Laura Boren

Professor Jennifer Courtney

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Mismanagement of Patient Wait Times in the Veteran's Health Administration

In recent years, the Veteran's Health Administration (VHA) has been the subject of an increasing number of scandals. Although the Veteran's Health Administration is critical to the proper medical treatment of America's veterans, reports surfaced about inconsistent wait times, resulting in improper or even non-existent medical care. Following the allegations of a whistleblower in early 2014, the Department of Veteran's Affairs began a series of investigations into several Veteran's Affairs Medical Centers, most notably the Phoenix VA Health Care System. The findings of these reports prompted Congress to draft reform legislation that would allow veterans to seek care outside of Veteran's Affairs Medical Centers, and increased funds to hire additional doctors and nurses.

As the second largest cabinet-level department of the United States Government, the Veterans Affairs office (VA) administers medical care to veterans through the Veterans Health Administration (*Returning Home*, 420). Established in the early 20th century, funding for the VHA took off after the return of 2 million veterans from WWI, followed by 12 million from WWII (*Returning Home*, 420). The VHA is currently the only national direct-care medical delivery system (*Returning Home*, 420), and even boasts better patient outcomes than most private healthcare system (Ibrahim et al, S514-S516). They serve as a model of health care coordination and have even been proposed as a viable example of a universal, single-payer

healthcare system that could be implemented on a national level.

The medical care itself is provided through Veterans Affairs Medical Centers (VAMC). There are 152 hospitals and 800 ambulatory clinics that make up the bulk of the VHA system, in addition to hundreds more residential and home health programs and centers, as well as skilled nursing facilities. The VHA creates an estimated 80 million appointments per year, but when it comes to appointment wait times the glowing reviews of VA healthcare turn to scathing accusations (*Returning Home*, 420).

In April 2014 CNN broke a story about dozens of veterans dying while waiting for medical care. The story focused on the primary testimony of one whistleblower, retired VA doctor, Dr. Samuel Foote. Dr. Foote alleged that at least 40 veterans died while waiting for medical appointments through the Phoenix Veteran's Affairs Health Care System. Due to VA policies about appointment wait times, VA managers at the Phoenix VAMC, knowing that they did not have the resources to schedule patients within the required time frames, began creating secret waiting lists. Patients were placed on these secret lists at the time they first attempted to make their appointment. As appointment slots opened up, patients would be moved off the secret list and onto the real list, where they would then receive an appointment (Bronstein & Griffin).

Current Veteran's Affairs regulations require that the maximum amount of time a patient can be on a waiting list is no more than seven days for primary care appointments and fourteen days for specialty care appointments ("Witness Testimony"). Time starts on the date of the patient's own requested date of appointment, and continues until the date of their scheduled visit ("Witness Testimony"). At the Phoenix VAMC, managers and employees acting at the request of those managers were forging official documents in order to make it appear that the facility was meeting all appointment wait time goals and requirements (Bronstein & Griffin). In some cases,

the requested date of appointment was altered to be no more than fourteen days prior to the date the patient finally came in for their appointment ("Interim Report," 4). In other cases, veterans were being recorded on unofficial lists, where they could spend weeks to months waiting to simply schedule an appointment in the first place ("Interim Report," 4). When official records were pulled, it would appear as though patients never spent more than seven or fourteen days on the official waiting lists, but according to Dr. Foote many had been on secret lists for as long as 6 months (Bronstein & Griffin).

Navy veteran Thomas Breen was one such veteran. He was admitted to the emergency room at the Phoenix VAMC on Sept 28, 2014 with blood in his urine, where he was referred for follow-up care. Although he had a history of cancer and emergency room doctors requested an urgent urology appointment for him, Breen was instead placed on a secret list, where he waited for someone to call him and schedule his appointment. Despite numerous calls to the VA inquiring about his appointment, Breen's family was told that he would have to wait because there were more urgent patients. Breen died of stage 4 bladder cancer on November 30, 2014, nearly a month before his urology appointment was finally scheduled (Bronstein & Griffin).

Breen was only one of dozens of patients whose medical records were recently reviewed by the VA. In an interim report put out on May 28, 2014, the VA Office of the Inspector General recognized that Dr. Foote's allegations, as well as those of Thomas Breen's family, were neither new nor surprising ("Interim Report," i). Acting Inspector General Richard Griffin stated that "since 2005, the VA [Office of Inspector General] has issued 18 reports that identified, at both the national and local levels, deficiencies in scheduling resulting in lengthy waiting times and the negative impact on patient care," ("Interim Report," i). Following the interim report, an official review was published, detailing 45 individual cases of patients harmed by scheduling problems.

