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The Impact of the Nursing Shortage on the Quality of Care of Veterans

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The Impact of the Nursing Shortage on the Quality of Care of Veterans

An in-depth historical and contemporary analysis of the nursing shortage and its impact on care provided to veterans

HONORS THESIS

Presented to the Pforzheimer Honors College at Pace University

In Partial Fulfillment of the Requirements for University Honors

By

Brian Alexander Fainguersch

Nursing

Thesis undertaken in the Department of Lienhard School of Nursing

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Pforzheimer Honors College
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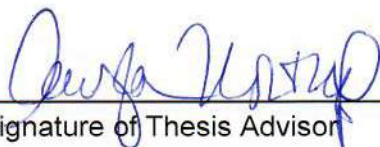
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As thesis advisor to Brian Fainquersch

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Abstract

The United States' involvement overseas in the Vietnam War (1955-1975) angered many U.S. citizens. The "first television war" brewed further domestic hostility against the actions of soldiers by presenting first-hand accounts of dead bodies, violence, and the gruesome reality of war. As a result, those protesting the war labeled Vietnam veterans as "baby killers." The War tripled the number of veterans seeking psychiatric care for PTSD, the unexpected increase in demand of staff delayed many veterans to acquire much-needed care. The increased wait-time affected all areas of healthcare and contributed to negative comorbidities in patients waiting to receive treatment. The national nursing shortage impeded the hiring of more medical professionals. In the 21st century, one cause of the nursing shortage is the lack of nursing educators. Without enough nursing educators, schools can only allow a minimum number of enrolled nursing students. With the lack of nurses within the field, nurses often are overworked and suffer from physical and emotional strain. This is furthered by government ineffectiveness related to distribution of funds, employment of medical staff in understaffed hospitals, and geographical discrepancies limiting veteran-accessible healthcare. Proposed solutions include consolidating government-sponsored healthcare, hiring nurse military officers as nursing school educators through incentivized programs leading to higher education, and incorporating programs to reduce the incidence of burnout syndrome will improve the quality of care provided to veterans nationally in VA hospitals and VHA systems.

Keywords: nursing shortage, quality of care of veterans, government ineffectiveness, VA hospitals, educators, geographical disparities, malpractice, delayed care

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The Impact of the Nursing Shortage on the Quality of Care of Veterans

The American society has not always been just and equal, especially when it comes to the care of those who helped shape the American culture and values. Such an example ought to be the treatment and care of veterans in Veterans Administration (VA) hospitals and in our communities. Veterans are one of the most overlooked populations existing in the United States today. Since the United States fought in WWI and WWII in the early 20th century, veterans were viewed as role models that patriotically protected their own country against war-waging countries. Yet, in the mid-20th century, the view of the military took a much less patriotic, but more political approach due to controversy on the aiding of South Vietnam. In other words, not all veterans were regarded as protectors, but as invaders. The impending retirement and increase in need of healthcare of Baby Boomers in concurrence with the negative political view of Vietnam veterans and a nursing shortage do not allow for the proper nor adequate treatment of patients in VA hospitals.

View of Vietnam War

The Vietnam War (1955-1975) was one of the most controversial wars the United States fought. Resulting from the Cold War, Soviet Russia attempted to set a foothold in the Far East by financially backing the Viet Cong of North Vietnam. As a result, Dwight Eisenhower attempted to prevent the spread of communism by allying with Great Britain, France, and South Vietnam, at the expense of the U.S. military. While fighting “the enemy,” Vietnam veterans expected for moral support from the United States. However, aggression brewed over the unjust war waged overseas. Hostility within the borders of the United States was born from the use of electronic reporting and media overseas. The first “television war” (Maniaty, 2008, p. 90) utilized many technological advancements, only to worsen the view of troops in Vietnam. As the invention of

live television developed during the years of the Vietnam War, censoring of violence and warfare was nonexistent, which allowed for camera-men to film dead bodies and the true nature of war (Maniaty, 2008). As a result, the public received a very negative view of the war, which resulted in aggression, protests and name-calling towards veterans who arrived home. Amanda Dolasinski (2017) and Rachel Rodgers (2016) interviewed Vietnam veterans Robert Proulx and Peter Georgean respectively, both of which were labeled as “baby-killers.” Even worse, anti-war protestors who opposed the United States’ involvement abroad committed criminal acts:

On September 24, 1968, fourteen religiously motivated, anti-Vietnam war activists removed, or in their words, "liberated," ten thousand draftrecords from the Milwaukee Selective Service office. The protesters, including five Catholic priests, hauled the draftfiles to a square in the middle of a busy Milwaukee throughway, poured what they called "homemade napalm" over the records, and lit them on fire (Thering, 2017, para. 1).

Hence, the patriotism derived from serving in the Vietnam War was absent, since veterans were not wanted back; any honor from serving in the military was lost.

Effect on Healthcare for Veterans

From the hostility at home and violence overseas, Vietnam veterans suffered PTSD which tripled the number of veterans seeking medical Disability Compensation (DC) (Autor et al., 2011, p. 340). In addition, Autor et al. describe that veterans who suffer from PTSD cannot work: “...falling employment and rising DC receipt [2000-2010 is] ...due to battle scars acquired decades earlier” (p. 341). Even worse, as many Vietnam veterans are Baby Boomers, there existed an even greater percentage of veterans seeking help. The sudden and rapid increase in necessity for medical care for these psychiatric veterans left VA hospitals with a deficit of

nurses. The overload of patients resulted in a longer waiting time for healthcare. The decrease in patient satisfaction is the least of veterans' problems: a 21% increase in mortality rate in geriatric patients waiting more than 31 days and a 2% increase in death rate and 9% increase in the chance of having a stroke for diabetic veterans waiting more than 10 days are valid reasons for worry (Pizer & Prentice, 2011, p.679). In fact, "10% of VA facilities had waits of more than 25 days" (Pizer & Prentice, 2011, p.677). PR Newswire (2014) presents the view of the American Federation of Government Employees (AFGE), who blame understaffing of medical providers for the extensive waiting times: "'understaffing has a strong, negative impact on employees' ability to do their jobs' said AFGE...President Alma Lee" (para. 6).

Malpractice and Negligence

Due to understaffing, some VA hospitals had to hire subpar medical professionals. Major Antonio Bueno's chronic heart disease went unnoticed by multiple doctors over 27 visits, and slowly worsened. He filed a lawsuit, and the court ruled that "military personnel breached the standard of ordinary care in failing to diagnose [Major Bueno's] ...heart condition" (Tammelleo, 1999, para. 3). Sally C. Pipes (2017) describes some of the atrocities that VA hospitals committed: hiring a physician with "more than a dozen cases of malpractice, including the death of a patient," hiring another physician "known [to be a] sexual predator and a dangerous felon," ignoring patient complaints, neglecting care which resulted in patient death, and a waiting time of more than three weeks "to see a primary care doctor." The appalling disregard for proper care of veterans in the Veterans Affairs Administration and hospitals causes Pipes (2017) to believe that "our veterans will continue to be subjected to subpar care" if no reform is pursued.

