VA's Response to the National Nursing Shortage

Department of Veterans' Affairs
Veterans' Health Administration

November 2001

TABLE OF CONTENTS

Preface

I am pleased to present the report of the Nursing Workforce Planning Group: *A Call to Action- VA's Response to the National Nursing Shortage.* The Nursing Workforce Planning Group was chartered in August 2000 for the purpose of providing advice on issues that impact the Veterans Health Administration's future supply and utilization of registered nurses. The Planning Group membership included representation from multiple components of the organization and varied clinical and administrative experts. The report supports the Veterans Health Administration's *Workforce Strategy*, October 2001 and Baldrige Health Care Criteria for Staff Focus.

The report offers a comprehensive description of VHA nursing workforce demographics, challenges and opportunities. The Planning Group relied on current literature, professional organizations' projections, and expert input/advice from within VHA to determine key findings and recommendations.

Recommendations for both legislative and non-legislative strategies are submitted for consideration. The recommendations are organized into the categories of Utilization, Recruitment, Retention, and Outreach. Although there are no "quick fixes" to assuring an appropriate VA nursing workforce, the report includes significant viable options to position our health care system with a reliable nursing workforce for the future.

Of particular significance, this report contains a comprehensive and annotated *Guide to VA Pay and Hiring Authorities.* Compiled by VHA Human Resource experts, this Guide provides essential information in a concise, easily used format. The Planning Group identified the need to demystify and disseminate current hiring and pay authorities as the first step in addressing nursing and other workforce shortages.

The Nursing Strategic Healthcare Group will take the lead in addressing the recommendations included in this report. The National Nurse Executive Council Workforce Workgroup will assist with this implementation process. I encourage each facility and VISN to consider the findings and recommendations in this report carefully. Developing local strategies will be as significant as a national approach to ensure our future nursing workforce.

I offer my sincere thanks to the Nursing Workforce Planning Group and individuals/groups who assisted them in the completion of their work.. The report is a significant contribution to the VHA Workforce Strategy. It offers the first step in crafting an overarching strategy that will maintain the highest quality nursing care for veterans in this time of a critical national nursing shortage.

Cathy Rick, RN CNAA CHE
Chief Consultant,
Nursing Strategic Healthcare Group
November 2001

Executive Summary

"I hope the current situation is a wake-up call for everyone. This is not a cyclical [nursing] shortage that will correct itself. Solving the problem is going to take major changes."

Carole A. Anderson, PH.D., RN, FAAN
Editor, Nursing Outlook
2001;49:113-4

Health care corporations across the nation recognize a worsening nursing shortage and are aggressively addressing nursing workforce issues. They are utilizing inventive and non-traditional approaches to retain and recruit nurses before their ability to provide quality care is severely compromised. The Department of Veterans Affairs (VA), Veterans Health Administration (VHA) needs to take bold and unprecedented action to position itself as an effective competitor for scarce nursing resources. VA is experiencing difficulties in hiring nurses with selected specialties and in certain geographical areas. In addition, 35 percent of current VA nurses are eligible to retire by 2005. When coupled with the national shortage, this potential loss of nurses could jeopardize VA's healthcare mission. Possible results include closing clinical programs, reducing bed capacities, and delayed treatment. If VA is to realize current plans to re-establish bed capacity in some specialized areas (i.e., long term care) to 1999 levels, immediate action must be taken to ensure that there are enough nurses available to meet the short and long term needs of caring for veteran patients.

Understanding the gravity of the situation, the Nursing Strategic Healthcare Group (NSHG), recognized the need to bring together nursing and health care management experts to fully explore all issues that have an impact on VA's ability to maintain a highly qualified nursing workforce. As a result, the Future Nursing Workforce Planning Group (Planning Group) was convened in August 2000. The charge of the group was to critically review salient aspects of the national shortage for VA and formulate strategies to ensure VA's ability to attract and maintain a qualified nursing staff (Appendix A). The group's membership represented a variety of key clinical and administrative VA stakeholders in nursing, medical center administration, human resources, and labor. (Appendix B). Through face-to-face meetings and teleconferences, members consulted with VA nursing experts and national experts in nursing workforce issues. The Planning Group conducted informal focus groups to increase the number and volume of nursing voices heard in the discussion. Finally, they studied the professional literature and reviewed data generated by VA and VHA staff offices and the Nursing Strategic Healthcare Group, to reach the group's conclusions and recommendations.

Findings

Throughout this extensive process, the Planning Group frequently heard nurse retention at VA is hampered because VA nurses perceive they are neither valued nor respected. VA nurses believe their work environment is not supportive professionally and does not include nurses in the decisions that determine patient care responsibilities that shape the work environment. In VA, nurses are routinely required to "substitute" for absent allied or ancillary staff, such as laboratory or clerical support, simply because in the past there have always been nurses present in the care environment to do so. This substitution for other workers diminishes nurses' capacity to provide nursing care and worsens the effect of the nursing shortage.

In the absence of a shared organizational vision regarding the nursing shortage, nurse executives, medical center directors, and other managers reported to the Planning Group that existing human resource (HR) and pay authorities do not offer the flexibility required to respond quickly to prevailing market forces. Community facilities offer nurses the flexible work schedules, competitive salaries, benefits and perquisites they demand. Furthermore, the Planning Group found that current VA efforts to combat the nursing shortage are severely hampered by inconsistent interpretation of existing authorities and inadequate use of such authorities at local, network and national levels.

The human and fiscal resources contributed by VA thus far to combat the nursing shortage are insufficient. Recruitment programs that are currently authorized have not been implemented; successful recruitment programs have not been expanded; and insufficient numbers of people are trained and dedicated to recruitment and retention activities.

Recommendations

The recommendations outlined in this report represent proactive opportunities for VA to unequivocally reaffirm its commitment to the nation's veterans through providing sufficient numbers of qualified nurses to meet their health care needs. The recommendations evolved from analysis of available data and are grouped around the four most salient issues of the nursing shortage: utilization, retention, recruitment, and outreach.

Nationally, the nurse employment environment is highly volatile and VA must move quickly to implement chosen strategies or lose the opportunity they present. This report includes both legislative and non-legislative strategies to position VA optimally. In addition, it includes comprehensive overviews of VA hiring authorities and recruitment/retention incentives, as well as a discussion of their uses prepared by experienced human resource executives. Finally, this report identifies a representative sample of creative and successful strategies in place at selected VA medical centers.

Conclusion

The overarching message of this report is that sufficient funding must accompany any selected actions to ensure their enduring success. If VA can shift from traditional, cumbersome employment and marketing practices to unprecedented, flexible and unique tactics, the potential negative results of a nursing shortage can be attenuated. If VA fails to invest in the future, the price we pay in costs and quality of care will be great.

The Planning Group conclusion can be simply stated:

"If nurses are appropriately utilized to provide nursing care in safe, clean work environments; if they are valued and have the resources they need to provide quality care; if they are involved in decisions regarding patient care processes and they are adequately compensated—they will come to VA for employment and they will stay."

VA Nurse Executive
2001

Workgroup Findings

Background

Planning Group. The Future Nursing Workforce Planning Group was convened in August 2000 to critically review the impact of the national nursing shortage on the Department of Veterans Affairs (VA), Veterans Health Administration (VHA). Members represented a variety of clinical and administrative roles in nursing, medical center administration, organized labor, and human resources. The Planning Group was charged with:

1) examining salient aspects of the nursing workforce shortage;
2) identifying strategies to ensure that a qualified workforce would be available to VHA , and;
3) identifying strategies that would optimize the utilization of the future nursing workforce.

This Planning Group was to submit a written report to the Chief Consultant, Nursing Strategic Healthcare Group by the end of fiscal year 2001.

Methods. Through a series of face-to-face meetings and teleconferences, the Planning Group consulted with national nursing workforce and education experts, members of Veterans Benefits Administration (VBA) Workforce Design Team, VHA National Succession Planning Taskforce, and the VA Nurse Recruiters Association. The committee also consulted with VA experts in human resources, recruitment, and retention. The Planning Group reviewed national literature, data reports produced by VA and VHA staff offices, and specific data regarding VA's nursing workforce produced by the Nursing Strategic Healthcare Group. In addition, the Planning Group conducted informal surveys and solicited position papers from VA and professional stakeholder groups. The Planning Group formed subcommittees on the topics of supply and demand, recruitment, retention, and utilization to explore these issues in greater detail and identify "best practices" within VA.

The national problem. National nursing leaders and health care organizations project a shortage of registered nurses that will be unlike any experienced in the past (AACN, 1998). In addition to registered nurses, the nursing workforce includes practical nurses and nursing assistants. However, the registered nurse is at the center of the nursing workforce; the registered nurse coordinates care for the individual veteran patient as well as for the population of veteran patients in our communities. Given the aging of the current registered nurse workforce, the decreasing number of students who choose nursing as a career, and the ever increasing demand for professional nursing services, the current and future number of professional, registered nurses (RN) will be insufficient to meet our national health care needs (Buerhaus, Staiger, & Auerbach, 2000a; Carpenter, 2000). Noted nursing economist, Dr. Peter Buerhaus, wrote that the total number of nurses per capita will likely peak in 2007 and decline steadily thereafter (1998). At the same time, changes in healthcare delivery will require larger numbers of well-educated nurses who perform increasingly complex functions in hospitals and the community. Based on current trends, jobs for RNs will grow 23 percent between 1999 and 2006 (Buerhaus, 1998). By 2020, the United States RN workforce is forecast to be roughly the same size as it is today, declining nearly 20 percent below RN workforce requirements (Buerhaus, Staiger, & Auerbach, 2000a).

