I will check to see what we can do on leased vs. owned.

MJ – In the policy, there is supposed to be notifications to the union for clinic closures and restructuring.

Al – I want to make sure we're fulfilling those obligations, but when we define clinic closure we're talking about the clinic closing for a day let's say, for the repairs to be made.

Ed – Correct, these are related to infrastructure closing.

MJ – I see inpatient beds being reduced. The concern is no notifications, ever.

Al – Let me go back and look at the clinical restructuring.

Claudia – Where are we with Brandywine?

AL – They're looking at new land for that specifically. Philadelphia is still trying to define what they want whereas you did that already. Looking at non-MOU we've decided not to go the MOU route. Vanderbilt would like to build a brand-new hospital. Discussion of VA-DoD partnerships of VA staff in DoD facilities.

MJ – Is this similar to how they are costed next to each other where it's all joint? Like Lovell?

Al – These facilities are not at that level, which is a 5, I don't see them being joint like Lovell. We also do resource sharing agreements. We do have veteran centers where we can share DoD resources, there are 166 across different markets. We're looking at how we can invest strategically for joint projects. This is a two-way street where we're both looking to fulfill the mission on both sides.

Bill – If you could tell me where the handbook for engaging in this activity is could you provide it? VA Directive for Sharing Agreements?

Al – Yes, I will find that and provide to the group.

MJ – With these agreements, what I've been seeing more of, is not a clear delineation of work for staff and who they work for.

Al – Thanks MJ, I'm happy to work with you on that offline. We have VA people there and although it's DoD space, it essentially becomes VA space. A collaborative summit is planned for May 2024. There is a lot of DoD space in VISN 6 where we're looking to expand and meet need. For our next NPC meeting I would love to give you a debriefing on this.

Bill – It seems like there is a lot of DoD space, is it overbuilt?

Al – There are a lot of facilities that have empty space. Years ago they started to scale down clinical services and are now realizing that was a mistake, which we're capitalizing on.

MJ – Are you looking at how, with a lack of funding, do you look at who is in crisis to see where to go with it?

Al – By collecting the data, we're better to share our story to express the need for more infrastructure dollars. We are trying to pull dollars, but also make them last longer.

MJ – How do you balance recurring maintenance with limited resources?

Al – We're putting together a tiger team of experts to look at those infrastructure issues, where they have a lot of issues and do not know where to start. I can update you on where we're at with looking at clinical visions as well, because they can be very different from one location to the next.
Jeff – We open a new clinic and it's already obsolete. Employees are expecting to go into a facility that can handle veteran's needs. Are we looking at those aspects...a clinic that is only 10 years old with a leaking roof and parking problems?

Ed – part of the issue is that one facility you mentioned is leased and we have to go and ask Congress for those appropriations. We're trying to address this so we can deliver construction projects more timely. The leased projects we're working to get more time.

Energy Weapons, VHA

- Troy M. Brown, VHA Senior Security Officer

Troy – Only the Secretary can authorize weapons for VA Police Officers. We're specifically talking about a 4th intermediate weapon. It's called a controlled electronic weapon, I can't say the word because it's a brand name, but it's yellow. There are benefits to energy weapons and there are also challenges. They may not work as well on people that are intoxicated or under the influence. We've received concurrence from VA, we've done a sequester, we want to make sure we're forthcoming and transparent.

Bill – Three issues that crop up. Why is it easier to investigate the use of energy weapons than other uses of force?

Troy – Not easier, but once the energy weapon is deployed, the bodycam is automatically turned on. In the past, many incidences were not recorded, and we relied on written reports.

Bill – What is the public perception issue? I would think they would rather have officers using tasers than firearms.

Troy – We're a veteran centric organization and we try not to look militant. This big yellow device does cause concern from an outside perspective and can look militant and tactical.

Bill – How can you reduce that?

Troy – We can make it more familiar; we can get messaging out beforehand so it's not so sudden and people can expect it. So, it's not as jarring.

Bill – What about the dependency issue?

Troy – We want to make sure they don't over-escalate the issue by having that energy weapon by their side. There can be a dependency there. We don't want people to have the weapon used on them unnecessarily or overuse the device.

Irma – Can using this device be detrimental to those patients with cardiological issues?

Troy – That's a very good point. But this energy weapon is being used in lieu of a gun or being shot. We are trying to use weapons that do not affect patients with cardiac issues.

Irma – When they're deployed, will you look at statistics about when they're used, how they're used, etc.?

Troy – Yes we track all uses of force. We're looking at using this weapon a little bit differently than what local police forces use them for. We are trying to reduce the need to pull that firearm out.

Troy left the call and NPC discussion followed on a possible recommendation for metal detectors. Discussion about records regarding weapon confiscation at VA facilities. Questions about the reporting of confiscation of weapons. Issues are an inconsistency of follow through on weapons confiscation, but also of the security concern of bringing weapons into facilities. Bill is asking for data to elevate the priority.

