Vietnam Veterans of America Chapter 825 South Jersey

103 Florida Ave., Egg Harbor Township, NJ 08234

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This newsletter is a production of Chapter 825 of the Vietnam Veterans of America. Its intended purpose is to provide our readers with information dealing with Chapter activities, veterans' issues and other useful information. It is made possible through the efforts of our members and our sponsors. Please support us by supporting our sponsors.

Thank you!

Meetings are held on the 1st Monday of the month at 7:30 PM, unless otherwise indicated, at the Township of Hamilton Rescue Squad 1400 Route 50 in Mays Landing.

We would like to see you there:
Please make an effort to attend!

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http://vvachapter825.org

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Bill Crafted In Response To VA Scandal Beginning To Falter

Well, lawmakers have left Washington for the Fourth of July holiday leaving behind a long to-do list. While that's nothing new - especially in an election year, getting just about anything of substance done is an achievement - Congress left without finalizing its response to the Veterans Affairs health care situation.

While both chambers have passed legislation to grapple with the crisis, June 24th's first meeting of a 28-member conference committee tasked with merging the bills revealed a number of fault lines that threaten to slow, if not altogether imperil, final passage.

An absolutely big issue is the price tag, and whether to pay for the legislation with spending cuts elsewhere. The Congressional Budget Office pegs the cost of the Senate bill at $35 billion over three years and the House version at $44 billion over five years.

"This is an emergency," Sen. John McCain, R-Ariz., said on the Senate floor earlier in June. "If it's not an emergency that we have neglected the brave men and women who have served this country and protected our freedom, then I don't know what is."

Along with Senate Veterans Affairs Committee Chairman Bernie Sanders, I-Vt., McCain is a co-sponsor of the Senate's legislation, which gives the green light to lease 26 new facilities, including one in Brick, N.J. and would allocate $500 million in unused funds for the hiring of additional doctors and nurses. Both the Senate and House versions would make it easier for the VA to fire or demote senior officials, though the Senate favors an expedited appeals process for those employees.

Central to both bills is the ability for veterans who are unable to get a timely appointment within the VA medical system to access private care. The Senate proposal would enable veterans living more than 40 miles away from a VA facility to seek outside care.

The House-Senate conference committee's first public meeting wrapped Tuesday, June 24th after just under an hour, during which time lawmakers expressed a universal desire to act and to act quickly, but it was clear there was disagreement over cost.

North Carolina Sen. Richard Burr, the ranking Republican on the Senate veterans panel, rejected the CBO estimate as "grotesquely out of line," a sentiment shared by other members of the GOP. House Veterans Affairs Committee Chairman Jeff Miller, R-Fla., and conservatives like Senator Coburn have insisted on finding necessary offsets; a goal that could prove a heavy lift for the conferees, who span the political spectrum.

For his part, Sanders has urged his colleagues to forge ahead regardless of cost if they want to honor the country's commitment to its veterans. "War is an incredibly expensive proposition in terms of human life, human suffering and in financial terms," the Vermont independent said. "If we are not prepared to take care of those men and women who went to war, then we shouldn't send them to war in the first place. Taking care of veterans is a cost of war, period."

While lawmakers didn't offer a timeline for conference negotiations, Miller said he hopes to at least hammer out the "parameters" of an agreement before they break for a weeklong recess. Originally, lawmakers had hoped to have a bill on the president's desk by that time. So much for hoping.

With 16 days until Congress lets out for summer recess from August 1st to September 8th and after that, only 10 days of session left until the end of the 2014 fiscal year, time is short.

We Pause To Remember

MAJ Dyke A. Spilman
USAF 14 July 1941
CWO George P. Berg
USA 16 July 1946
MAJ Harold W. Kroske, Jr.
USA 30 July 1947

The Clock Is Running!

When Congress returns from the Fourth of July recess, it will have only 28 days left to work before Election Day.