Review of the Literature

Determinants of the Nursing Shortage

Deteriorating care in VA hospitals can be offset by hiring more nurses. Therefore, a multidisciplinary approach to determine factors influencing the nursing shortage will uncover solutions to the shortage. The American Association of Colleges of Nursing (AACN, 2019) compiled a list of facts and statistics relating to determinants of the nursing shortage. Themes influencing the nursing shortage include: the increasing number of nurses retiring, a slowing nursing school enrollment, a shortage of nursing educators, and insufficient staffing which leads to burnout syndrome.

Retiring Population

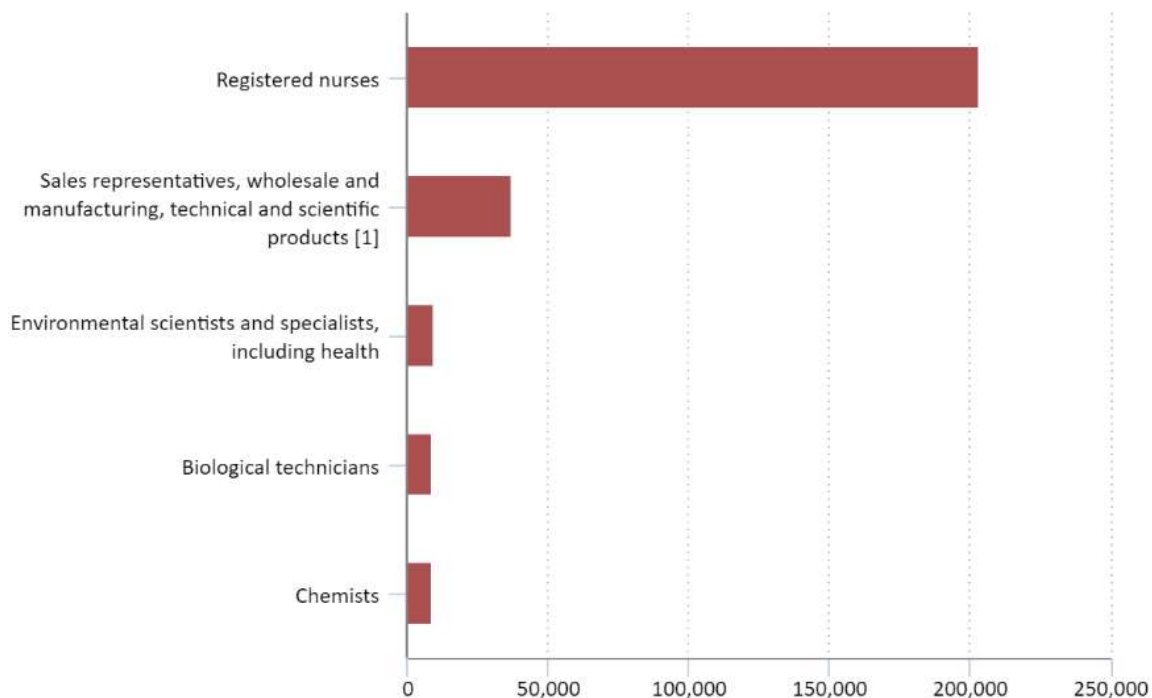
The Baby Boomer Generation born between the years of 1946 and 1964 is the largest generation born. The current nursing workforce consists heavily of the 76 million people born in during the mid-20th century, Buerhaus et al. (2017) calculated that approximately one million Baby Boomers accounted for two-thirds of the nursing workforce in the 1990s. These high-value nurses collected much “substantial knowledge and clinical experience” which have already been lost in the past years since 2008, the year when 1.26 million Baby Boomers started retiring (Buerhaus et al., 2017, p. 42). The nursing expertise of 660,000 Baby Boomer nurses in 2020 (Buerhaus et al., 2017, p. 42) will be replaced by approximately 203,700 registered nurses for the next six years as seen in Figure 1 (Torpey, 2018).

Between 2012 and 2050, the United States will experience considerable growth in its older population. In 2050, the population aged 65 and over is projected to be 83.7 million, almost double its estimated population of 43.1 million in 2012. The Baby

Boomers are largely responsible for this increase in the older population, as they began turning 65 in 2011.³ By 2050, the surviving baby boomers will be over the age of 85 (Ortman et al., 2014, p. 1).

Figure 1

Healthcare and science occupations, selected, that typically require a bachelor's degree for entry, by projected openings, 2016-26 annual average



Note. Torpey, E. (2018). Employment outlook for bachelor's-level occupations. *Career Outlook*.

Retrieved from <https://www.bls.gov/careeroutlook/2018/article/bachelors-degree-outlook.htm>

Even more nurses will be needed to compensate for citizens retiring at a later age with more chronic illnesses which require intricate nursing expertise passed down by Baby Boomer nurses. However, education of nurses relies heavily on leaders and educators of the nursing field; the shortage of nursing professors impedes proper allotment of medical staffing to care for retirees.

Nursing School Shortage

To combat the nursing shortage in the United States, programs can be implemented to incentivize a larger nurse output from registered educational programs. For example, “the federal government intervened by...providing subsidies for nursing education” in the early 1960s (Egenes, 2012, p. 20). Likewise, Ward (2019) describes scholarship programs offered by hospitals such as Comanche County Memorial Hospital in Oklahoma attract students to nursing schools; scholarship programs ensure employment and reimbursement of loans. However, the shortage of nursing faculty caused many U.S. nursing schools to turn away 75,029 qualified applicants from baccalaureate and graduate nursing programs (Ward, 2019). Regardless of scholarship and loan-repayment hospital programs, the shortage of nursing professors consistently inhibits more than 70,000 potential nursing students from entering nursing programs every year; the AACN estimated 78,587 applicants were turned away also due to educator shortages (Cox et al., 2019, p. 7).

Nurse Educator Shortage

The AACN (2019) repeatedly presented trends which suggested that many nursing schools turn away students due to the lack of faculty, which began in 2005. A study conducted on Pace University’s Lienhard School of Nursing analyzed the factors surrounding the faculty shortage present in 2015 as well as possible solutions which can be implemented at other licensing institutions (Feldman et al., 2015). Feldman et al. (2015) recognized that working in health care settings appealed to more doctoral graduates as the salaries and opportunities were greater than those in academic education settings (p. 171). Compiled with the elimination of associate-level licensing programs, there existed an abundance of adjunct faculty without doctorate requisites to educate at the baccalaureate level. An attempt to fill the lack of full-time