Troy rejoined the call.

Bill asked about data that is available regarding weapons confiscation because the NPC is weighing metal detectors. Troy said weapons are collected daily. Data is tracked electronically, and Troy will ask for the data of what was sent to Congress and he will share with NPC. Data is not tracked nationally about weapon confiscation. Gia asked whether there is a national uniform policy for following weapons confiscation since they vary by state. Law can vary by state, but

VA's policy applies. George raised all of NCA's unique circumstances and how they have to work with VA police, who are not physically located at the cemeteries, but also local police. Gia asked about the electronic processing in the place of RCS and perhaps the top 3 locations where weapons are confiscated? Troy will ask his staff and get the information back quickly.

HRML Rescission – Classification Review, VHA/WMC

- Lauren Kuiper-Rocha, Executive Director, HR Center of Expertise
- Leah Brady, Director, Compensation and Classification

Lauren – OPM directs consistency reviews when appeals come to OPM. Six occupations are being reviewed for the consistency review. All work should be completed by May 17 to be provided to OPM by May 31. There are approximately 4,080 employees impacted. We are looking at standardizing some of this work or these items for future mitigation strategy to not land back here in the future. Whether this is sunsetted through attrition or newer announcements. The consistency review is underway, the training has been done, and we plan on returning here to brief you on updates as we move forward.

MJ – The standardization of PDs, if they get a standardized PD at a lower grade, are you effectuating save pay?

Lauren - The approach we're using is to allow employees to attrition out of their positions. So the save grade. When we standardize a PD for occupation X and it comes out a lower grade, the same philosophy will apply in applying that PD across the enterprise. We will allow folks to stay at the higher grade but moving forward they will be announced and recruited at the lower grade.

MJ had concerns about all 0500 series

Laruen – We're not looking to expand anything but we're sticking only with the 0503 which are mainly in the CPACs.

MJ – Asked for the OF-8 form, did it not grade out and what was presented to OPM? Infection control issues and Biological Exposure issues.

Lauren -We can pull a WG-3 PD?

MJ – I would like to see the OF-8 form that was regarded back at a WG-2.

Laruen – We will take a look at what materials we have in that regard and what we can share.

Bill – Did OPM consider a 3 PD or only look at the 2 to see if it was evaluated?

Leah – It was a WG-2 that was appealed but the employee believed they were at the WG-3, but OPM came back at the WG-2 and sustained it. All appeal decisions originated from VHA employees.

MJ – How many PDs have you already gone through? How many occupations do we have to do this to? Will it end at the 6 positions?

Lauren – We have not received any other instruction at the moment that require us to do anything else. We have PDs that are incumbent only, and we need to go through the process of identifying those to sunset them through attrition. We are getting closer and closer to syncing up with standardized PDs across the enterprise.

David – There were originally 16 or 17 and these 6 are left from 2010/2011 consistency review.

ETS Next, FSC

- Edward Bernard, Executive Director, Business Operations and Administration
- Ron Jackson, Director, Corporate Travel & Charge Card Service

Ed - ETS Next is not necessarily the official name, just a placeholder name for now. A new vendor will be selected and we're still in part of the contracting phase now. Contract is now out at bid. Will impact 471,000 employees. 508 compliance was a big issue with the new VA Time and Attendance system, and we want to make sure it's done right for this system. Expecting VA to be online with new software by February 2027. It will also depend on how the roll-out goes for the rest of the federal government. We'll have 6 months between the new software and the expiration of the existing software. Communications will go out through various methods and we will collaborate with union partners. Training will be available for employees. Vendor is responsible for providing training modules, but VA has discretion in terms of what will work for it.

Bill – Asked about retired employees and access to training if they do not have TMS. Bill will likely have to read pdf's or go to a computer lab to complete his training.

David – Asked about why DoD doesn't have to use the same system, its written into law, there is no expectation that employees will have to get new travel cards, and asked about migration and cost centers. That is still unknown, but that will be likely.

Integrated Critical Staffing Program, VHA

- Dr. Ryung Suh, VHA Chief of Staff

Federal supply schedules mean to provide greater access but 40% of dollars were going to just 2 companies. This led to the creation of ICSP. This is a novel and creative contract structure that gives VHA the depth that VHA is seeking. SAC and OHT assisted in setup. Eight contracts were awarded and it allows access to 570 recruiting/staffing firms. Currently we're 2-3 months into vehicle so we're pretty early on in the implementation phase but are seeing some VAMCs utilize it and fill critical staffing needs.

MJ – We have an executive order about hiring union and now we have a hiring freeze. How are we not circumventing union jobs?