Congress has quite the to-do list including such items as the National Defense Authorization Act, more than 50 ambassador nominations to hotspots such as Iraq and Egypt and what was once thought to be expedited, bipartisan legislation to overhaul the embattled Department of Veterans Affairs. The White House and members of both parties are putting the pressure on congressional leadership to act, however the infamously do-nothing 113th Congress is unlikely to hold votes that could make lawmakers vulnerable before the November midterm elections, leaving crucial national security, foreign policy and veterans legislation in limbo.

The Senate has no finalized plan for amendments or scheduled floor time for its $514 billion Pentagon spending authorization bill whether before the July recess or just before November.

There are 28 days, 16 until Congress lets goes home for summer recess from August 1st to September 8th and after that, only 10 days of session left until the end of the 2014 fiscal year. Then it's just two work days more until a month of stumping in their home districts before polls open on November 4th, after which they'll take another week off.

Passage for the VA reform bill, once a source for optimism given the momentum following revelations about wait times at VA hospitals and the resignation of VA Secretary Eric Shinseki, is unlikely to be quick. Lawmakers initially vowed to have a VA fix on President Barack Obama's desk by July 4th, now they are merely hoping for a July vote, with members of the congressional conference committee balking at the Congressional Budget Office's $44-$50 billion annual cost estimate for the legislation and how to pay for it.

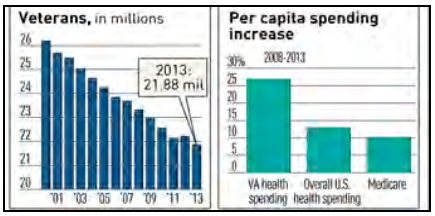
The Obama administration's 2015 war funding request, with money for Afghanistan, though reportedly not for Iraq, is due to Congress any day now, according to the Pentagon. It will join other appropriations bills to provide fiscal year 2015 funding to agencies crucial to national security and foreign policy, from the Department of Homeland Security to Veterans Affairs to State, all recently introduced and placed on the calendar.

Despite the pressure — from both the calendar and Congress itself — it's unlikely substantial legislation on national security and foreign policy will be signed into law before November — not the least because of the risk of votes being wielded against vulnerable Senator, trying to hold onto their seats. If not for the politics, important matters could be concluded without all the last minute drama. We should all be so lucky.

VA By The Numbers

Last month there was an article in Investor's Business Daily that reported from 200 to 2013 VA spending nearly tripled while the population of veterans declined by 4.3 million.

"Medical care spending — which consumes about 40% of the VA's budget — has climbed 193% over those years, while the number of patients served by the VA each year went up just 68%, according to data from the VA," according to the article. IBD supplied the below chart to make their point.



For the most part these numbers are right on track. The numbers of veterans who served in WWII or Korea are passing away at a steady rate. The numbers of veterans enrolling in the VA are increasing due to aging Vietnam veterans and those veterans returning from the prolonged combat in Iraq and Afghanistan. What the chart does not show however, is the increasing number of veterans enrolling in the VA health care system. Nor does the chart reflect the expensive, serious injuries suffered by the returning veterans from Iraq and Afghanistan. Also, there is no mention of medical inflation. Simply put, there are major considerations as to why the costs have gone up that are not part of the article unfortunately. It is sort of like telling a half of the story, which does not reflect the whole story by any means.

One starts to wonder what was the purpose of the article when only some of the information is provided.

A complete picture would serve to educate the public, the veteran community and those elected officials who veterans count on to provide them with the benefits and health care they have earned through their service to our nation.

On the other hand if there is some other purpose behind the article, such as one that would serve to support the call by some to dismantle the VA health care system, this might be a useful method to employ.

It would help to know what inspired such an article before any real judgment can be made as to the utility of the article itself. If nothing else it may just serve to muddy the waters when some clarity should be the order of the day. There is one point here to make that no one should forget. The costs of warfare continue on well past the end of combat for those who served.

"Friendly Fire - Death, Delay & Dismay at the VA"

Reports, statements, comments and opinions with regard to the situation at the VA are coming in from all directions. Some are better written then others, some are written well, some lay bare the problems that have been uncovered, some are axe grinding at its best. Before all is said and done we will have ample opportunity to develop our own sense of what is needed going forward.