educators led to the development of Clinical Practice Educators (CPE), and after its failure, Clinical Instructor Roles (p. 171). As discussed in Feldman et al. (2015), continued education through the U.S. Department of Labor Grant of Clinical Instructors allowed for the progression of CPE experience. The successful increase of Clinical Instructor retention led Feldman et al. to increase the number of diverse faculty by contracting alumni interested in education through “support[ing] their doctoral study in a research-focused program with the ‘payback’ of a full-time teaching job when they graduate,” labeled as the Grow Our Own program (p. 172). The successful Grow Our Own program guided Feldman et al. to assimilate the Veterans Affairs Nursing Academy (VANA) clinicians to fill vacant spots for educators in the accelerated baccalaureate program. Numerous Blackboard workshops, observation of the education of didactic material, evaluation of the integration of evidence-based practice into curricula, and more “enabled [Lienhard School of Nursing] to increase [their] second career student enrollment by 50%” (p. 173). Along with accepting federal grants and hiring VANA expert clinicians, Feldman et al. depicted that externally funded scholarships incentivized graduating nurses to become educators. For example, the U.S. Department of Health and Human Services Health Resources Services Administration Nurse Faculty Loan Program financially assisted 15 students in attaining masters-level nursing education by covering all tuition and fees. Similarly, the Jonas Nurse Leaders Scholars Program allowed Lienhard to “support two DNP student for 2 years with partial scholarships, one-on-one mentoring,” and leadership programs (p. 173). These three programs incentivized numerous nurses and graduates to pursue a career in nursing education. However, Feldman et al. states “attracting faculty is one thing; retaining them is another” (p. 173). The Grow Our Own initiative included a mentorship which boosted program success through “availability, accessibility, and approachability” (p. 174). Jaffe-Ruiz explains: mentees

in the program appreciated that they could approach any faculty member in regards to questions of program information and didactic material to reduce personal anxiety, at formal and informal times, and in a comfortable manner as close relationships formed between mentors and the potential educators. (p. 174). One significant downfall of the Grow Our Own program noted by Cignarale included the lack of accountability between mentors and mentees regarding academic excellence (p. 177). The lack of an official reporting system led some participants to require an extension of the four-year scholarship at the expense of more financial spending than anticipated in the program (p.177). As a result, the program could not be considered a complete success – the return of investing into potential educators did not outweigh the cost of affording an extra year of education. Feldman et al. (2015) believe that such a program can be successful if outcomes from the program defined in Figure 2 are considered into a reinstatement of the Grow Our Own program (2015).

Figure 2*Lessons learned in mentoring faculty*

<p>Approachability</p> <ul style="list-style-type: none"> • Mentoring has typically occurred between an assigned mentor and faculty member. In other places this is a chosen relationship and not one of assignment. Our overall climate has not always supported a mentoring culture. Though the dean is, and has been, very committed to faculty development and mentoring, the culture of mentoring has been difficult to establish with total faculty support. • A successful mentoring program needs to be embraced by everyone and must be part of the organizational culture. New faculty appreciates the opportunity to discuss different approaches to teaching, different perspectives on the academic environment, and different ideas about professional development.
<p>Accessibility</p> <ul style="list-style-type: none"> • Being on different campuses with limited on-the-spot availability was seen as a deficit in the mentoring relationship in spite of numerous phone calls, emails, and in person meetings where the mentees were able to seek advice on how to manage academic life and success.
<p>Availability</p> <ul style="list-style-type: none"> • Mentees cited immediate availability of other faculty on their campus as helpful to them even though that particular faculty member was not assigned to them as a mentor. They could pop in, catch them in the hall and get immediate answers to questions as well as relief from anxiety. • Regular meetings, discussion around helping mentees learn to prevent and to cope with problems, and helping them with what feels like overwhelming teaching responsibilities, including classroom, on line and clinical teaching, are essential. Listening without judgment and being supportive is perhaps the most important mentoring activity. • The role of the chairperson as colleague and supervisor is also crucial to the success of a mentoring program, as the chairperson has the responsibility for orienting and keeping the faculty member on track. Clarification of standards for evaluation need to be made very clear with frequent opportunities for the chairperson and faculty member to review progress being made and identify areas of concern. The role of the department chairperson is threefold: mentoring, coaching, and evaluating faculty. These multiple roles can be challenging for faculty and administrator since there are often blurred lines and unclear guidelines. At what point is the administrator mentoring, coaching or evaluating? What, if any, conflict occurs in these roles? And, to what degree, if any, should the chair be in communication with the novice faculty member's mentor? • Mentors are expected to keep conversations and work with faculty members confidential. This is essential to gain credibility with the faculty members and to not be seen as an arm of administration. This is the hard part. When the dean and others have a commitment and a desire to effect change in the faculty, how do you maintain confidentiality while at the same time give feedback to administrators so that changes in the environment might facilitate ease of adjustment for the new faculty members and others? Another question is how do you get senior faculty buy in to support these newcomers? How do you create a culture where all members of the faculty feel comfortable being mentor and mentee throughout their professorial careers? • New faculty members are particularly sensitive to different voices and experience challenges in departmental, school, and campus contexts. Students, and some faculty, are not used to having faculty of color or faculty who have regional or language accents different from their own. Even though the student body is very diverse, because of their limited experiences, their own anxiety around doing well, and youth, they are often insensitive to and exploit the vulnerable faculty member. • For new faculty, especially faculty from underrepresented groups, issues around how much service to do without getting distracted from their main goals is a constant concern. New and minority faculty often gets tapped to do advisement and service activities because minority students tend to gravitate to them, which then sacrifices their own time for scholarship. • The faculty as a whole needs to discuss and consider how not to isolate or marginalize the new faculty, how not to see them as tokens, and how to embrace their presence, new ideas, and necessity for increasing the number of faculty with doctorates and from diverse racial and ethnic backgrounds.

Note: Reprinted from Feldman, H. R., Greenberg, M. J., Jaffe-Ruiz, M., Kaufman, S. R., & Cignarale, S. (2015). Hitting the Nursing Faculty Shortage Head On: Strategies to Recruit, Retain, and Develop Nursing Faculty. *Journal of Professional Nursing*, 31(3), 170–178.