The projected shortage will result in part from a number of substantial changes that continue to take place in the profession. Factors identified that will intensify a nursing shortage are (AACN, 2000; Bednash, 2000a; Carpenter, 2000; Curren, Horner, & Eldridge, 2000; Havens & Aiken, 2000):

- A decline in enrollment in schools of nursing;

- Aging of the nursing workforce (average age nationally, 45.2 yrs, VA 46 yrs);
- Average age of a new graduate in nursing has climbed to 30.5 in 1995 - 2000 versus 24.3 in 1985 or earlier;
- Neither racial or ethnic minorities nor men enter nursing in numbers that reflect the national population;
- Young women, who in the past made up the preponderance of nursing students, now have a wide range of alternative career options available;
- Poor image of nursing as a career choice. In a 2001 Gallup Poll of public perceptions of the professions, nurses ranked number one in honesty and high ethics for the second, consecutive year. However, in the same poll, nursing ranks 137 out of 250 professions in desirability;
- Pay inequities between nurses and other occupations that require less education and have less responsibility;
- Perceived negative work environments, such as: lack of respect and nursing being required to mop floors and clean beds;
- Inadequate numbers of qualified faculty to educate the numbers of nurses needed.

Scope of the problem in VA. Registered nurses comprise the largest segment of healthcare workers within the Veterans Health Administration (VHA N=35,000). VA nursing workforce data support the conclusion that it is likely the current VA nursing workforce will "age out" and numbers will decline sharply and rapidly (VA Nursing Strategic Healthcare Group, 2001):

- 23 percent of VA RNs are under the age of 40; in contrast to 31.7 percent in the US
- Average age of a VA RN new hire in FY 2000 was 41.65 years;
- VA is experiencing difficulty in recruiting nurses;
- National nurse supply will decline;
- VA nurses will be eligible for retirement in large numbers through 2005 (RNs 35 percent, LPNs 29 percent, Nursing Assistant 34 percent).

In addition, the veteran population is aging and requires more complex, professional nursing care than ever before (Office of Performance and Quality, Health status and Outcomes of Veterans, 1998).

In this evolving healthcare environment, nurses must possess clinical decision-making and critical thinking skills, and must have professional preparation in community health, patient education, and nursing management/leadership. Professional nurses use a breadth and depth of knowledge to care for veteran patients in multiple health care settings from the rapid patient assessments and complex care provided during critical stages of an acute illness through the compassionate attention to detail that enhances quality of life for veterans who are making the transition into a long-term care environment. Technological advances in health care treatment and equipment, evolving health care trends, modifications in delivery settings, and consumer expectations will require nurses to constantly adapt to change. Based on this intense and complex care environment, the National Advisory Council on Nursing Education and Practice (1996) has recommended that by the year 2010 two-thirds of all practicing nurses must possess a baccalaureate degree if optimal care is to be provided. Through the adoption of VA's Nurse Qualification Standards and with continued commitment to funding academic education for nurses, VA will be well positioned to attain this mix and provide optimal care to veterans.

Key Findings

Through a series of face-to-face meetings and teleconferences, the Planning Group consulted with national nursing workforce and education experts, members of Veterans Benefits Administration (VBA) workforce design team, VHA National Succession Planning Taskforce, and the VA Nurse Recruiters Association. The committee also consulted with VA experts in human resources, recruitment, and retention. The Planning Group reviewed national literature, data reports produced by VA and VHA staff offices, and specific data regarding VA's nursing workforce produced by the Nursing Strategic Healthcare Group. In addition, the Planning Group conducted informal surveys and solicited position papers from VA and professional stakeholder groups. The Planning Group formed sub-committees on the topics of supply and demand, recruitment, retention, and utilization to explore these issues in greater detail and identify 'best practices' within VA. The Planning Group identified utilization, retention, recruitment, and outreach for registered nurses as key elements to VA' ability to attain a qualified nursing workforce. The following discussion presents these elements in priority order.

Utilization A number of variables have an impact on the utilization of registered nurses in VA; however, the Planning Group found three to be most often mentioned and most influential in both the national literature and VA specific data:

1) Registered nurses must have appropriate clinical and clerical support;
2) Work environments must have adequate technology to support work processes, and;
3) There must be an increasing emphasis on technology that ensures a safe working environment as the nursing workforce ages.

Clinical and clerical support. VA nurses are engaged in non-nursing functions. Most commonly this is seen in the use of nurses to complete non-nursing tasks such as housekeeping, messenger and other clerical duties. Nurses are used to complete tasks and functions of absent clinical support and ancillary personnel, particularly on off tours and as allied health and ancillary positions are eliminated. In addition, LPNs and Nursing Assistants, who should be available to perform patient care are similarly used as substitutes for other services. Such inappropriate utilization is not only costly to patient care processes, but it is also a strong employment dissatisfier that impedes both retention and recruitment of nursing staff. In addition to ensuring that appropriate numbers of clinical and support staff are available daily on all tours of duty, VA will need to develop models of care that optimize the experience, knowledge and time of nurses.

Technology also influences the appropriate utilization of registered nurses. VA should support efficiencies in nursing care by acquiring and maintaining state of the art equipment and computer software that is necessary to facilitate coordinated and comprehensive care of the veteran patient. Nurse end-users should be involved in evaluating equipment and software, and VA must ensure that adequate training takes place prior to introducing new technology into the patient care areas. Adequate training requires more than simply offering classes or training sessions to nurses; adequate training requires a commitment to release nurses for needed educational sessions and provide for the continuity of safe patient care. Nurses reported to the Planning Group that it is frustrating at best and counterproductive at worst when technology requires more, rather than less, time and effort. The example most often raised was the early versions of Bar Code Medication Administration (BCMA).

Safety. The nursing workforce is vulnerable to injury in the workplace and a 1996 Institute of Medicine study noted that older RNs have a reduced capacity to perform certain tasks (IOM, 1996). Health care workers are a priority population group for Centers for Disease Control and Prevention

(CDC) injury prevention efforts, and conditions known to plague nursing such as: low back injury, latex allergy, assault, and stress are among the primary occupational illnesses targeted by the CDC. In addition to these and other overall health risks associated with being a nurse, the population of VA registered nurses is older than the national population of registered nurses and the need for labor saving technology that promotes a healthy, and still productive, older workforce will be paramount. As with all new interventions, nursing staff will require sufficient time to learn how to use technological supports as well as to evaluate the intended and unintended consequences of proposed technology.

Nursing Executives. Fewer nurses, coupled with increased patient demands, will require a cadre of highly skilled and innovative nurse executives and managers with the knowledge and experience to develop responsive care delivery models in an ever-changing health care environment.

The need for systematic development of nurse leaders was a concern presented to the Planning Group, noting that the past national program to prepare nurse leaders had been discontinued. Since that time, potential nurse leaders have not been equitably represented in existing VA career development and succession planning activities. Seventy-five percent of all VA Key Nurse Executives are eligible for retirement by 2005; this includes early outs. (63 eligible, 41 early out eligible, total: 139)

Retention As the national pool of qualified and available registered nurses continues to diminish, the ability of each VA facility to effectively retain the nurses already on staff becomes increasingly critical. VA Medical Centers vary in their ability to retain Registered Nurses (The average VA turnover is 9.5% for FY 2000 with some facilities reporting rates as high as 20%.) Retention of nurses, especially those with valuable experience, is possibly more important than recruiting nurses into the workplace. In an unstable employment environment of higher employee expectations and a continuing decline in nursing school enrollments, VA must act quickly and decisively to support local facilities in their retention efforts.

The Planning Group identified four general domains of interventions from the current nursing literature that increase the retention of nurses. Interviews with VA nurses confirmed that these themes are also concerns of VA nurses. Effecting positive change and developing new programs in these four areas of concern to nurses will be critical to retaining VA nurses.

1) Nurses have expressed their desire to work in an environment that is safe for patients, safe for staff, and staffed appropriately for the acuity and type of patients for which they are responsible. This includes the authority for nurse executives to significantly collaborate in the management of patient census and the ability for individual nurses to manage their own schedules.

2) Nurses have expressed their expectation to be recognized as contributing professionals, to be respected and treated as professionals by each other, by physicians, and by hospital administration.

3) Nurses have placed great value on opportunities to develop as professionals and expand the scope of their contributions through active participation on decision-making groups that affect patient care and the work environment. This includes participation in academic programs and "just-in-time" professional education and includes mentoring other nurses.

4) Nurses want to be fairly compensated, both monetarily and through various benefits, for the work they do.

To attract and maintain a qualified nursing workforce, VA medical centers must develop and sustain positive work environments that reflect the expectations noted above. In doing so, VA will have created a positive climate not only for nursing, but also for all employees. This change will require both strategic planning and evaluation.

Nursing involvement in decisions that have an impact on patient care has been linked to an increase in positive patient care outcomes (Havens & Aiken, 1999). Within VA, Public Law 109-419 states that VA is to involve registered nurses in decision-making committees at all levels of the organization. VA compliance with this requirement would have a significant impact on the retention of registered nurses. However, there is no mechanism or institutional guidance for monitoring and assuring compliance with this requirement.

The American Nurses Credentialing Center's (ANCC) Magnet Hospital Recognition Program is designed to recognize excellence in nursing care. The ANCC model includes most of the ideas noted above.[1] Research has shown that magnet hospitals demonstrate outstanding outcomes in patient and staff satisfaction, staff productivity, and reduced length of hospital stay for patients. The Tampa VA Medical Center is the first in VHA to have attained Magnet status. Future VA encouragement and support would make it possible for other facilities to pursue and attain Magnet recognition and, as a result, Magnet outcomes.

Recruitment Variables that were identified as impediments to retention efforts can also be viewed as barriers to nursing recruitment. Non-competitive salaries, inflexible pay practices, perceived negative working environments, dissatisfaction with working conditions and out of date benefit packages were cited in interviews with VA nurses as hindrances to recruiting nurses.

While the Planning Group found that VA does have a number of HR and pay authorities that could be used to support recruitment and retention efforts, it also found that current efforts to proactively manage nursing workforce issues are severely hampered by inconsistent interpretation of existing authorities and by inadequate use of such authorities. This appears to result from confusion, lack of training, and in some instances, a lack of shared priorities across the organization regarding the nursing shortage. VA administrative processes that govern recruiting and hiring nurses strike what is often the final blow to an already tenuous recruiting situation.