Dr. Suh – 23 billion dollars was taking a conservative estimate of the gap of vacancies across VHA. The choice of whether to use ICSP is local. We know that VHA has to accomplish our missions and we just brought on 61,000 people last year. This vehicle is designed to fix very temporary local specialized needs.

MJ – You can call it a hiring freeze or pause, but we went up 10K FTE, we had a 30% increase in veterans come in. We have budget constraints and we've never been solicited about how to do that.

Irma – In the last 2 days, all of the RN vacancy announcements in the last 2 days are gone and off of USA Jobs. Maybe it is the continuous announcement, but during this record hiring they used it for their pet project, two hundred RN positions are cut in Tampa. We can talk semantics but the bottom line is that VA isn't hiring positions. I don't know why VA isn't talking to the union and sitting down with us.

David – I want to be careful we're not going down rabbit holes...does anyone in this room know what we've grown since October first? It's 3.1%.

Dr. Suh – The decision to hire, or to use ICSP, is at the local level.

Jeff – These decisions need to go to the VISNs. I want to solve problems. That is where this conversation should be driven down. If you're telling me it's about local, it should be all the locals and all the unions coming together at the VISN level and getting clarification. Right now I don't know anything.

Dr. Suh – We've always viewed our unions as important partners. We're providing this update to you because it has just launched. Our first two awards have gone out. There have been 458 local training sessions, major briefings are provided to VISNs, we're trying to tell people how the vehicle works.

MJ – We over hired or is our retention better than we thought it was, and we have 30% increase in veteran enrollees, it should be showing up on USA Jobs.

David – A 30% increase does not correlate to a 30% increase of care in VA. And there may be slowdowns in hiring in some areas with increases in others. But we're at a point where we are comfortable, it's definitely a balancing act, its budgetary means, it's where is there growth, it's community vs. in-house, and we did not over hire last year, so now where do we utilize the resources to meet mission requirements. Those decisions are at the local level. ICSP is a tool that allow me to get that care before a permanent solution can be made.

Jeff – Are there any checks and balances on helping educate on what these facilities need? This money is just being thrown out of a window. The VISNs are supposed to be educators and there is no oversight. Your intent is there.

Dr. Suh – With the amount of funds that Congress and the American people have provided to us, it's very important that we do it right.

Bill asked why there isn't an announcement to fill Philadelphia MSAs.

David – MSAs have grown 5% in VISN 4.

Bill – I want to know why it's not posted right now.

David – I think we can get that answer for you.

VHA Budget and Community Care, VHA

- Laura Duke, VHA Chief Financial Officer

Laura - FY25 President budget request is $369.3 Billion. Discretionary is slight reduction of 24 at $134 billion. There are decreases across part of the budget. We are increasing dramatically the request for major construction projects, in West LA and in Dallas and capital infrastructure. We are still a growth industry, largely because of the PACT Act, but even without we were expanding offerings. 18 million clinical appointments while excelling above private sector in trust. The budget gets more and more complicated, and we have to track all the different purposes of the funds. The Toxic Exposure Fund (TEF) was meant to support resources but can only be utilized for exposure purposes. This is a separate line of funding. We've requested additional TEF in FY26. We also have carryover; we have money that we've carried over from COVID but this will probably be the last year. VA is asking for a transfer of funds authority to recognize facilitates are extremely old and it's been hard retrofit them, and we're dusting off an old OMB request, which is the third budget category. Our growth trajectory is problematic to be in the 'everybody else' category outside of DoD. One way to do that would be to separate VHA into its own pot and not impact other agencies and our department. Congress has not acted on this yet, but it will be interesting to see if this idea gets some traction.

MJ – asked questions about TEF and spending:

Laura – TEF Covers the cost of providing healthcare as a result of environmental exposure above the FY21 baseline. We calculate that based off the statute, we request it, they've provided that, and we use it to deliver health care. The PACT Act envisioned opening over a 5-year period and its been authorized to speed up rather than phasing it. TEF is general care, but it goes to a proportion of the population, and we have to show how. TEF excludes certain things so we only spend it on things we know it will be spent on within the law, which are: medical support and compliance, medical services, medical community care and medical facilities.

MJ asked about anomalies with 21 and 23.

Laura – We pay pretty promptly, much more so than before.

MJ – Community care growth 15-20% so you have it as an even split, what about others?

Laura – Provided tables on what VHA is projected to spend in FY25 by category. There is an assumption that total FTE will come down. We have to take our foot off the accelerator, but we're looking at the total volume of RVUs and where they will be delivered. I will probably be in a position to move funds back from the community but we know that switch follows the veteran.

MJ – What is available for average people to look at the balance sheets quarterly?

Laura – there is a form we fill out that Treasury posts. I can get that to David to get to you, where it's posted. Sticking with the Treasury number is probably the best bet.

Meeting ended at 4:00 p.m. EST