<https://doi.org/10.1016/j.profnurs.2015.01.007>

Nursing Distress

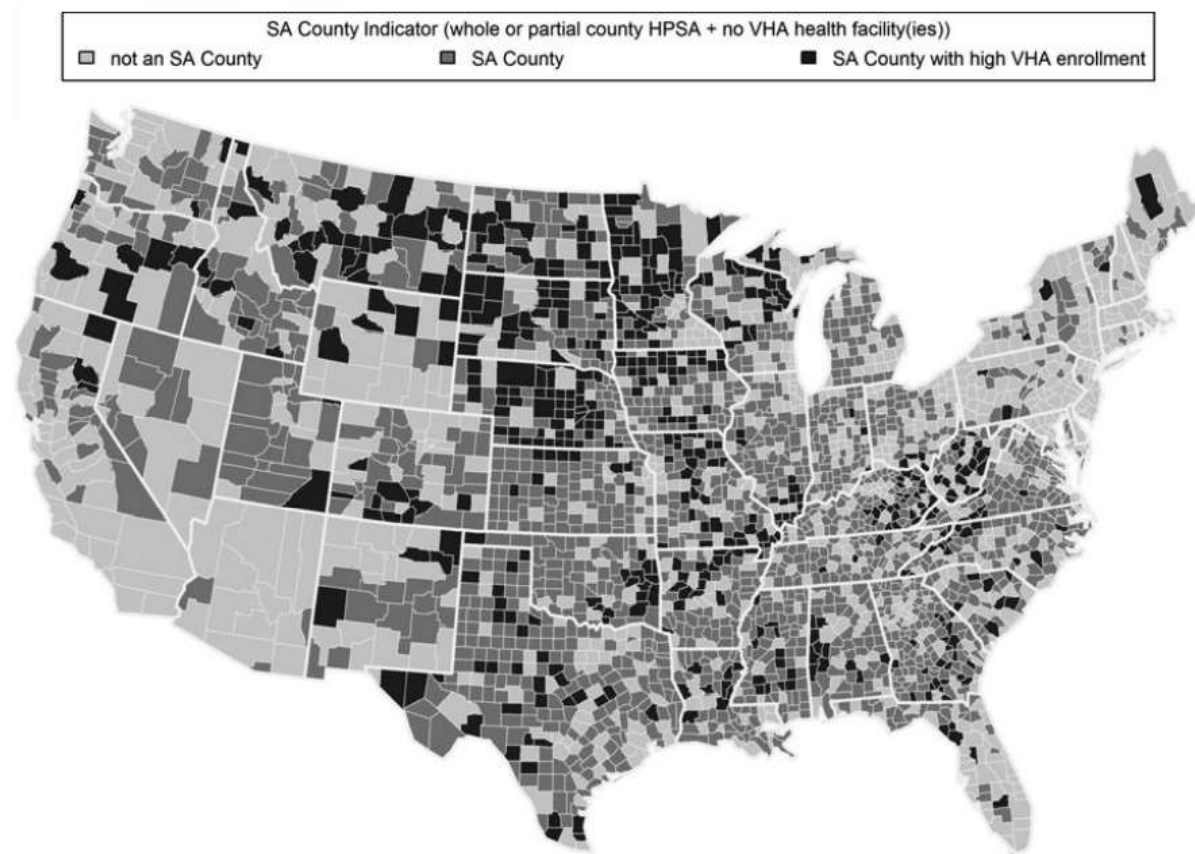
The retirement of the Baby Boomer Vietnam veterans and nurses will require expertise nursing care as well as more supplies for the aging population (Snaveley, 2016, p. 99). However, the lack of nursing educators leads to the inability to compete with the sudden shortage of nurses caring for elderly patients. As a result, the supply of nurses in the workforce will not offset the demand of the patients. For nurses, caring for patient with increased intricate nursing care creates overburdening, exhaustion, and stress, known as burnout syndrome. Nurses with chronic burnout are “associated with increased medical errors, impaired patient care, ... depression, marital dysfunction, substance abuse, and suicide” (Atkinson et al., 2017, p. 551). Atkinson et al. (2017) recognized an inverse relationship between therapeutic stress management techniques and burnout syndrome in staff working at VA hospitals. If the nurses in VA hospitals are stressed, then the quality of care provided to patients would decrease; preventing burnout would ensure veterans receive the most beneficial nursing care possible. In particular, 21 to 67% of mental health staff at Veterans Health Administrations (VHA) experience burnout syndrome due in part to the necessity to suppress emotions when dealing with veterans who experienced trauma, have PTSD, and require nonjudgmental empathy (Garcia et al., 2015, p. 8). Supplying nurses and medical staff with resources to decrease the incidence of burnout syndrome through therapy sessions, promotion of self-care, and self-prioritization will allow for nurses to care for themselves so they can provide efficient and effective nursing care to patients. Affecting nurses nationwide, certain states implemented Nursing Staff Ratio laws which limit the number of patients assigned to each nurse. For example, California – the first state to implement a staffing law in 1999 – forces all hospitals and medical facilities to maintain a nurse-to-patient ratio of one ICU nurse to two patients, a 1:3 step-down unit ratio, and a 1:6 psychiatric ratio (Kasprak, 2004).

Although numerous states across the nation are starting to incorporate preventative measures against burnout syndrome, there still exists a shortage of nurses within the workforce.

Geographical Disparities

The multitude of factors influencing the nursing shortage within the United States create employment disparities within for-profit and federal medical institutions. While one geographic area might experience a nursing shortage, another district in the same state might have an abundance of nurses. Doyle and Streeter encompassed an in-depth analysis of the distribution of healthcare professionals within VHA nationwide (2017). Doyle and Streeter (2017) determined an underusage of VHA services: approximately 3 million veterans are enrolled in the VHA system but do not receive healthcare (compared to 6 million veterans who already utilize VHA) and 60% of unenrolled veterans are eligible to receive care, amounting to 8 million additional veterans (pp. 459-460). Doyle and Streeter (2017) included the Institute of Medicine's research to conclude: "in 2014, the average wait time for new primary care appointments was 43 days, with a range of 2 to 122 days across all VHA facilities" (p. 460). These extended wait times increase the risk for adverse health outcomes such as spinal fracture and heart disease, agreeing with Pizer and Prentices' research in 2011. The long wait times forced veterans to look for third-party private practices with timely treatment options; the inclusion of the Veterans Access, Choice, and Accountability Act (VACAA) of 2014, allowed for Veterans to seek such care outside of the VHA health system through the Veterans Choice Program (VCP) (Doyle & Streeter, 2017, p. 460). However, only 27,000 veterans took advantage of the program between August and November 2014 (Doyle & Streeter, 2017, p. 460). Unfortunately, the potential of the VCP Act fell due to primary care provider shortages in medical centers and the VHA (Government Accountability Office [GAO], 2016). Failure of the VCP allowed Doyle and

Streeter (2017) to investigate veterans' needs and the supply of healthcare providers versus the demand of veterans in different geographic areas, also known as Health Resources and Services Administration (HRSA)-designated Health Professional Shortage Areas (HPSAs) (pp. 461-462). Doyle and Streeter (2017) defined a Shortage Area (SA) County – lacking in primary care providers – as previously HRSA-designated HPSAs counties and areas without a VHA facility (p. 464). Examination of certain populations within SA Counties – women veterans and veterans older than 65 – presents that 23 to 24% of the total 21 million veterans live in Shortage Area Counties (Doyle & Streeter, 2017, p. 465). Figure 3 depicts states with the highest prevalence of SA Counties as well as those with high VHA enrollment: Montana, Nebraska, North Dakota, South Dakota, West Virginia, Kentucky, Virginia, and North Carolina (Doyle & Streeter, 2017). Statistical data reinforce that “70% (2,143) of the 3,142 U.S. counties with [v]eteran populations are considered Shortage Area Counties” (p. 474), leaving a quarter of veterans nationwide without appropriate medical care due to the lack of VHA health care facilities or medical centers (Doyle & Streeter, 2017). The worst state for veteran-accessible healthcare is Mississippi, with the highest proportion of veterans living in SA Counties nationwide and 71% of its veterans 65 years and older living in SA Counties (Doyle & Streeter, 2017, p. 465 & 469). Although data collected from Doyle and Streeter (2017) expose counties with veteran-related primary care provider deficiencies, it is important to note the nationwide concern of veterans encountering barriers to timely and adequate healthcare from VHA and associated healthcare centers.