*Administrative Barriers***.** The Planning Group found that current VA HR and pay authorities are cumbersome and of minimal value to recruiting nurses in an environment that is constantly adjusting to local market changes. This analysis was expressed to the Planning Group by nurse executives and medical center administrators who note that existing HR and pay authorities do not offer the flexibility required to respond quickly to prevailing market forces, most especially with regard to offering flexible work schedules, competitive salaries, benefits and perquisites. Among the frequent examples given, these executives indicated that they compete with: the variety of working tours offered by community hospitals[2], cafeteria-style benefits, and such perquisites as health and wellness programs and valet services. In stark contrast, one VA nurse executive stated that she could not even offer a cafeteria open to serve food to staff on all tours of duty.

---

[1] ANCC refers to Magnet status as representing a culture of excellence that includes nurses who have the status needed to influence people and procure necessary resources; good collaboration between nurses, physicians, and administrators; and established systems needed to insure nurse participation in policy decisions.

[2] Flexible tours noted were—A) two or three 12 hour tours in difficult to recruit areas or for difficult to recruit days. (24/36 hours) paid as 40 hours. B) 7 ten hour days on/7 days off [70 hours per two week pay period considered FT]. C) 6 twelve hour tours on/7 days off [72 hours per pay periord considered FT]. D) 9 months of work with 3 months off—pay extends over a 12 month period. Each of the tours listed is a common scheduling practice for nurses across the country and nurses indicate such tours are highly desirable.

Nurse executives, nurse recruiters, and human resources professionals cited a critical need to remain competitive in the hiring of nurses. Of concern was the 6 –12 weeks (or longer) it can take to bring a nurse into VA employment while competitors can, and do, employ a nurse within a week. Local VA facilities currently have existing authorities and policies that would enable them to significantly lessen entry time, however these strategies are only used with hesitancy.

Other examples of hiring impediments are non-competitive recruitment and retention bonuses and difficulty in hiring annuitants for critical positions for which they are already experienced. It was stated repeatedly to the Planning Group that the process for obtaining approval to exercise these options is lengthy and cumbersome. The extent of the prevailing authorities are unknown or misunderstood and hiring situations are further complicated when the urgency and priority of nurse recruitment is not immediately felt by those who must collect, review, or approve data. When this clash of priorities is coupled with rigid or inflexible interpretation of regulations or policy, not only do medical center staff become frustrated, but facilities also slip further behind the "power curve" in coping with a shortage of nurses. VA would benefit from a national summit of VA nurse executives, medical center directors, human resource executives and other stakeholders to identify and interpret existing authorities, to evaluate the successes or limitations of these authorities, and to propose policy changes or legislative initiatives.

*Legislative Barriers***.** While a number of the barriers to assuring an adequate nurse workforce identified by the Planning Group were within VA's authority to change, there are additional barriers that will require legislative intervention to assure an adequate VA nurse workforce. Of major importance is the need for broad and sweeping changes in HR and pay authorities to allow medical center directors to rapidly implement locally competitive programs. Other examples of legislative barriers or needs include:

1) VA's National Nursing Education Initiative and Employee Incentive Scholarship Program. These programs are difficult for staff and local stations to access, complex to utilize, and restricted in their usefulness to VA staff by the legislative language used;
2) the highly successful VA Health Professional Scholarship Program, which is legislatively authorized, but has no current appropriation;
3) VA Education Debt Reduction Program which requires a legislated increase to the dollar amounts available to individuals who apply[3] (Of note, although this was authorized in 1998 by Public Law 109-419 for VA to repay the educational loans of newly hired employees, the program is not yet implemented);
4) VA Learning Opportunities Residency Program (VALOR)[4], which has had a positive impact on nurse recruitment in the past, could be a rich source of new nurses if it were funded at an appreciable level, and;.
5) re-employing annuitants to capitalize on the experience of former employees who can fill critical vacancies in nursing areas. The current cap on annuitant earnings and the method by which VAMCs obtain permission to hire annuitants serve as disincentives for this option.

Outreach The Planning Group concluded that VA must initiate substantial outreach efforts to present the profession of nursing (and specifically VA nursing) as a viable career option for youth, individuals making initial career decisions and adults considering second careers. Also, VA must increase outreach efforts to nursing academe. A vast number of VA nurses have excellent credentials

[3] Based in part on the deliberations of this Planning Group, changes to this program appear in S 1188 "Department of Veterans Affairs Medical Programs Enhancement Act of 2001."

[4] The nationally acclaimed Veterans Affairs Learning Opportunities Residency Program (VALOR) is an honors program administered by local VA facilities but funded centrally. VALOR provides specialized summer educational and clinical experiences to nursing students with GPA's of 3.0 or higher. Participants are paid 80% of RN pay and if they elect VA employment after graduation they are given special salary consideration. In FY 2001 there are 267 VALOR students being supported in 77 VA medical centers.

to collaborate with academic institutions as faculty and as clinical preceptors. At the same time, schools of nursing struggle with insufficient numbers of faculty to accommodate their current student enrollments and will be unable to increase enrollments to the levels that are needed to stall or attenuate the future workforce shortage. Collaborative academic sharing models increase job satisfaction on the part of VA nurses and address the need for nursing faculty. While these models do require an adequate and qualified workforce to continue providing, managing, and planning for the ongoing nursing care needs of veteran patients, they also increase job satisfaction of VA nurses. In addition, increased positive contact with VA nurses will increase VA potential to recruit new graduates.

Conclusion

The persistent message across VA is a serious lack of flexibility to compete effectively in a rapidly changing marketplace. The current human resources directives, policies, and practices are complex, confusing, and often contradictory. These limitations leave VA medical centers struggling to stay competitive; VA is now reactive rather than being proactive in the competition for nurses. The Planning Group suggests broad changes to address problems rather than 'quick fixes.' In conclusion, the Planning Group found the most hazardous conditions in VA to include failure to value nurses and failure to address archaic personnel practices that prevent local competition. Nothing less than a rapid commitment to a national strategy with measured and monitored outcomes can reverse this current downward trend, likely to leave VA unprepared to provide quality nursing care to the nation's veterans.

Recommendations

The Future Nursing Workforce Planning Group makes the following recommendations to assure an adequate and qualified VA nursing workforce. Within categories, these recommendations are listed from highest priority. These recommendations are additionally noted as L (lesiglative) or N (non-lesiglative) to indicate the type of change needed to implement the strategy.

Many of the recommendations in this report are innovative to VA, and as such have no baseline data from which to generate a budget estimate. It is recommended that a **small, multidisciplinary group under the leadership of the Nursing SHG be formed to establish cost projections** for specific initiatives.

1.0 UTILIZATION

1.1 Implement **VA Nurse Work Limits Initiative** (L/N):

1.1.1 Eliminate shift rotations and dependence on overtime.

1.1.2 Hire ancillary support staff to relieve nurses from routinely performing non-nursing tasks

Note: With fewer numbers of registered nurses, it is essential that the work of nurses be optimized 7 days a week, 24 hours a day. This recommendation immediately and tangibly relieves undesirable working conditions. VA Resident Work Limits Initiative may be used as a template [5]

1.2 Establish **authority for medical center directors** to implement **locally determined and competitive** pay structures, work schedules, and benefits systems.

1.2.1 pay structures,

1.2.1.1 Enable part-time employees to earn compensatory time in lieu of overtime. (L)

1.2.1.2 Remove cap on Title 5 overtime. (L)

1.2.1.3 Responsive and flexible process of monetary recognition to compete with local community practice. e.g.: community practice of paying a bonus to nurses who work one extra shift per week; or to nurses who accept an assignment to any area of greatest need in a facility. (L/N)

1.2.1.4 Implement direct hire authority for Nursing Assistants (L)

1.2.1.5 Initiate additional pay for assistant head nurse/charge nurse duties (L)

1.2.2 work schedules, and;

[5] VA Circular 10-89-3; OIG Report 4R8-A19-137. In FY 1992, 1993, and 1994 Congress provided a total of $219.1 million in recurring funds for the Resident Work Limit Initiative. These funds were intended to allow VAMCs to hire additional staff for the purposes of reducing resident work hours, providing adequate resident supervision, and relieving residents of non-physician tasks. According to VHA officials, Resident Work Limit Initiative funds were considered to be "fenced"- that is, used only to meet the Resident Work Limit objectives and not used for other purposes. Part I funds were to be used to hire ancillary support staff to relieve residents from routinely performing non-physician tasks. 72 VAMCs received $53.0 million in Part I funds to hire ancillary staff.

1.2.2.1 three 12 hour tours (36 hours) paid as 40 hours (L)

1.2.2.2 seven 10 hours days on/7 days off; six 12 hour days on/7days off (per 2 week pay period—considered full time employment) (L)

1.2.2.3 9 months of work, three months off- pay extends over 12 month period (L)

1.2.2.4 promote models of nurse self-scheduling (N)

1.2.3 benefits systems.

1.2.3.1 "Cafeteria style" benefits plan. Establish additional benefits, enable employees to pick and choose from a variety of personal and dependent care benefits, and pay employee for benefits not used. (L)

1.2.3.2 Cash-in option for accumulated annual leave balances. (Currently, beyond the accrued maximum, unused annual leave must be used by the end of the calendar leave or forfeited.)(L)

1.2.3.3 Single category of paid leave combining annual leave and sick leave, i.e. Personal Leave. Employees would use this leave and have an option to cash in unused leave at the end of each year. (L)

1.2.3.4 Provide additional quality-of-life benefits such as meals, dry cleaning services, health and wellness options, and enhanced childcare services. In addition to meeting applicant demand, health and wellness options would contribute to the safety and well-being of the workforce. (N)

Note: If successful for nurses, authorities listed above could be extended for other shortage occupations. Authority would be unrestricted by current law, regulation and policy, but directors would be required to operate within existing budget authority.

1.3 **Authorize Nurse Executive to** evaluate staffing variances and, when critical shortages exist, **to make timely staffing adjustments** or limit the number of patients to be managed. (N)

1.4 Make **maximum use of technology** to optimize nursing practice and create safe working environments. Require **clinical end user participation** in development, trials and evaluation prior to implementation.