Recently I had the opportunity to read an oversight report from Senator Tom Coburn, M.D. With 1,047 endnotes it appears to be well documented as well as being quite the interesting read. I recommend its reading. If you can't find it at http://www.coburn.senate.gov/, send me an email and I'll email you a copy. At that point, you can draw your own conclusions.

Here's the press release:

June 24 2014

Beyond the Waiting Lists, New Senate Report Reveals a Culture of Crime, Cover-Up and Coercion within the VA

(WASHINGTON, D.C.) – U.S. Senator and doctor Tom Coburn, M.D. (R-OK), today released his new oversight report "Friendly Fire: Death, Delay, and Dismay at the VA." The report is based on a year-long investigation of VA hospitals around the nation that chronicled the inappropriate conduct and incompetence within the VA that led to well-documented deaths and delays. The report also exposes the inept congressional and agency oversight that allowed rampant misconduct to grow unchecked.

"This report shows the problems at the VA are worse than anyone imagined. The scope of the VA's incompetence – and Congress' indifferent oversight – is breathtaking and disturbing. This investigation found the problems at the VA are far deeper than just scheduling. Over the past decade, more than 1,000 veterans may have died as a result of the VA's misconduct and the VA has paid out nearly $1 billion to veterans and their families for its medical malpractice. As is typical with any bureaucracy, the excuse for not being able to meet goals is a lack of resources. But this is not the case at the VA where spending has increased rapidly in recent years," Dr. Coburn said.

"The Administration and Congress have failed to ensure our nation is living up to the promises we have made to our veterans," Dr. Coburn added. "As a physician who has personally cared for hundreds of Oklahoma veterans, this is intolerable. As a senator, I'm determined to address the structural challenges of the Department of Veterans Affairs so we can end this national disgrace and improve quality and access to health care for our veterans. But make no mistake. Whatever bill Congress passes cannot ignore the findings of this report. While it is good that Congress feels a sense of urgency we are at this point because Congress has ignored or glossed over too many similar warnings in the past. Our sense of urgency should come from the scope of the problem, not our proximity to an election."

Key findings in the report include:

A CULTURE OF MANIPULATION PERMEATES THE DEPARTMENT.

The cover up of waiting lists for doctor's appointments at the VA is just the tip of the iceberg, reflecting a perverse culture within the department where veterans are not always the priority and data and employees are manipulated to maintain an appearance that all is well.

Bad employees are rewarded with bonuses and paid leave while whistleblowers, health care providers, and even veterans and their families are subjected to bullying, sexual harassment, abuse, and neglect. For example, female patients received unnecessary pelvic and breast exams from a sex offender, a noose was left on the desk of a minority employee by a co-worker, and a nurse who murdered a veteran harassed the family of the deceased to get them to admit guilt for the death.

The care at more centers is getting worse and some VA health care providers have lost their medical licenses, and the VA is hiding this information from patients.

Delays exist for more than just doctors' appointments—disability claims, construction, urgent care, and registries are also slow or behind schedule.

Despite a nursing shortage, many VA nurses spend their days conducting union activities to advocate for better conditions for themselves rather than veterans.

VA MADE WAITING LISTS WORSE.

As waiting lines were growing, the VA expanded eligibility in 2009 to those who already had insurance without any service related injuries, making the delays longer.

Despite having the authority to do so, the VA was reluctant to let vets off the waiting lists by freeing them go to doctors outside of its system while sitting on hundreds of millions of dollars intended for health care that went unspent year to year.

VA doctors are seeing far fewer patients than private doctors and some even leave work early.

VA EMPLOYEES BEHAVE AS IF THEY ARE ABOVE THE LAW.

Criminal activity at the department is pervasive, including drug dealing, theft, and even murder. A VA police chief even conspired to kidnap, rape and murder women and children.

Many VA doctors and staff are overpaid and underworked, some are paid not to work and more and more employees are not even showing up for work.

THE VA WASTES AND MISMANAGES BILLIONS OF DOLLARS.

The report identifies $20 billion in waste and mismanagement that could have been better spent providing health care to veterans.