Figure 3*Shortage Area (SA) Counties*

HPSA: HRSA-designated health professional shortage area (primary care or mental health or both)
High VHA Enrollment: proportion of enrolled Veterans > 0.493 (3rd quartile)
Not shown: Alaska (24 SA Counties), District of Columbia (0 SA Counties), and Hawaii (1 SA County)

Note: Reprinted from Doyle, J. M., & Streeter, R. A. (2017). Veterans' location in health professional shortage areas: Implications for access to care and workforce supply. *Health Services Research*, 1, 459. Retrieved from <https://doi.org/10.1111/1475-6773.12633>

Government Ineffectiveness

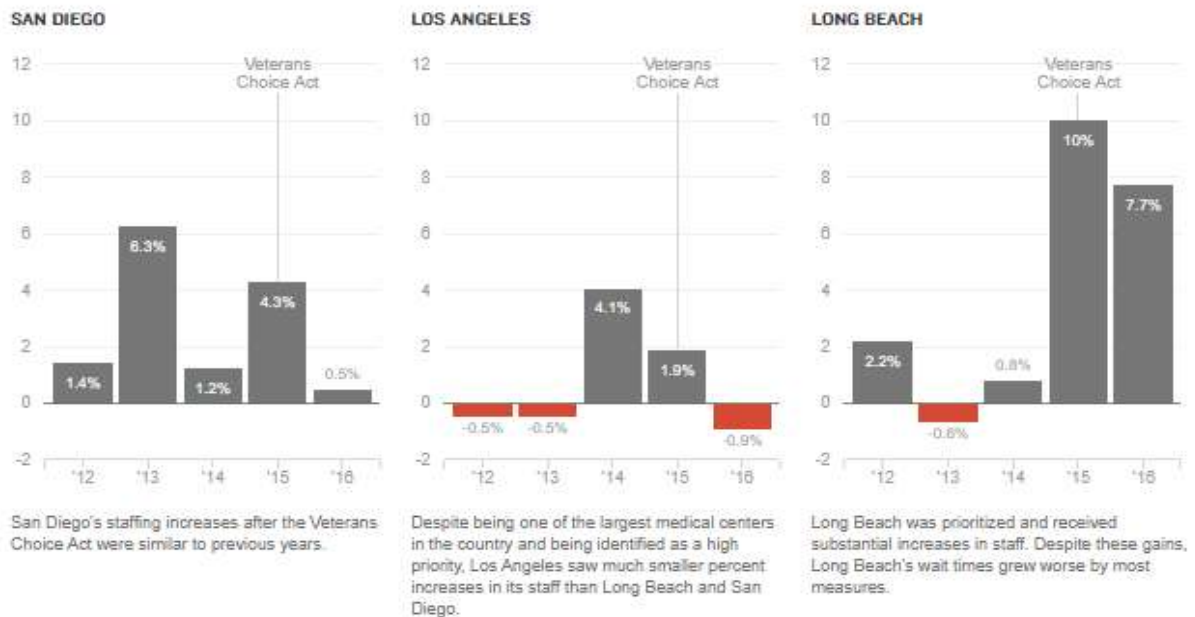
There exist a multitude of factors which affect the ability for the adequate staffing of nurses and medical professionals within hospitals and government-owned organizations: (a) the lack of nursing educators decreases the number of potential nursing students who could care for the many Baby Boomer veterans requiring more intricate long-term critical medical and psychiatric care; (b) the national geographical discrepancies create a barrier for veterans seeking prompt appointments; and (c) burnout caused by insufficient staffing from reasons stated above minimizes therapeutic treatments provided to patients. With nursing as the most trusted profession and one of the most stressful, it is imperative for the government to recognize these trends and difficulties of nurse-provided veteran care.

Veterans Access, Choice, and Accountability Act of 2014

VACAA was designed to expedite the waiting time for veterans seeking care by allotting \$16 billion to hire new medical staff (\$2.5 billion) and to promote veterans seeking care outside the VHA system (\$10 billion) (Walsh et al., 2017). However, the non-systematic distribution of monies across VHA organizations nationwide led to the indirect and unfortunate death of Afghanistan veteran Charlie Grijalva, who's psychiatric needs were cut out when his San Diego VA began the transition to incorporating the Veterans Choice Act (Walsh et al., 2017). David Shulkin, the Secretary of Veterans Affairs, noted that prioritized VA hospitals received hires under the VACAA, but data collected from the Department of Veterans Affairs shows otherwise in Figures 4 and 5 (Walsh et al., 2017).

Figure 4*Additional Staff for Southern California VAs Distributed Inconsistently*

Percent increases in staffing at different VA stations as of May for each fiscal year show that new staff didn't necessarily go to the facilities with the longest wait times or even places the VA had designated as top priorities.

**Notes**

- The Veterans Choice Act was enacted in August 2014. The reflection of the additional funding would start in the next fiscal year.
- VA stations include one or more major medical center and any facilities that may report to those centers.

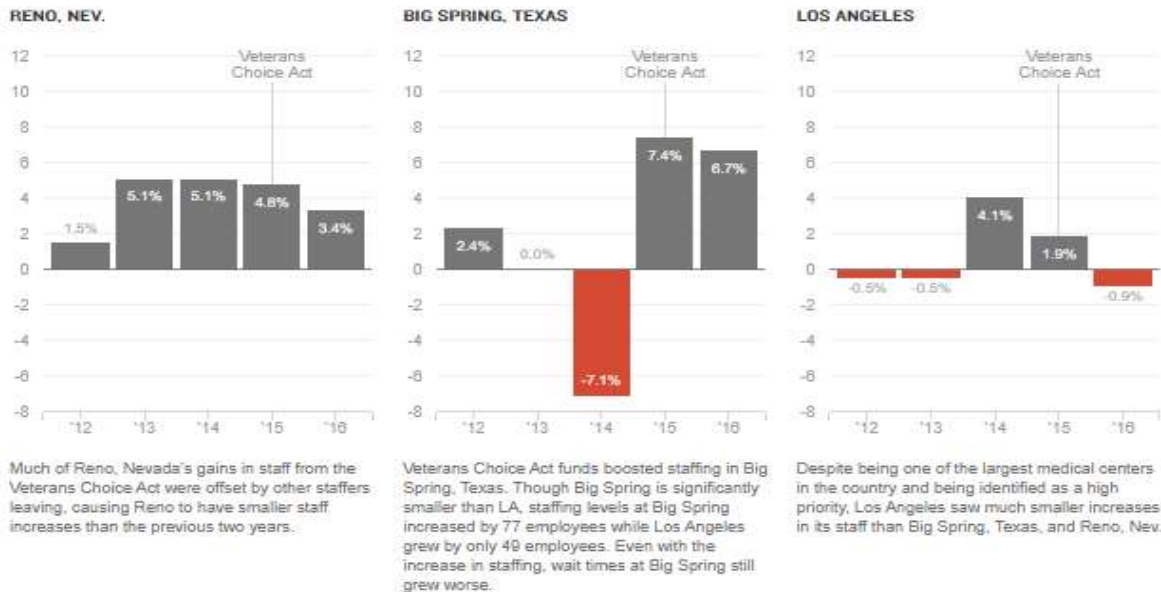
Note: Reprinted from Walsh, S., Murphy, P., Bisaha, S., & Lawrence, Q. (2017). VA Hospitals

Still Struggling with Adding Staff Despite Billions from Choice Act. *National Public Radio*.