1.4.1 Involve nurses in expert systems software development and evaluation (N);

1.4.2 Provide state of the art software on all nursing units; focus specifically on technology to eliminate manual, repetitive tasks (N);

1.4.3 Evaluate effects of new technology on nursing prior to implementation (N);

1.4.4 On an ongoing basis, provide state of the art equipment to support physical care, i.e. lifting equipment, patient scales, etc. (N);

1.4.5 Ensure adequate training on all new technology. (N);

1.4.6 Ensure that revisions to existing technology are evaluated by clinical end users (N).

1.5 Establish a **National Commission on VA Nursing**, appointed by the Secretary. Review legislative and organizational policy changes to enhance recruitment and retention of nurses and assess the future of the nursing profession in VA (L)[6]

1.6 **Develop models of care that maximize the skills and knowledge** of all levels of nursing staff. Enhance the capacity of nurses to provide increasingly complex care in a rapidly changing healthcare environment. (N)

1.7 **Enable nurse executives to develop excellence in managing within the context of a nursing shortage.** Establish a national budget for nurse executive training by industry leaders in such areas as: creating magnet organizations, creating and supporting self-governance models, designing optimal care models, creative management, use of aggregate data to drive decision-making. (N)

1.8 **Develop a cadre of well-qualified nurse leaders** by ensuring that a representative number of nurses are included in all levels of VA leadership training. Since the demise of the Nurse Preceptor Leadership program, the training, education and experiences required to move into facility leadership and executive roles are hard to access. (N)

1.9 At the national, network and facility level, **support the development of nursing self-governance models** through education, funds, and time for professional development. Nurse autonomy and self-governance are characteristics of magnet hospitals. (N)

2.0 RETENTION

2.1 Require that a standardized, reliable, valid, nurse-sensitive satisfaction tool be utilized as part of local performance measurement.[7] While the current One-VA survey does provide the ability to identify nurse participants, it fails to query those items that are identified in the literature as strong predictors for nurse retention. Aggregate data should be used at the facility, network and national levels. (N)

2.2 **Fund Nursing Upward Mobility positions for each facility,** and convey the expectation that career development and upward mobility programs be fully utilized. (N)

Note: Upward mobility programs have been particularly successful in the development of the nursing workforce, providing opportunities for strong VA employees to enter the nursing profession.

2.3 **Fund retention incentives to encourage RNs to work past retirement eligibility.** Provide retention incentives to retirement eligible nurses employed in critical work areas and include incentive as part of base pay for retirement eligible RNs. (L/N)

2.4 **Annually report network and facility compliance with Sec. 201 of Public Law 106-419** which mandates the involvement of registered nurses in decision making activities. This ensures the input of nursing in workforce practices and patient care. (N)

2.5 Require all network **reorganization plans to include impact statement on authority and autonomy of nursing**. (N)

---

[6] proposed in HR 2792.

[7] Stamps Piedmont (1978) or Kramer & Schmalenberg (1988)

2.6 **Establish a dedicated, equitable and consistent awards budget for nurses** at the medical center level and remove "already compensated restriction" from Special Contribution Awards. (L)

2.7 **Encourage use of VA sabbatical program by nurses** and fund replacement staff. Program reference available: M-8, PT V, Chapter 4 "Extended Leave for VHS&RA Educational Purposes; URL http://vaww.va.gov/publ/direc/health/manual/080500.html.

2.8 Initiate a national program that **demystifies and facilitates the use of existing pay and HR authorities** to enhance recruitment and retention practices.

2.8.1 Convene a summit of Human Resources personnel, nurse executives, and other facility and network leaders to define aggressive strategies that may be implemented with current authorities. Topics would include payment of retention and recruitment bonuses, locality pay and salary flexibility and scheduling alternatives. (reference recommendation 3.9.1) (N)

2.8.2 Widely publicize current authorities and how to best utilize them to support workforce strategies. Monitor their use (contained as a supplement to this report). (N)

2.8.3 Identify and provide incentives for successful practices in recruitment and retention. (N)

2.8.4 Encourage the use of recruitment and retention bonuses, awards, and non-monetary incentives. Publish and widely distribute an annotated inventory of these practices (contained as supplement to this report). (N)

2.9 Create strategies to **encourage and reward nurses for staying** in patient care positions. (N)

2.10 Establish an **aesthetic physical work environment**: Clean, well lit rooms and passages; break rooms for staff; 24 hour food service; lockers for staff; storage for patient care equipment when not in use (N).

2.11 **Establish a Nurse Executive Special Pay Program**. Recommended special pay $20,000-$30,000 per year (L).

Note: There is little or no incentive for current nurse executives to take on other more complex assignments or for potential nurse leaders to assume executive roles in VA. This change matches community standards.

2.12 Implement **position-specific**, **formal training on retention** strategies. Promote a concept that "everyone is a retention officer". (N)

2.13 Establish an **environment of respect and recognition** for all VA employees.

2.13.1 **Require inclusion of nursing role in hospital-wide orientation programs.** Create a culture of mutual respect among nurses, medical students, residents, physicians and other hospital staff through education and dialogue. (N)

2.13.2 Identify and reward best practices in employee communication (N)

2.13.3 Establish consistent, equitable awards budget at the local level (N)

2.13.4 Expand and encourage the use of non-monetary incentives (N)

2.14 **Expand Nurse I pay band** to provide more competitive salaries for experienced RNs with Associate Degrees.

Note: Change 3 to locality pay system handbook 5103.9/3 gives directors greater authority to expand nurse I pay. (N)

2.15 **Allow the use of unused sick leave in annuity computation of registered nurses who are under the Federal Employees Retirement System (FERS)**[8]

2.16 **Eliminate the "all or nothing" provision for relocation** expenses--allow facilities to negotiate relocation expenses. (L)

3.0 RECRUITMENT

3.1 **Streamline and facilitate processes for hiring in local medical centers** (N). Barriers to hiring make VA noncompetitive with the private sector.

3.1.1 implement physicals within 24 hours; (N)

3.1.2 24 hour Nurse Professional Standard Board review; (N)

3.1.3 contract for 48 hour drug screens, and; (N)

3.1.4 utilize temporary hiring authorities as needed. (N)

3.2 Fund and re-implement VA Health Professional Scholarship Program (HPSP) (L). [9] Appropriate a minimum of $13 million.

3.3 **Expand VA Learning Opportunities Residency Program (VALOR)**, the successful program aimed at student nurses (N). See footnote number: 4

3.4 Eliminate or reduce 2 year waiting period for Employee Incentive Scholarship Program and National Nursing Education Initiative programs. (Proposed in S 1188) (L)

3.5 **Implement VA's "Education Debt Reduction Program"** (at the time this report went to press, guidance for implementing VA Education Debt Reduction Program was under review by VA Central Office). (N)

3.6 Create **re-employment** opportunities **for annuitants**.

3.6.1 Establish a group request process rather than the current requirement of requesting an exemption for each individual hired. (N)

3.6.2 Eliminate cap on earnings of annuitants (L).

3.7 Review data obtained from **recruitment and retention impact surveys** and studies for use in decision making (reference recommendation 1.5). (N)

3.7.1 Annual Locality Pay Director's Survey (N)

---

[8] Contained in S.1188 The Department of Veterans Affairs Medical Program Enhancement Act of 2001

[9] The currently authorized and highly successful HPSP supports students in nursing and other scarce healthcare occupations during the last two years of academic education. Recipients incur a service obligation (payback) upon licensure/certification. During the previous implementation of the program, more than 50% of nurse participants remained employed in VA one year after their service obligations were complete. Current, proposed legislation (S. 721 HR. 3020) in the House and Senate include the implementation of a national scholarship program with payback at non-VA sites. The past appropriation for this program was $13.1 million.

3.7.2 NNEI Qualifications Standards Evaluation (N)

3.7.3 One VA Employee Satisfaction Survey (N)

3.7.4 Public/private health care surveys (e.g.: AHA/AONE) (N)

3.8 Commit adequate fiscal resources and well-trained staff to the **implementation of recruitment and retention activities**.

3.8.1 Convene a national summit of Nurse Executives and HR Chiefs to identify recruiting strategies and clarify interpretation and use of all existing authorities (reference recommendation 2.9.1).(N)

3.8.2 Fund training for nurse recruiters and human resource staff; focus on required expertise in recruitment activities and flexible implementation of Title 38 appointments. (N)

3.8.3 Provide formal support to those facilities lacking nurse recruiters. (N)

3.8.4 Identify, and deploy as needed, teams that can go into facilities needing specific, immediate recruitment assistance and consultation. (N)

3.8.5 Develop a resource list of individuals as references and develop toolkits. (N)

3.9 Implement an electronic system for **conducting and recording RN exit interviews.** A uniform national system is needed to aggregate and utilize data at a facility, network and national level. The electronic interview located at http://vhacoweb1.cio.med.va.gov/vasurvey does not as yet meet these needs. (N)

3.10 Formulate a **national nursing recruitment campaign** and update recruitment materials.

3.10.1 Fund additional staff positions to manage national recruitment and retention programs (L)

3.10.2 Hold focus groups to determine the most appropriate ways to market VA nursing as a career to minorities, men and new graduates. (N)

3.11 Create a **VA Traveling Nurse Corps**, a nationally coordinated internal pool of RN's available for temporary assignments of at least 90 days with funding to support travel and other expenses. (N)

4.0 OUTREACH

4.1 **Collaborate with external partners** to improve the image of nursing, to increase recruitment into nursing careers, and to encourage outreach programs. (N)

4.1.1 Create recruitment strategies for nurses from community and government facilities that are downsizing/resizing and for retiring or separating military staff. (N)

4.1.2 Recognize and reward VA outreach programs that extend to elementary, middle, and high schools, and community organizations to market VA nursing and other healthcare careers. (N)

4.1.3 Centrally fund local programs that employ, mentor, or subsidize educational expenses for Student Nurse Technicians to increase visibility of VA nursing as a career choice and as a recruitment tool for employment. (N)