The federal government has paid out $845 million for VA medical malpractice since 2001.

Most VA construction projects are over budget and behind schedule, inflating costs by billions of dollars.

THE SENATE VETERANS AFFAIRS COMMITTEE HAS BEEN AWOL WHEN IT COMES TO KEEPING PROMISES MADE TO VETERANS.

The Senate Veterans Affairs Committee largely ignored the

warnings about delays and dysfunction at the VA for decades, abdicating its oversight responsibilities and choosing to make new promises to veterans rather than making sure those promises already made were being kept.

This report details how Congress was repeatedly alerted and warned of the problems plaguing the VA over decades.

The Senate Veterans Affairs Committee has only held two oversight hearings the last four years, and was even profiled in Wastebook 2012 for being among the committees in Congress holding the fewest number of hearings.

VA Healthcare Facilities in New Jersey

Healthcare System

In many areas of the country, several medical centers and clinics may work together to offer services to area Veterans as a Healthcare System (HCS) in an effort to provide more efficient care. By sharing services between medical centers, Healthcare Systems allow VHA to provide Veterans easier access to advanced medical care closer to their homes.

Examples of Healthcare Systems include the VA New Jersey Healthcare System which serves most of the counties in New Jersey at either the East Orange Campus of the VA New Jersey Health Care System or the Lyons Campus of the VA New Jersey Health Care System.

The Philadelphia VA Medical Center provides health care to veterans living in America's fifth-largest metropolitan area, including the city of Philadelphia and six surrounding counties in Southeastern Pennsylvania and Southern New Jersey.

Wilmington VA Medical Center provides services to three lower counties of Delaware and four counties of southern New Jersey.

Community-Based Outpatient Clinics

To make access to health care easier, VHA utilizes more than 800 Community-Based Outpatient Clinics (CBOC) across the country. These clinics provide the most common outpatient services, including health and wellness visits, without the hassle of visiting a larger medical center. VHA continues to expand the network of CBOCs to include more rural locations, putting access to care closer to home. There are clinics located in NJ at: Camden VA Outpatient Clinic, James J. Howard Community Clinic (Brick, NJ), Cape May County CBOC, Elizabeth CBOC, Hackensack CBOC, Hamilton CBOC, Jersey City CBOC, Ft Dix OPC at Marshall Hall, Morristown CBOC Atlantic County CBOC, Paterson CBOC, Piscataway CBOC, Veterans Health Clinic at Gloucester County, Tinton Falls CBOC, Cumberland County CBOC & VA Clinic NJ Veterans Memorial Home.

Community Living Centers

Community Living Centers (CLC) are skilled nursing facilities, often referred to as nursing homes. Veterans with chronic stable conditions such as dementia, those requiring rehabilitation or those who need comfort and care at the end of life are served within one of VA's 135 Community Living Centers.

Domiciliaries

Forty-eight VHA Domiciliaries provide a variety of care to Veterans who suffer from a wide range of medical, psychiatric, vocational, educational, or social problems and illnesses in a safe, secure homelike environment. The VA New Jersey Health Care System's 85-bed Domiciliary program is located on the grounds of the Lyons VA medical center.

Vet Centers

Vet Centers provide readjustment counseling and outreach services to all Veterans who served in any combat zone. Services are also available for family members dealing with military related issues. VHA operates 278 community based Vet Centers in all fifty states, the District of Columbia, Guam, Puerto Rico, and the US Virgin Islands. There are Vet Centers in Bloomfield, Ewing, Lakewood, Secaucus and Ventnor, N.J.

Veterans Integrated Services Networks

The U.S. is divided into 21 Veterans Integrated Service Networks, or VISNs — regional systems of care working together to better meet local health care needs and provides greater access to care. Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester and Salem counties are part of VISN 4 headquartered in Pittsburg, PA. The other 14 counties are part of VISN 3 headquartered in Bronx, N.Y.

Former P&G CEO McDonald Nominated as Next VA Secretary

June 30th, 2014 President Barack Obama nominated former Procter & Gamble CEO and West Point graduate Robert McDonald as the next Veterans Affairs secretary, as the White House seeks to shore up an agency beset by treatment delays and struggling to deal with an influx of new veterans returning from wars in Iraq and Afghanistan.