Retrieved from <https://www.npr.org/2017/01/31/512052311/va-hospitals-still-struggling-with-adding-staff-despite-billions-from-choice-act>

Figure 5*Additional Staff for VAs Distributed Inconsistently*

Percent increases in staffing at different VA stations as of May for each fiscal year show that new staff didn't necessarily go to the facilities with the longest wait times or even places the VA had designated as top priorities.

**Notes**

- The Veterans Choice Act was enacted in August 2014. New staff paid for by the additional funding would be reflected in the hiring levels for subsequent fiscal years.
- VA stations include one or more major medical center and any facilities that may report to those centers.

Note: Reprinted from Walsh, S., Murphy, P., Bisaha, S., & Lawrence, Q. (2017). VA Hospitals Still Struggling with Adding Staff Despite Billions from Choice Act. *National Public Radio*. Retrieved from <https://www.npr.org/2017/01/31/512052311/va-hospitals-still-struggling-with-adding-staff-despite-billions-from-choice-act>

In addition to uneven hiring in hospitals which already provide above-par care, the VHA lacks a timely hiring process: Almetta Pitts had to wait four months between her employment acceptance (May) and her start date (September), due to budget shuffling and maintenance of VHA's current hiring practices (Walsh et al., 2017). Lastly, Shulkin identified the higher salaries of hospitals in the private sector compared to the VHA. Hence, the lack of recognition of hospitals in need of more medical attendants, prolonged hiring process, and differences in pay distinguish the level of quality of care between hospitals in the VHA and those in the private sector.

United States Government Accountability Office

There is not one definitive answer to rectifying the deficient care in VHA systems and VA hospitals, however, the United States GAO identified challenges of 2020 by the VA's Geriatrics and Extended Care office (GEC) presented in Figure 6 below:

Figure 6

VA-Identified Challenges to Meet Projected Long-Term Veteran Care in VHA Systems

Key challenge	Description
Addressing workforce shortages	<ul style="list-style-type: none"> VA officials described nationwide shortages of geriatricians and palliative care providers—provider shortages that will affect VA's ability to provide long-term care services to veterans in the future. VA also faces shortages in other workforce areas, such as nursing assistant and health technician positions that have contributed to waiting lists. For example, according to VA officials, staffing challenges were the key factor creating a waitlist of 1,780 veterans for the Home-Based Primary Care program.
Aligning care geographically	<ul style="list-style-type: none"> VA faces challenges aligning its services (provided or purchased) with where veterans live, including providing care for veterans living in rural areas. For example, according to VA officials, veterans have moved away from the Northeast and to the South, and that VA now has too many long-term care beds in the Northeast and too few in the South.
Meeting needs for specialty care	<ul style="list-style-type: none"> VA faces challenges finding appropriate long-term care settings for veterans with certain specialty care needs such as dementia, behavioral issues, and ventilator care.

Note: Reprinted from Government Accountability Office [GAO]. (2020). “VA Health Care: VA Faces Challenges in Meeting Demand for Long-Term Care” *Testimony Before the Subcommittee on Health, Committee on Veteran’s Affairs, House of Representatives. Government Accountability Office*. Retrieved from <https://www.gao.gov/assets/710/705066.pdf>

Alas, the GEC failed to ameliorate the situation which has affected thousands of veterans nationwide for decades:

1. GEC has not established measurable goals to address workforce shortages, such as staffing targets to address the waitlist for the Home-Based Primary Care program.
2. GEC has not established measurable goals for its efforts to address the geographic alignment of care, such as specific targets for providing long-term care within the Home Telehealth and Veteran Directed Care programs.
3. GEC has not established measurable goals for its efforts to address difficulties meeting veterans' needs for specialty care, such as specific targets for the number of available ventilators or the number of caregivers educated to help veterans with dementia (GAO, 2020).

This 2020 report from the Government Accountability Office presents complete disregard for a nationwide crisis. In conjunction with failed programs such as VACAA, many Americans are entirely frustrated with United States' lack of commitment to "provide the highest quality care possibly every day" (U.S. Department of Veterans Affairs, 2020).

Distressed Veterans

Failure of the government to appropriately implement billions of dollars of funds into balancing the VHA along with the acknowledgement of problems afflicting millions of veterans, but the lack of effort to propose a solution, leads to many understaffed positions at VA hospitals. Costello and Snow (2015; NBC Nightly) reported a year after the implementation of the VACAA the atrocities of understaffing in the VA Medical Center in Fayetteville, NC. Costello reported that Rick Leslie, a Vietnam veteran, needed to travel two hours to another facility for

radiation therapy and treatment due to the lack of urologists at the Fayetteville VA Medical Center. Another patient, Scott Goostrey, a veteran who served two tours in Afghanistan, sought out psychiatric care for his diagnosed PTSD and was only able to acquire two appointments within an 18-month period (Costello & Snow, 2015). As a result, Goostrey self-medicated “because [he isn’t] receiving the care that [he] needs,” as he told Costello. In the Phoenix, AZ VA hospital, a patient died in April 2014 from unmonitored metastatic prostate cancer, similar to the case of Major Antonio Bueno in 1999 (Costello & Snow, 2015; Tammelleo, 1999). Costello emphasized that according to USA Today, 41,000 full and part-time jobs are unfilled nationwide in the VHA, with 59 of 187 positions in the Fayetteville VA Medical Center empty. In addition, 21% of psychologist positions nationwide are vacant (Costello & Snow, 2015); psychologists are one of the most needed professionals for Vietnam veterans and those who experienced traumatic events. The Fayetteville VA Medical Center’s Director Elizabeth Goolsby resonates with Doyle and Street (2017) and Feldman et al: “[t]he challenges with hiring the staff are the location of rural-ness, lack of having a medical school nearby, and some of the salary caps for specialties that are hard to recruit for” (Costello & Snow, 2015). Consequently, medical professionals who work in the VHA are overworked since the patient load is too high and the pay is less than that from the private sector. Moreover, veterans must wait extensively for their appointments, at the risk of their own health. The VHA seems to prioritize treatment over prevention; once Rick Leslie’s prostate cancer spread to his bladder after waiting too long for appointments, the Fayetteville VA Medical Center offered to pay for “his cancer care outside the VA system” (Costello & Snow, 2015).