4.2 Develop **national level programs in partnership with professional and health care organizations**, e.g. Continue the collaborative effort with the University Health System Consortium (UHC) and American Association of Colleges of Nursing (AACN) to develop a Post Baccalaureate Residency Program for new graduates that, when implemented, will provide an organized transition for new BSN graduates into the work setting and will contribute to VA's ability to recruit new graduates. (N)

4.3 **Enhance academic affiliations and faculty appointments** by realigning VA's nurse affiliation model to a model that is similar to medical affiliations. VA will continue to align closely with those nursing schools that have strong academic and research programs to extend the knowledge base of nursing and to advance evidence-based practice in nursing. A relationship with these schools will have positive impact on veterans' care. (N)

4.3.1 Fund faculty positions at schools of nursing that have strong academic and research programs (faculty will have a clinical appointment at VA and academic appointment at the school of nursing); and (N)

4.3.2 Use existing authority (Authorized Absence) to encourage active participation of VA nurses in the affiliated school's academic and clinical activities, such as shared faculty and clinical teaching appointments; memberships in school/university standing committees. (N)

Guide to VA Pay and Hiring Authorities

Compensation Strategies to Meet Growing Competition for Registered Nurses, Practical Nurses, and Nursing Assistants

The VA is faced with growing competition for a declining supply of new Registered Nurses (RN), Licensed Practical Nurses (LPN) and Nursing Assistants. While this paper focuses on available compensation strategies to become more competitive in recruitment and retention, it should be realized that there are many factors that go into an individual's decision to choose one employer over another or to remain employed within an organization. VA facilities must address conditions of work as well as salary to effectively compete for dwindling numbers of nurses.

Registered Nurse

Base Pay

1) *Pay Surveys.* If the competition for Nurses is especially volatile in your area you may wish to consider doing your Locality Pay Survey (LPS) surveys more often than annually. Facility directors may expand the survey area for any covered nurse occupation or specialty if the survey area does not adequately represent the Local Labor Market Area (LLMA) for an occupation or specialty or if there are less than 3 job matches per grade. LLMAs may be expanded differently for different occupations or specialties. LLMAs may be expanded as far as necessary to obtain the required survey data.

Reference: VA Handbook 5103.9, Part 2, paragraph 3 and 4b.

2) *Deviations to Periodic Step Increase (PSI) Waiting Periods***.** If your competitors provide increases to base pay based on tenure at a rate different than the VA you may request a change to the waiting period for step increase to mirror the advancement and promotion patterns in the community.

Reference: VA Handbook 5103.9, Part 1, paragraph 12d.

3) *Exceptions to the 133 Percent Rate Range***.** The rate range under the LPS is normally 133 percent of the beginning rate of the grade (12 steps). Facility directors may request extension of the rate range for a grade, up to 175 percent (26 steps), if such an extension is necessary to recruit or retain well qualified nurses. Facilities submitting requests must exhibit staffing problems specific to the grade for which the extension is requested, and show that the problems are related to higher maximum rates in the community. This authority is particularly useful for retention as it gives on-board employees greater earning potential.

Reference: VA Handbook 5103.9, Part 4

4) *Setting Beginning Rates of Pay Under LPS***.** Policy states that facility directors will normally set the beginning rate for a grade within 5 percent of the survey average. However, there are often instances when there is little or no survey data for a grade or the survey data collected does not adequately represent community pay practices. The flexibilities listed below provide mechanisms for adjusting rates outside the normal plus/minus 5 percent parameter.

a) Setting Beginning Rate up to Community Maximum. The beginning rate for any grade for which survey data was collected may be set equivalent to, but not exceed, the highest beginning rate for corresponding non-VA positions in the LLMA. Facility directors should consider all factors which affect the facility's staffing abilities when choosing the beginning rates of pay, including the geographic relationship of their facility to major non-VA health care facilities in the LLMA, the rates paid by the facility's major competitors, and benefit packages offered by competing establishments.

Reference: VA Handbook 5103.9, Part 3, paragraph 2.

b) Setting Beginning Rate up to 7th Step of Next Lower Grade. When data is not available for a grade and an adjustment is necessary to recruit or retain well qualified employees, the facility director may increase the beginning rate of Nurse II, III, IV or V up to the 7th step of the next lower grade. The beginning rate for Nurse I may be adjusted so that the beginning rate for Nurse II falls in the range from the 4th through 7th step of Nurse I. The beginning rate for the levels with Nurse I may be adjusted to provide a 3-step differential between them.

Reference: VA Handbook 5103.9, Part 3, paragraph 2c(2)(b).

5) *Specialty Schedule.* A separate LPS salary schedule may be established for any nurse category, except head nurse, by conducting a survey of pay rates for the corresponding specialty in the local labor market. This allows the facility to pay higher rates for assignments that are typically difficult to fill, such as critical care nurse, operating room nurse and nurse practitioner. Employees reassigned to a specialty schedule normally receive the rate for the same grade and step held on the day before the effective date. If the covered employees were receiving a higher step rate for specialized skills based on the same specialty, their new step rate will be determined by reconstructing their employment history, disregarding the higher rates for specialized skills. This may result in placement at a lower step, but will not result in a salary reduction.

Reference: VA Handbook 5103.9, Part 1, paragraphs 5 and 4d(2)(c).

6) *Higher Rates of Additional (Premium) Pay***.** Facility directors may authorize higher rates of premium pay (tour differential, Sunday pay, Saturday pay, holiday pay, overtime and on-call) for nurses when necessary to address recruitment or retention problems being caused by higher non-Federal rates of premium pay in the community. For instance, VA may have difficulty staffing positions because VA's tour differential rate is 10 percent and other establishments in the community pay 15 percent for similar tours. This gives facilities a mechanism to ensure all areas of pay are competitive to meet staffing needs.

Reference: MP-5, Part II, Chapter 3, Section D, paragraph 4d and its VHA Supplement

7) *Higher Rates of Pay for Specialized Skills***.** If you are having difficulty recruiting for a specialty such as intensive care but are unable to collect sufficient data to establish a separate pay schedule, you may appoint a new Nurse at a higher step rate based on the attainment of

specialized skills and placement in an area utilizing these skills. When this occurs, the facility director may adjust the salary rates of other nurses in assignments requiring the same specialized skills up to the same number of steps. If a nurse subsequently leaves the specialty or if a specialty schedule is later established to recognize the same skills, the nurse's employment history is reconstructed disregarding the higher rates for specialized skills.

Reference: VA Handbook 5103.9, Part 1, paragraph 4b.

8) *NPSB Pay Setting Policy.* If you are having difficulty in hiring experienced Nurses, review your Board policy on pay setting and creditable experience. Some Boards continue to limit the amount of experience they will consider in setting pay. While any change to this policy is likely to raise issues with those hired under the previous policy, you will need to weigh this against the problems inherent in less than optimal staffing.

9) *Baylor Plan.* Nurses on the Baylor Plan receive full-time (40 hours) pay for working two regularly scheduled 12-hour tours of duty entirely within the period commencing at midnight Friday and ending at midnight the following Sunday. They are not entitled to additional pay (i.e. tour differential, weekend pay, overtime) for working normal hours on this tour. Use of this provision may enable facilities to staff undesirable weekend tours. Facility directors may request authorization to use the Baylor Plan if necessary for recruitment and retention purposes.

Reference: MP-5, Part II, Chapter 3, Section E and its VHA Supplement.

10) *Pay Retention upon Transfer***.** Nurses who transfer between VA facilities normally receive the rate of pay at the gaining facility applicable to their existing grade and step. This may result in a salary decrease if the employee transfers to a facility with lower rates of pay. Facility directors may authorize the individual to receive pay retention or an intervening rate of pay (a rate which is above the rate of pay for the corresponding grade and step but less than pay retention) based on a special recruitment need or solicitation of an employee to fill an assignment requiring special qualifications. Use of this authority enhances recruitment abilities by attracting experienced VA nurses who are seeking to relocate.

Reference: VA Handbook 5103.9, Part 1, paragraph 10a(2).

Incentive Awards.

Recognition and awards programs motivate employees to make contributions that support and enhance organizational goals and objectives. The types of awards available include special contribution awards (e.g., time-off awards and on-the-spot awards), suggestion awards, gainsharing awards, honor awards, and non-monetary awards. Detailed information regarding these awards can be found in the handbook referenced below.

Reference: VA Handbook 5451

1) Exemplary Job Performance and Exemplary Job Achievement. Cash awards may be authorized of up to $2,000 may be granted to Nurses who demonstrate both exemplary job performance and achievement.

Reference: VA Handbook 5103.9, Part I, paragraph 8c.

2) **Referral Bonus**. Cash awards of up to $3,000 for the referral of a qualified Nurse applicant who is subsequently hired. These programs are highly effective for several reasons. Not only do they produce better results for the dollars spent but both the "recruiter" and "recruitee" tend to stay longer.

3) **Special Advancement for Achievement (SAA).** Advancements of up to 5 steps within the grade may be granted to recognize professional achievement provided the individual has demonstrated excellence in performance above that expected for the grade level or assignment and potential for assumption of greater responsibility. SAAs are considered by the appropriate Nurse Professional Standards Board for approval by the facility director.

Reference: VHA Supplement to MP-5, Part II, Chapter 5, paragraph 5.10.

4) **Special Advancement for Performance (SAP).** Advancements of 1 step within the grade may be granted when there has been a demonstrated high level of performance and ability over and above that normally expected of nurses in the particular grade. SAPs are considered by the appropriate Nurse Professional Standards Board for approval by the facility director. One advancement may be granted at any appropriate time within any 52 week period.

Reference: VHA Supplement to MP-5, Part II, Chapter 5, paragraph 5.11

5) **Specialty Certification.** A cash award of up to $2,000 must be granted to nurses who become certified, while employed by VA, in a specialty related to the accomplishment of VA's health care mission. The facility director establishes local written policies for granting cash awards for certification, including the criteria for the amount of the award.