The interim report initially identified 1,400 individual Phoenix-area veterans whose appointment dates and times had been forged on official Electronic Waiting Lists, along with 1,700 more veterans who had been waiting for care but had never appeared on an Electronic Waiting List ("Interim Report," iii). The follow-up report, released on August 26, 2014, expanded on those findings, bringing the total number of veterans on unofficial waiting lists up to 3,500 ("Review" 34). Although the VA Office of the Inspector General was unable to substantiate any claims that waiting lists directly resulted in the death of patients, primary care for patients during their last weeks greatly eases pain and suffering. Delays in appointment scheduling also resulted in veterans missing the opportunity to receive palliative care through home health and hospice programs.

The keystone of the scheduling problems was the senior management of both the VHA and local VAMCs. In the follow-up report, it was reported that employee performance contracts stipulated goals for decreasing patient wait times and offered incentives for meeting or exceeding goals (72). These incentive programs created an environment where employees were asked by their managers to forge waiting lists. After their interim report was published, the Secretary of the VA removed incentive-based appointment goals for employees and management ("Review," iv)

Following Dr. Foote's allegations and at the prompting of families such as Breen's, Congress drafted legislation to reform the broken VA healthcare system. On August 7, 2014 President Obama signed this new VA Reform Bill into law (Griffin et al). The bill works to eliminate inconsistent wait times and secret waiting lists by approving private care for those who cannot obtain an appointment within 30 days of their requested appointment date. It also allows for private healthcare for those living more than 40 miles away from a VAMC ("Veteran's

Access"). Much of the new VA Reform Bill echoes measures that have already been implemented in the Tricare Healthcare System for active duty military members and their family (*Returning Home,* 417-419). The $16 billion VA reform measures provide funding for more doctors and nurses, to fill in the gap in care managers that is resulting in the excess wait times themselves ("Veteran's Access"; Griffin et al). The bill also gives unprecedented power to the new Secretary of the VA, Robert Mcdonald, allowing him to more easily remove any leadership officer caught falsifying documents or engaging in unethical practices (Griffin et al).

On September 12, 2014 Washington Sixth District representative Derek Kilmer announced his own supplementary bill, which has yet to be introduced to Congress. His supplement urges the Government Accountability Office to conduct further studies to examine additional problems with the VHA (United States). Because many of the employees who were tailoring waiting lists did so under threat of their job, Kilmer's supplementary bill also seeks to create an ombudsman program for VAMC employees to safely report issues without job repercussions (United States).

Because the Veteran's Health Administration is so critical to the care of veterans returning home from Operation Iraqi Freedom and Operation Enduring Freedom, these kinds of dangerous appointment discrepancies cannot be tolerated. With new legislation and the elimination of employee incentives and scheduling goals, veteran's care can begin to move forward, returning to the positive example it once was.

# Works Cited

Bronstein, Scott and Drew Griffin. "A Fatal Wait: Veteran's Languish and Die on a VA Hospital's Secret List.' *CNN*. 23 Apr. 2014. Web. 18 Sept 2014.

Griffin, Drew, Scott Bronstein, and Tom Cohen. "Obama Signs $16 Billion VA Overhaul into Law." *CNN*. 7 Aug. 2014. Web. 18 Sept 2014.

House Committee on Veteran's Affairs. *The Veteran's Access, Choice, and Accountability Act of 2014 Highlights*. 2014. Web. 16 Sept. 2014.

House Committee on Veteran's Affairs. *Witness Testimony of Ms. Debra A. Draper, Director, Health Care Government Accountability Office*. 14 Mar. 2013. Web. 15 Sept. 2014

Ibrahim, Said A, Leonard E. Egede, Uchenna S. Uchendu, and Michael J. Fine. "The Struggle for Health Equity: The Sustained Effort by the VA Healthcare System." *American Journal of Public Health*. 104.S4 (2014) S514-S515. Web. 15 Sept. 2014.

*Returning Home From Iraq and Afghanistan: Assessment of Readjustment Needs of Veteran's, Service Members, and Their Families*. The National Academies Press. 2013 eBook Collection (EBSCOhost). Web. 15 Sept. 2014

United States House of Representatives, Washington Sixth District. *Kilmer Announces Bill to Address Issues in Veteran's Health Administration Scandal*. 12 Sept. 2014. Web. 15 Sept. 2014.

VA Office of Inspector General. *Veteran's Health Administration Interim Report: Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix VA Health Care System*. 28 May 2014. Web. 18 Sept 2014.

VA Office of Inspector General. *Veteran's Health Administration: Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix VA Health Care System*. 26 Aug 2014. Web. 18 Sept 2014.