Methodology

This section describes the search criteria and databases utilized to collect articles and academic publications. Keywords and phrases such as “nursing,” “nursing shortage,” “nursing deficit,” “VA hospitals,” “quality of care of veterans,” “treatment of veterans,” “nursing shortage factors,” “malpractice,” “hiring subpar professionals,” “VA inadequacies,” and “VA frustration,” and “VA satisfaction” were searched within in the following databases: CINAHL, EBSCO, Medline, Gale Online, Academic Search Premier, and ProQuest. In addition, Google Scholar and relevant books yielded approximately 29 articles, websites, and books that were selected from analyzed 50 sources.

Pilot Data

Three interviews conducted in 2018 – prior to an in-depth study of factors influencing veteran-centered care – explored the opinions and values of three distinct individuals: Interviewee 1 (I1), a nurse working at the Franklin Delano Roosevelt Campus VA hospital in Montrose, NY; Interviewee 2 (I2), a nursing professor of Pace University and Army veteran; and Interviewee 3 (I3), a student attending Pace University and Army veteran. The interviews were conducted in a semi-structured format designed to evaluate the views of nursing shortages within the general public, the military, and care within the VHA. Names are omitted to maintain confidentiality. Convenience sampling yielded three potential candidates for interviews, and all three were utilized. All interviews occurred within neutral areas beneficial and comfortable with the interviewees. Subjects provided consent to audio recording and note-taking during the sessions.

Interviewee 1

The first interview took place in an isolation room of the psychiatric unit at the Franklin Delano Roosevelt Campus VA hospital. The interview lasted for 34 minutes. I1 described her interactions and history with the military: initially, her opinion of the military is mostly negative: “whenever I heard about [the military and wars], read about it, saw news productions, anything about the military, it always gave me a feeling of insecurity and fear.” Additionally, I1’s father, a Korean War veteran, had not talked much about his war experience while he was alive. Once I1 started working at the VA, she recognized signs of PTSD which her father exhibited before his death. Albeit she felt a disconnect between what she knew about her father and his personal story, I1 felt honor in working with other veterans to aid them on their journey of coping with PTSD. In her words, “I never had as much of a sense of the importance of caring ... for these individuals because they have defended our country and they are so supportive of us [nurses].” Throughout her four years at the Montrose VA, she identified a mutual respect and compassion between nurses and patients. For example, I1 observed that veterans are protective and supportive of each other. The mindset of “we will do anything for you [nurses]” stems from the military training emphasizing respect for authority and those who care for others; the veterans nurse themselves and attempt to resolve intrapersonal issues between veterans. From such behavior, I1 does not feel overworked and prefers working in the VA environment rather than in civilian hospitals where she has experienced staffing shortages and increased stress. I1’s experience in the Montrose VA exposed her to the kindness and generosity of veterans who desire to support each other; such camaraderie exemplifies the nature of military education and accentuated her own desire to help veterans. The only qualm I1 mentioned during the interview included a time-limit for nurses to assess their patients: nurses were mandated to limit

approximately 15 minutes per patient per interaction. Therefore, some patient needs could not be addressed due to the time constraint – potentially hiring more nurses could decrease the necessity for such restrictions.

Interviewee 2

The second interview occurred in I2's office at Pace University and lasted for approximately 52 minutes. I2 began by describing that she joined the Army because she valued service and honor for one's country. Once she joined, she slowly learned that the military promotes independence. Complaints related to procedures, tasks, or responsibilities were discouraged unless the soldier also presented a solution. I2 was no exception: she complained about the numerous phone calls she received requesting for shift coverage for the pediatric hospital. As such, her officer put her in charge of finding a solution. The promotion of accountability and maximization of imagination in the military provides those enlisted with life skills viewed as exceptional in the civilian workforce. After her time in the military, I2 utilized the VHA for her primary healthcare. When asked about her opinion on the VA system, I2 stated that the healthcare system ought not to be privatized as this is how "people get lost in the system;" a 100% government-owned healthcare system would centralize all veterans and dependents. I2 described her own experience with the VA hospital sending her to multiple locations for medical screenings off-site. This hassle lengthened I2's waiting period for her procedure, like many veterans' medical experiences such as Major Antonio Bueno (Tammelleo, 1999). Otherwise, I2 did not have enough information to determine whether there is a nursing shortage; I2 stated that the nursing shortage is cyclic in nature. However, I2 echoed I1's statement concerning nurse-patient time-limits: hiring more nurses in hospitals would reduce the

need for such a time-limit given that the more nurses that a hospital has, the more time and care could be given to the patient.

Interviewee 3

The third interview occurred in the cafeteria of Pace University and lasted for 12 minutes. The interview began with I3 describing the brotherhood and empathy that military nurses held for their units. In a sense, I3 felt more comfortable talking to military nurses since they understood more of what he went through during his 10 years of service. However, I3 explained that some military nurses view the care they provide to their comrades as simply an income, a view ignorant of the essence of the selfless nursing profession and service of veterans. I3 elucidated that civilian nurses have a “great understanding of military service” when treating veterans in VA hospitals. During his time in the Army, there were many occasions when he had concerns regarding his own health, but the limitations on the amount of time that nurses can interact with each patient impeded his own quality of care. As a result, I3 is usually unable to discuss all his questions and concerns within one appointment. He describes:

The military is a real physically demanding job and there’s a lot of people whose bodies can’t deal with it and afterwards when you’re not on that constant on-the-go all the time with being in the military, your body starts breaking down even more and if we had more nurses, we could schedule more appointments and get the proper care.

I3 felt like a number: the VHA (as opposed to individual nurses) cared more about the quantitative number of people cared for than the quality of treatment/education. I3 believes that unless veterans save money while they are enlisted, they would not be able to find adequate and timely nursing care through third-party medical facilities. According to I3, the management of

VA hospitals did not optimize the quality of care: information I3 submitted to the VHA at 1 PM did not appear for his appointment later that day at 5 PM. Alas, the nurse could not follow up on any concerns I3 submitted relating to his last visit. Towards the end of the interview, I3 reminisced all which he learned in the military: independence, respect, discipline, the value of teamwork, and compassion towards others.

Results

The nursing shortage has distressed countless Americans related to insufficient care due to burnout syndrome, the lack of educators to promote enrolling more potential nurses in school, and the larger retiring veteran and nurse population requiring more intricate nursing care than generations past. Veterans encounter many barriers to receiving medical assistance: the medical and nursing shortage leads VA hospitals to hire subpar and inefficient licensed staff to combat understaffing at the expense of veterans' health, geographical disparities impede access to healthcare in rural areas, failed government programs led to a hiring imbalance and wasted financial potential, a time-limit for each patient leaves many veterans seeking further appointments, and an ineffective patient database impeding opportune same-day care.