Reference: VA Handbook 5103.9, Part 1, paragraph 8b.

Practical Nurses

Base Pay

1) When the base pay is no longer competitive and you have, or anticipate having, a pay-related staffing problem the facility director may establish a Special Salary Rate (SSR). Much like the LPS, the SSR allows you to survey competing employers and set pay at a competitive rate. This process allows you to set initial (step 1) pay for a grade as high as the 19th step of the General Schedule Base Pay.

Reference: Handbook 5103.4 and MP 5, Part II, Chapter 3, Section D

2) The higher rates of premium pay discussed above for Nurses also apply to Practical Nurses once the Director authorizes LPNs to receive premium pay on the same basis as RNs.

Reference: VHA Supplement to MP-5, Part II,Chapter 3, Section D, para 3D.03

3) You may appoint a Practical Nurse who possesses higher or unique qualifications, is currently receiving a higher rate of pay or who meets a special need of the VA at a rate above the minimum rate for the grade. This authority allows you to respond selectively to individuals rather than establishing across-the-board pay rates or policies.

Reference: VA Directive 5103.7

4) As discussed above, the pay setting policy of the Standards Board should be reviewed to ensure it is not a barrier to establishing competitive salaries.

5) Incentive Awards. Practical Nurses are eligible to receive referral awards, special contribution awards and special advancements for achievement and performance.

Reference: VHA Supplement to MP-5, part II, Chapter 5.10 I and VA Directive 5451 and Handbook.

Nursing assistant

Base Pay

1) SSRs are also available for Nursing Assistants. Approval for SSRs is different in that the Under Secretary for Health is the approving official and the Office of Personnel Management must concur with the proposed new rates.

Reference: MP-5, Part II and VHA Supplement, Chapter 3, Appendix C

2) Higher rates of pay upon appointment for those individuals possessing higher or unique qualifications or currently receiving a higher rate of pay may be authorized by the Director.

Reference: VA Directive 5103.7

Incentive Awards

1) Nursing Assistants are eligible for special contribution awards, which include on-the-spot and time off awards, quality step increases and other monetary and non-monetary awards.

Reference: VA Handbook 5451

Additional Strategies Common to All Occupations

Recruitment Bonus

A recruitment bonus of up to 25% of base pay may be authorized for a new appointee. In return, the employee must agree to a period of obligated service. The service agreement is generally for a period of not less than one year but may be longer. Payment is in a lump sum.

Reference: MP-5, Part I, Chapter 575, Section A.

Relocation Bonus

A relocation bonus of up to 25 percent of the rate of basic pay may be authorized for an employee who must physically relocate and change duty stations to accept a position in a different commuting area. It must be determined that, without the bonus, it would not be possible to fill the position with a high quality candidate. Similar to the recruitment bonus described above, this bonus requires a service obligation and is paid in a lump sum.

Reference: MP-5, Part I, Chapter 575, Section B.

Retention Allowance

A retention allowance of up to 25% of base pay may be paid to an individual who possesses unique or unusually high qualifications or is in a difficult to fill occupation and is likely to leave the VA. This allowance may also be paid to a group when a significant number of the group are determined to be likely to leave Federal service. For a group authorization, the allowance may not exceed 10%. In both cases, to be eligible the employee must have been appointed for a year or more and is not currently covered by a service agreement for a recruitment or relocation bonus. Payment is bi-weekly based on hours worked, up to 80 hours. There is no obligated service requirement and the VA retains the right to discontinue the allowance at any time.

Reference: MP-5, Part I, Chapter 575, Section C.
Additional information for these three is available at http://www.opm.gov/oca/pay/.

Appendix

FUTURE NURSING WORKFORCE PLANNING GROUP

Statement of Work

PURPOSE

The Future Nursing Workforce Planning Group will advise the Chief Consultant, Nursing Strategic Healthcare Group on issues that impact the Veterans Health Administration's future supply and utilization of registered nurses.

ACTIONS

The Planning Group will:

I. Use existing data as well as current and projected workforce trends to identify those factors that will impact VA's veteran care mission.

II. Identify strategies to ensure that an adequate, qualified nursing workforce is available to VA (e.g. recruitment, retention).

III. Identify strategies that will optimize the utilization of the future nursing workforce (e.g. staffing, scope of practice, clinical privileges, and licensure).

PRODUCT

Formulate recommendations, strategies and appropriate timelines to address the identified issues.

Conditions

All activities are to be accomplished within Fiscal Year 2001.

Rebecca Newsom Williams, Nurse Executive, VAMC Denver will chair the Planning Group.

The Planning Group membership will reflect the diverse areas of expertise that impact on nursing workforce supply and utilization. In addition, the Planning Group may identify and use the expertise of internal or external consultants when necessary.

Activities will be accomplished primarily through video or audio teleconferences; with face to face meetings scheduled as necessary.

Cathy Rick, RN, MS, CHE
Chief Consultant, Nursing Strategic Healthcare Group

Appendix B
Future Nursing Workforce Planning Group

NAME	TITLE	OFFICE LOCATION
Chair		
Rebecca Newsom-Williams, RN, MPH	Associate Medical Center Director for Patient Focused Care	VAMC Denver, CO
Co-Chair		
Cynthia McCormack, RN, MS	ACOS/In Patient Care, Nurse Executive	VAMC Phoenix, AZ
Maragaret Alderman, RN,DNSc	ACOS/In Patient Care, Nurse Executive	VAMC San Francisco, CA
Mablene Bailey, RN,BSN	Nursing Coordinator	VAMC Richmond, VA
Louis Cobuzzi, RPh, MS	Chief, Pharmacy	VAMC Baltimore, MD
Judy H.Cook, RN, MNSc	ACNS, Long Term Care	VAMC Little Rock, AR
Ann Converso, RN	United American Nurses, AFL-CIO	VAMC Buffalo, NY
Dennis Curley, MBA	Director, Human Resource Mgt. Program and Policy Service	VACO
Joseph Dean, MA	Special Asst. to Director	VAMC Albuquerque, NM
Daniel Deininger, RN, MS (Recorder)	ACNS, Nursing Systems	VAMC Tampa, FL
Manuel L. Fabela, RN, BSN	Staff Nurse	VAMC Salt Lake City, UT
Iris Fernandez, RN, MSN	Clinical Support Service Line Chief/Nurse Executive	VAMC Beckley, WV
Sheldon Fine	Network Chief Financial Officer	VISN 21
Roger French, BA, MPA	Service Line Leader, HRM	VAMC Seattle, WA
Veronica Kirchhofer, RN, BSN	Clinic Coordinator	VAMC Dallas, TX
James Lee	Director, HRM Group, VHA	VACO
Dolores Lefridge, RN, MSN	Chief Nurse	VAMC Houston, TX
Floss Mambourg, RN, MS	Director, Rehabilitation and Long Term Care	VAMC Portland, OR
Jane Nygard, RN	American Federation of Government Employees	VAMC Minneapolis, MN
Robert Perreault, MBA	Medical Center Director	VAMC Charleston, SC
Coordinator		
Charlotte F. Beason, RN Ed.D	Program Director, Nursing Strategic Healthcare Group	VACO

VA NURSING DATA

FY2000[10]

VHA Nursing Personnel Statistics

Total VHA Employees	
RN	34,891
LPN	9,566
NA	8,759
Total	**53,216**

Advanced Practice Nurses	
Nurse Practitioner	2,222
Clinical Specialists	690
Total	**2,912**

RN Turnover Rate	
FY 2000	9.05%

VHA Age Statistics

Average Age of VHA GS Employees	
Licensed Practical Nurses	44
Nursing Assistants	45

VHA RN Age Statistics	VHA	US Over-all
Average Age	45.98	45.2
Percent of Nurses under 40 yrs	23%	31.7%
Percent of Nurses under 35 yrs	11.2%	18%
Percent of Nurses under 30 yrs[11]	4.7%	9.1%

New Hire Age (RN)	
Average Age	41.65
Percent between 35-49	56%
Percent over 50	20%
Percent under 35	24%
Percent under 40	40%

RETIREMENT

- VHA RN retirement eligibility through 2005 is projected as 35% [12]. "Based on best-judgment predictions now, it's not a large, violent, sudden wave, but rather a prolonged, gradual, manageable wave of retirements that should extend well beyond 2005." Other VHA retirement eligibility through 2005 is 29% LPN and 34% NA.
- RNs enrolled in CSRS equal 10,543 versus 24,348 in FERS. Retirement predictions regarding FERS-enrolled RNs is limited due to lack of historical trend data (as a result of its newness) and lack of data re the influence of the portability of FERS on overall recruitment and retention.

EDUCATION

- Average age at graduation from basic nursing education is increasing, i.e., 30.5 years in 1995-2000 versus 24.3 years in 1985 or earlier.
- 35%[13] of VA new RN hires would not advance beyond entry level with the new Qualification Standards. It is unclear if hiring these less than BSN-prepared nurses is a result of facility preference or indifference, and/or an inability to attract RNs with a BSN.
- As compared to the U.S. RN education distribution, VA has a greater proportion of higher educated RNs, 19% with more than a BS versus 10.2% in the general population and 40%[14] with less than a BS versus the nation's 56.6%.

FUTURE TREND

Dr. Peter Buerhaus predicts that the total number of nurses per capita is likely to peak by 2007 and decline steadily thereafter. By 2020, US RN workforce is forecast to be roughly the same size as it is today, declining nearly 20% below RN workforce requirements. This shortage – possibly large – is unprecedented because it will be driven by rapidly aging RN workforce that will not be replaced by younger cohorts.

From the data available, there seems to be a potential for VA nurses to 'age out'. VA needs to focus more effort on increasing its desirability to younger nurses. In concert with the new Qualification Standards, targeted hiring of new BSN graduates, which are generally younger (27.5 yrs) than AD (33.2 yrs) or diploma (30.8 yrs) graduates, is one strategy to help achieve this goal.

---

[10] Based on VA PAID FY 1998, 2000and US Dept of Health and Human Services' Findings from the National Sample Survey of Registered Nurses, March 2000. VA Nurse Anesthetist data are excluded from this analysis.

[11] In 1980, US RNs under 30 = estimate 25.1%

[12] To place this in perspective though, for RNs, [other than the current year retirement percent rate, which because it includes retirement eligible RNs who have not as yet retired, is always larger than average, i.e., 12%] the retirement rate is incremental at a seemingly manageable 3.7 to 5.3 % per year. The new RN hires in 2000 comprises 9 % of total VA RNs. therefore, to date, new hires are replacing retirees.

[13] 41% in 1998

[14] 47% in 1998

Contacts

The Planning Group sought information and comment from a wide variety of nurses and stakeholders. VA nurses provided comments to the Planning Group in response requests made via national conference calls and information posted on the Nursing Strategic Healthcare Group website. The Planning Group also solicited Issue Papers and invited guest presentations. Inquires were also made of specific individuals or groups in order to clarify issues raised in Planning Group discussion. The list from which information and comments were received includes, but is not limited to, the following:

Geraldine Bednash, RN, Ph.D., Executive Director, American Association of Colleges of Nursing

Veterans Benefits Administration Workforce Design Team

Executive Board, VA Nurse Recruiters Association

Linda Moore, RN, Ph.D., Chair, Nursing Hiring Time Lind Task Force

Denise Carey, RN, MA, Nurse Executive VAMC Charleston, SC

Sarah Williams, RN, MA, VAMC Charleston, SC

Julia Anderson, RN, MSN, VAMC Charleston, SC

Nurse Executive Orientation Groups (2)

National Nursing Executive Council

Registered Nurse Staff, VAMC Denver, CO

VA Labor Partners

Nurses Organization of the Department of Veterans Affairs

VA Licensed Practical Nurse Task Force, Kathleen Cole RN, MS, Chair

Nursing Strategic Healthcare Group, VA Central Office

- Cathy Rick, RN, MS Chief Consultant
- Charlotte F. Beason, RN, Ed.D.
- Paulette R. Cournoyer, RN, DNSc.
- Audrey C. Drake, RN, MS

VA Central Office Human Resource Group

Donna Schroeder, VACO Human Resources

Washington, DC Area Federal Nurse Recruiters

Network 2 Nurse Recruitment and Retention Work Group

Leland Winger, RN CRNA, MSN, Deputy Director. Headquarters Anesthesia, Acute Care SHG

Federal Chief Nurses Council

Acknowledgements

The VA Nursing Workforce Planning Group and the Nursing Strategic Healthcare Group acknowledges the special contributions made to this report by the following individuals:

Betty (Betsy) Oliver, VACO

Katherine Bent, RN, Ph.D., VAMC Denver

Donna Schroeder, VACO

Donald Kelly, VA Healthcare System Puget Sound

Dana Epstein, RN, Ph.D., VAMC Phoenix

Robert McGear, VACO

Donald Trembly, VAMC Denver

Jenny Lee Rowley, VAMC Denver

Joann Addington, VAMC Denver

Nancy Hicks, VAMC Denver

Successful VA Strategies

In January 2001, the Nursing Strategic Health Care Group asked VA Nurse Executives to submit outreach activities and programs planned or in place to address the national nursing shortage. A number of innovative programs in the organization of nursing services or in which VAMCs were collaborating with elementary, middle, and high schools; community organizations; and institutions of higher education were submitted.

The following are examples of these successful nursing strategies.

Magnet Hospitals- The VAMC Tampa Experience

"Magnet" status represents the highest recognition awarded by the American Nurses Credentialing Center (ANCC) for excellence in nursing services. The Tampa VA Medical Center is the only VA organization to have achieved magnet status and one of only a few hospitals across the country to hold this prestigious recognition. To comply with Magnet Standards, a nursing service must be autonomous, in control of professional nursing practice and show evidence of commitment to excellence in the provision of nursing care.

Why

Historically, magnet hospitals have demonstrated improved patient outcomes, staff satisfaction, and the ability to attract and retain professional nurses. Our decision to apply for magnet status was governed by these findings and other important factors. Our service has a proud history of achievement and quality driven improvement in patient care and professional growth. Magnet was seen as a way to recognize the past achievements of the nursing staff. It was also viewed as a vision for the future, providing a framework for strategic planning and continuous improvements in quality and performance. We were also motivated by the fact that accomplishments of VA nursing are often not well known outside VA. We saw the Magnet application process as a means to help communicate VA's commitment to excellence in nursing service to our professional colleagues and customers in the public and private sectors.

How

While Magnet recognition is for nursing excellence, it cannot be achieved without hospital-wide involvement. The application process consists of providing documentation to the ANCC to show compliance with a comprehensive set of Standards of Care and Standards of Professional Performance in addition to a detailed demographic description of nursing service and the hospital. Preparation of the application took a year of planning and an additional year of work by all levels of nursing staff and others outside the department. Educating the nursing and hospital staff on Magnet Standards and the application process was a major portion of the program. Our slogan "Partners in Excellence" helped develop awareness in all hospital departments that magnet status recognizes teamwork, an interdisciplinary approach and is a source of pride for the entire hospital.

The application is reviewed and scored against the standards. If the score indicates sufficient compliance, a site visit is scheduled by Magnet appraisers to "verify, clarify and amplify" the application. The site visit consists of formal and informal interviews with administrators and staff, tours of nursing units and open sessions where staff, patients or the general public can meet with the appraisers. Both strengths and weaknesses of the application are discussed during formal interviews and the exit meeting. Magnet status is later awarded or denied based on the strength of the application and verification by the site visit.

What now

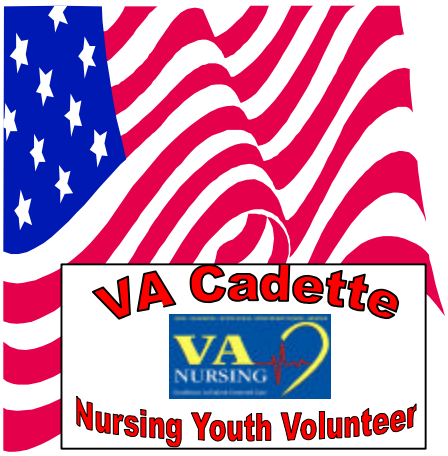
The application in itself is an invaluable learning tool. It forces a detailed self-examination of all aspects of the service from strategic planning to how care is delivered on a daily basis. Self-governance, collaboration and autonomy of practice are constant themes throughout the standards. We were able to examine and critically assess our nursing practice and system processes. As the application progressed, it was clear that we met or exceeded most standards, but were clearly weak on others. We developed action plans for all areas that lacked strength. Measuring our practice and performance against the Magnet standards has provided a roadmap to improve both our professional performance and care delivery systems. We are exceptionally proud that we have achieved Magnet recognition and are mindful that we now have a reputation to maintain. We now often frame decisions around the intent or spirit of Magnet standards. This helps ensure we continue to strive for the best possible care for patients and provide a rich environment for professional growth for our staff.

For further information about the Magnet recognition program, contact:

American Nurses Credentialing Center
600 Maryland Avenue, SW, Suite 100 West
Washington, DC 20024-2571
ANCC@ana.org
ANCC catalogs: 1-800-284-2378

For further information about the VA experience in attaining Magnet status, contact:

Sandra.Janzen@med.VA.gov



VA Cadettes
Nursing Youth Volunteer Program

Overview: The VA Cadette program is structured at two levels. The Junior Cadette at first level provides orientation to the hospital setting and to identified simple nursing support tasks. Following successful completion of 60 hours of volunteer work in the program the student can progress to the second level as a Senior Cadette. The Senior Cadette performs more complex tasks and independent functioning while still in a supervised setting. Supervision of the Cadettes is provided by the nurses on the patient care units and the Nurse Officer of the Day. The minimum age for a VA Cadette is 14 years old.

Orientation: Initial Orientation will be provided quarterly on Saturday (5 Hours) and will include general orientation to the volunteer role as well as specific training with return demonstration of expected tasks at the Junior Cadette level. Training and orientation for the Senior Cadette level will be provided as students are ready to progress. Detailed orientation plan and content for each level is attached. The students will receive a Cadette Pin on completion of each level.

Attire: The students will be provided coats which will identify them as VA Cadettes. Clothing and shoes will be appropriate to the hospital setting. Shorts and extremely short skirts will not be worn while in the Cadette role.

Volunteer Status: The VA Cadettes are registered as VA Volunteers and will receive appropriate credit for hours worked. They will be recognized at the annual VA Volunteer Ceremony. Participation in the program is contingent on receipt by the Medical Center of the youth's signed parental consent form. The Application for Voluntary Service (VAF 10-7055) is attached as Appendix A.

Assignments: The Cadettes will be assigned to inpatient units (medical/surgical and extended care) and the emergency room/admissions unit. Preferably the Cadette will work in 2 hour increments at a minimum. However, this may be flexible for the individual student. The students will report to work at the Office of Nursing Professional Practice and receive their assignment for the day.

Physical Requirements: The Cadette must have a current TB Skin Test. This will be provided by the VA Medical Center during the Orientation Program. The Cadettes must be able to perform the functions of the Position Description.

The VA Cadette Nursing Youth Volunteer Program was developed by: Mary C. Raymer, RN, MA, CNAA; Associate Chief of Staff for Patient Care Services (118); Nurse Executive, VA Medical Center; Salem, Virginia

Puget Sound Health Care System
American Lake & Seattle

Partners Program

(Content excerpted from Web Site. URL to view page: http://www.puget-sound.med.va.gov/nurse/partners/default.htm)

In 1996, the VA Puget Sound Health Care System embarked on a journey to partner with our community in an effort to promote awareness of our veterans accomplishments, while providing an opportunity for middle and high school students to gain valuable experience. Since then, many students have participated, demonstrating a remarkable level of maturity and a commitment to service.

We asked participating students to write brief essays describing their experiences while working in the partners program. While not everyone had entirely positive experiences, each student gained an increased understanding of the tremendous contributions veterans have made, as well as a better understanding of many career opportunities that exist in the healthcare industry.