All the conducted interviews presented an overall theme: hiring more nurses would decrease the necessity for a time-limit between veterans and nurses. Both I1 and I2 indicated that veterans are high-demand and usually come to appointments seeking medical advice for multiple issues. As evidenced by I3, he feels discouraged when he must create multiple appointments to ask questions to a physician or nurse when they could have been answered within one session. In addition, I3 discussed that due to the extensive amounts of patients seeking care in VA hospitals, he was obligated to seek care from private practices for his time-sensitive questions and concerns. Reminiscent of Pizer and Prentice, longer waiting times increase the risk for

potentially fatal comorbidities in veterans, as was the case with Major Antonio Bueno with his chronic heart disease (Tammelleo, 1999), Rick Leslie with his metastatic prostate and bladder cancer (Costello & Snow, 2015), Charlie Grijalva who committed suicide due to insufficient psychiatric care (Walsh et al., 2017), and Scott Goostrey with untreated – and self-medicated – PTSD (Costello & Snow, 2015).

Discussion

Potential Solutions

The multitude of factors influencing the level of quality of care provided to veterans requires immediate intervention. As government programs such as the Veterans Access, Choice, and Accountability Act fail and ignorance surrounding impediments stated by the United States Government Accountability and VA's GEC offices continues, radical reform to completely nationalize veteran care is required. In addition, recognition of potential sources to equalize the nursing shortage and provide improved healthcare excellence to veterans.

Government Reform

The foremost improvement required to enhance veteran care is for increased government efficiency. The VACAA of 2014 could be considered a failure as many VA hospitals nationwide still had a shortage of staff in the tens of thousands. In addition, the scarce staffing included much-needed psychiatrists pertinent to veterans afflicted with PTSD. If monies were distributed accordingly to deficient VHA, then there would exist a smaller proportion of veterans unable to access geography-based care. Research agrees with I2's opinion; upon analysis, the dichotomy of care provided to veterans is one of the major culprits for governmental inefficiency. VACAA funds were split to improve government-owned hospital staffing and to provide veterans with

privatized care outside the VHA. Therefore, consolidation of all veteran-associated care supersedes the implementation of more government funding. Although eliminating care outside the VA system will limit availability of services to veterans, this would force the government to renovate all VA hospitals and ensure adequate staffing and up-to-date equipment and procedures. In the case of Rick Leslie (Costello & Snow, 2015), if the Fayetteville VA Medical Center had a radiation department, then early therapy for his cancer could have prevented the spread of the disease. Movement away from relying on private medical facilities will always force adequate staffing in every VA hospital. In addition, financial aid allocated to VHA systems would allow for more intricate analysis of issues, such as: the disorganized electronic health record system, nurse-patient time-limit, and disrespect for veterans stemming from employees who lack value for their patients.

Finding Those Who Care

Not only will veterans receive better care with the merging of all nationwide VA hospitals, but with the hiring of those who are already familiar with veterans and the military lifestyle. I2 discussed that her involvement in the military promoted her own independence but I3 exposed the respect, discipline, the value of teamwork, and compassion towards others taught in the military. Therefore, military nurse officers (MNOs) would have the greatest understanding of veterans within the VA system. While hiring MNOs into the VHA would immediately ameliorate the nursing shortage, educating nursing students about veteran-specific care and inspiring them to treat and protect veterans would create a foundation for quality long-term care in VA hospitals. Lake et al. (2016) published an editorial and Chargualaf et al. (2018) conducted a descriptive and qualitative study to determine the experiences and effectiveness of MNOs as nurse educators. Lake et al. (2016) attempt to inspire nursing schools to “embrace the idea and

take specific steps aimed at recruiting, hiring, orientating, mentoring, and supporting” a “talented and already prepared cadre” (p. 243) of leaders. The professionalism and critical thinking skills instilled in servicemembers allows MNOs quickly adapt to fill the faculty positions. Chargualaf et al. (2018) attributed the success of 13 retired veteran nurses becoming educators to the autonomy and independence learned in the military:

The participants were self-directed in their pursuit of learning the role and fitting into the academic environment. They were transparent in divulging their needs and sought guidance from colleagues and mentors to bridge perceived gaps in knowledge. As such, they were both assertive and proactive in their approach to getting what was needed, ... [v]eteran faculty were not “going to sit back in the weeds and wait for the dean to tell them to do something” stressing the importance of not “waiting for people to come to you because they won't” (p. 356).

The ability for MNO educators to have difficult conversations with students (Chargualaf et al., 2018, p. 357) and expose inequalities and injustice in the workplace would transfer to students upon their graduation and employment in various workplaces. Hopefully, MNO faculty would inspire enough students to acquire utile life skills in the military or to help those who have served by working in VA hospitals. In addition, assertiveness passed from veteran nurse educators to students will allow them to advocate for improved therapeutic care in VHA settings.

As salaries in private practices are higher than those in government-owned institutions, imperative incentivization for higher education will attract considerable number of potential candidates. Feldman et al.'s evaluation of their success and takeaways from the Grow Our Own program from 2015 ought to be considered when nursing schools create programs for MNOs.

Eliminating Stress

Fixing the nurse educator shortage by enticing MNOs to pursue further education in exchange for teaching at nursing schools will ultimately increase the number of proficient nurses treating veterans. MNO educators will teach their students how to cope with workplace stress and handle conversations with supervisors concerning burnout syndrome. However, programs to reduce the incidence of emotional and physical strain would improve the quality of care provided to veterans.

Closing Notes**Further Research/Limitations**

The comprehensive literature review encompassing the determinants of the nursing shortage, barriers to veterans receiving the best care possible, and possible solutions can be furthered by incorporating further research, reviewing statistical analyses of programs implemented to reduce stress in the workplace, and outcomes of hiring MNOs as nurse educators.

In contemporary times, the media has placed more emphasis on the nursing shortage within the 21st century. In light of the recent COVID-19 pandemic, many hospitals are required to put more nurses to work overtime to treat the hundreds of thousands of infected patients. As a result, nurses are extremely burnt out. Hence, more attention needs to be called to the nursing shortage to prevent such disorder during a pandemic. Furthermore, the pandemic impeded the ability to schedule potential interviews depicting subjective qualitative data about opinions of the VA system and the nursing shortage.

Vietnam veterans require more care in medical institutions, but malpractice and deficient care is caused by a nursing shortage in the civilian and military population, misperceptions of the Vietnam War, an increase in the number of Baby Boomer hospitalizations (of Vietnam veterans), and the disregard for VA hospitals to hire professionals. “Our nation’s vets deserve world-class care, free of extended wait times and unnecessary bureaucracy” (AFGE, 2014). The citizens of the United States need to put aside their own political differences and treat veterans with the care they deserve. Veterans gave their lives, their sanity, and their time to protect the freedoms which we utilize daily, such as the freedom of the press and speech. Snively (2016) put it best: “[i]f America is to continue to be a leader in health care delivery throughout the world, a perpetual supply of highly trained and qualified nursing personnel is essential” (p. 98).

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