The essays were added as written by the authoring students, and without edits. To read the full essay, click on any quote.

Essay Excerpts

"This job gives me a good idea of what work will be like when I grow up, and it helps me prepare for it."

"one thing that I hated the most and that was being a loner, I had nurses to talk to but I wasn't used to communicating with adults."

"My goal is to become a doctor and after that I can help them with my knowledge."
"I have learned to always finish it no matter how much time has passed"

"I like seeing patients laugh cause then that tells me that they're doing good. That makes me feel good too."
"Working in the VA has changed my life so much because I became more responsible, more helpful, and mature."

"I've learned that just because people aren't easy to get along with, I can't just walk away and ignore them because I'm mad or frustrated"

"I was close to most of the patients so when it was time for them to leave I was sad."
"The things I've learned is to be more respectful of others, I learned to listen more carefully, staying on task..."

"I hope that I will be working here at the VA for a long time"

"Working with veterans has influenced me greatly. They have made me realize that I have more patience than I would ever expect."

"I feel so thankful, now more than ever, for the rare things I have, such as living in a free country..."
"Working with veterans who have served our country make me feel special and proud. Being able to help a patient in any way makes me feel very proud, and flattered when he or she compliments me, or even a single "thank you" brightens my day."

Contact Information

Partners Program Coordinator, (206) 764-2626
VA Puget Sound Healthcare System
Seattle, Washington

BIBLIOGRAPHY[15]

Anderson, C (2001). Hanging Tough. Nursing Outlook, 49, 113-114.

Aiken, L. et al. "Nurses' Reports on Hospital Care in Five Countries," Health Affairs, May/June 2001, 43-53.

American Association of Colleges of Nursing (1998). With demand for RN's climbing, and shortening supply, forecasters say what's ahead isn't typical "shortage cycle". Issue Bulletin February 1998, Author, Washington, D.C.

American Association of Colleges of Nursing (2000). Amid nursing shortages, schools employ strategies to boost enrollment. Issue Bulletin June 2000, Author, Washington, D.C.

American Organization of Nurse Executives. (2000). Nurse recruitment and retention study. Author: Chicago.

Bednash, G. "The Decreasing Supply of Registered Nurses," JAMA, June 14, 2000, Vo. l283, No 22, 2985-2987.

Bednash, G. (2000a). Nursing School enrollments decline as demand for RN's continues to climb. American Association of Colleges of Nursing: February 2000.

Bednash, G. (2000b). The decreasing supply of Registered Nurses: Inevitable future or call to action? Journal of the American Medical Association 283(22), 2985-2987.

Bell, F., Wade, A.H., & Gross, S.C. (1993). Life Tables for the United States security area 1900-2080 (Actuarial Study No. 107; Publication 11-11536).
Washington DC: Social Security Administration.

Bognanno, M., Hixson, J., & Jeffrers, J. (1974). The short-run supply of nurse's time. The Journal of Human Resources, 9, 80-94.
Brewer, C. (1996). The roller coaster supply of registered nurses: Lessons from the eighties. Research in Nursing and Health, 19, 345-347.

Buerhaus, P. "Is Another RN Shortage Looming?" Nursing Outlook, May/June 1998, Vol. 46, 103-108.

Buerhaus, P. & Staiger, D. "Trouble in the Nurse Labor Market? Recent Trends and Future Outlook," Health Affairs, January/February 1999, Vol. 18, No. 1, 214-222.

Buerhaus, P., Staiger, D. & Auerbach, D. "Implications of an Aging Registered Nurse Workforce", JAMA, June 14, 2000, Vol. 283, No. 22, 2948-2954.

Buerhaus, P., Staiger, D., & Auerbach, D. "Policy Responses to an Aging Registered Nurse Workforce," Nursing Economic$, November/December 2000, Vol. 18, No. 6, 278-284.

[15] This is a combined bibliography of nursing workforce issues and reference list for the Planning Group Report. It is presented as a reference for the use of nurse executives and others as they address nursing workforce issues.

Buerhaus, P.I. (1993). Effects of RN wages and non-wage income on the performance of the hospital RN labor market. Nursing Economics 11(3), 129-135.

Buerhaus, P.I., & Staiger, D.O. (1999). Trouble in the nurse labor market? Recent trends and future outlook. Health Affairs, 18, 214-222.

Buerhaus, P.I., Staiger, D.O., & Auerbach, D.I. (2000a). Implications of an aging Registered Nurse workforce. Journal of the American Medical Association 283(22), 2948-2954.

Buerhaus, P.I., Staiger, D.O., & Auerbach, D.I. (2000b) Why are Shortages of Hosoital RNs Concentrated in Specialty Care Units? Nursing Economics 18 (3), May, 111-117.

Carpenter, D. (2000). Going, going, gone? HH&N June. www.hhnmag.com
Coffman, J., & Spetz, J. (1999). Maintaining an adequate supply of RN's in California. Image: Journal of Nursing Scholarship 31(4), 389-393.

Coffman, J., Blick, N., & Wong, S. (1998) The nursing workforce and nursing education: An overview of trends. In O'Neil, E., & Coffman, J. Eds., (1998). Strategies for the Future of Nursing. Jossey-Bass, San Francisco, pp 8-20.

Curran, C., Horner, D., & Eldridge, R. (2000). Nursing shortage facts: What Healthcare Executives should know. Audio conference, August 19, 2000, American College of Healthcare Executives. Chicago.

Department of Veterans Affairs (2000) Strategic Plan 2001-2006, Washington, DC: Department of Veterans Affairs.

Fagin, C. When Care Becomes a Burden: Diminishing Access to Adequate Nursing. Milbank Memorial Fund, February 2001

Fralic, M., et al. Nurse Workforce: Condition Critical. No. 763 Issue Brief National Health Policy Forum, Friday, June 1, 2001.

Friss, L. "Nursing studies laid end to end form a circle," J Health Politics, Policy and Law. 1994, Vol. 19, 597-631.

Guralnik, J.M. La Croix, A.Z., Everett, D.F., & Kovar, M.G., (1989, May 26). Aging in the Eighties: The Prevalence of co-morbidity and its Association with Disability. Advance Data, 170, 1-8.

Havens, D. S., & Aiken, L. H. (1999). Shaping systems to promote desired outcomes: The Magnet Hospital Model. JONA, 29(2), 14-20.

Health Care Financing Administration. (1996) 1996 Data Compendium, Washington, DC: US Department of Health and Human Services.

Heinrich, J. Nursing Workforce. Emerging Nurse Shortages Due to Multiple Factors. GAO Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives, July 2001.

Kramer, M & Schmalenberg, C. (1988). Magnet Hospitals: Part I, Institutions of Excellence, J of Nsg Admin,18(1):13-24 also Part II, Institutions of Excellence, J of Nsg Admin, 18(2):11-19

Link, C., & Settle, R. (1980). Financial incentives and labor supply of married professional nurses: An economic analysis. Nursing Research, 29, 238-243.

Moses, E. B., (1997). The Registered Nurse Population: Findings from the national sample Survey of Registered Nurses, March 1996. Division of Nursing, U.S. Bureau of Health Professions, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and human Services, Rockville, MD.

National Advisory Council on Nurse Education and Practice (NACNEP), Report to the Secretary of the Department of Health and Human Services on the Basic Registered Nurse Workforce. USDH&HS, HSRA, Bureau of Health Professions, Division of Nursing, 1996.

Nursing Leadership Council (2000). Report on the status of nursing with workforce recommendations. Author, Department of Public Health, San Francisco County, San Francisco.

Office of Performance and Quality (1998) Health Status and Outcomes of Veterans: Physical and Mental Component Summary Scores (SF-36V) 1998 National Survey of Ambulatory Care Patients Mid-Year Executive Report, Bedford, MA: Department of Veteran Affairs.

Office of Performance and Quality (2000). Health Status and Outcomes of Veterans: Physical and Mental Component Summary Scores. Veterans SF-36. 1999 Large Health Survey of Veteran Enrollees. Executive Report, Bedford, MA: Department of Veteran Affairs.

Patterson, J.A., Bierman, A.S., Splaine, M., Goodlin, S.J., Schreiber, R., & Wasson, J. (1998). The Population of People Age 80 and Older: A Sentinel Group for Understanding the Future of Health Care in the United States. The Journal of Ambulatory Care Management 21 (3) 10-16.

Reality √ III, Searching For Trust: America's Message to Hospitals and Health Systems, AHA, National Focus Group Research, 1998 –1999.

Reverby, S.M. (1987). Ordered to Care. Women's Studies Program. Wellesley College. Cambridge University Press: Cambridge.

Scanlon, W. Nursing Workforce. Recruitment and Retention of Nurses and Nurse Aides is a Growing Concern. GAO Testimony Before the Committee on Health, Education, Labor and Pensions, U.S. Senate, released May 17, 2001.

Slavitt, D. B., Stamps, P. L., Piedmont, E. B., & Haase, A. M. (1978). Nurses' satisfaction with their work situation. Nursing Research, 27, 114-120

Tarlov, A.R., Ware, J.E., Greenfield, S., Nelson, E.C., Perrin, E., Zubkoff, M., (1989). The Medical Outcomes Study: An Application of Methods for Monitoring the Results of Medical Care. Journal of the American Medical Association. (309) 1426-34.

U.S. Bureau of Health Professions. (1996). Eighth Report to the President and Congress on the Status of Health Personnel in the United States. Author: Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services (1996). The Registered Nurse population: Findings from the National Sample Survey of Registered Nurses. Author: HRSA, March 1996, Washington, D.C.

U.S. Department of Health and Human Services (2001). National Sample Survey of Registered Nurses 2000, Preliminary Findings. Author: HSRA, February 2001, Washington, D.C.

Wasson, J.H. Bubolz, T.A., Lynn, J., & Teno, J.M. (1998). Can we Afford Comprehensive, Supportive Care for the Very Old? Journal of the American Geriatrics Society, 46 (7), July, 829-3