In tapping the 61 year-old McDonald for the post, Obama is signaling his desire to install a VA chief with broad management experience. McDonald also has a military background, graduating near the top of his class at the U.S. Military Academy at West Point and serving as a captain in the Army, primarily in the 82nd Airborne Division.

The VA operates the largest integrated healthcare system in the country, with more than 300,000 fulltime employees and nearly 9 million veterans enrolled for care. But the agency has come under intense scrutiny in recent months amid reports of patients dying while waiting for appointments and of treatment delays in VA facilities nationwide.

According to an article in Modern Health, McDonald's nomination was praised by his peers in the private sector and military.

The article reported Jim McNerney, chairman and CEO of the Boeing Co., called McDonald an "outstanding choice for this critically important position." Retired U.S. Army General Stanley McChystal, who served with McDonald in the 82nd Airborne, said the nominee's "business acumen, coupled with his dedication and love of our nation's military and veteran community, make him a truly great

choice for the tough challenges we have at VA."

Senate Veterans Affairs Committee Chairman Bernie Sanders, I-Vt., said in a statement that he looked forward to meeting with McDonald next week to get his views on issues he views as important.

Among them, Sanders said in a statement, "The VA needs significantly improved transparency and accountability and it needs an increased number of doctors, nurses and other medical staff so that all eligible veterans get high-quality health care in a timely manner."

McDonald led Procter & Gamble from 2009 to 2013. During that time, the company website states: "P&G realized annual sales of over $84 billion. The company had more than 120,000 employees, 120 plants and 200 brands in 35 categories, of which 25 brands generate over $1 billion in sales each year."

McDonald has also served on the board of directors of the Xerox Corp., the United States Steel Corp., the McKinsey Advisory Council and the Greater Cincinnati regional initiative intended to "grow high-potential startups" in the Cincinnati region.

McDonald, a native of Gary, Ind., grew up in Chicago and graduated from West Point in 1975 with a degree in engineering. He also earned an MBA from the University of Utah in 1978.

"Significant And Chronic System Failures" At VA

A recently released review ordered by President Barack Obama, citing "significant and chronic system failures" in the nation's health system for veterans, portrays the Department of Veterans Affairs as a struggling agency battling a corrosive culture of distrust, lacking in resources and ill-prepared to deal with an influx of new and older veterans with a range of medical and mental healthcare needs.

The report by deputy White House chief of staff Rob Nabors says the Veterans Health Administration that provides healthcare to about 8.8 million veterans a year, has systematically ignored warnings about its deficiencies and must be fundamentally restructured.

President Obama ordered the review in response to widespread reports of long delays for treatment and medical appointments and of veterans dying while on waiting lists. Nabors' report goes far beyond the lengthy waits and manipulated schedules raised by whistleblowers and chronicled in past internal and congressional investigations.

The review offers a series of recommendations, including a need for more doctors, nurses and trained administrative staff — proposals that are likely to face skepticism among some congressional Republicans who have blamed the VA's problems on mismanagement, not lack of resources.

"We know that unacceptable, systemic problems and cultural issues within our health system prevent veterans from receiving timely care," Acting VA Secretary Sloan Gibson said in a statement following an Oval Office meeting Friday with Obama and Nabors. "We can and must solve these problems as we work to earn back the trust of veterans."

While the review finds deficiencies throughout the VA, it is especially critical of the Veterans Health Administration, which has already undergone some housecleaning. Earlier this week, the VA announced that Dr. Robert Jesse, who has been acting undersecretary for health and head of the VHA, was resigning. Jesse has been acting undersecretary for health since May 16th, 2014 when Robert Petzel resigned under pressure months before he was set to retire.

The Nabors' report found that the VHA, the country's biggest healthcare system, acts with little transparency or accountability and many recommendations to improve care are slowly implemented or ignored. His report says concerns raised by the public, monitors or even VA leadership have been dismissed at the VHA as "exaggerated, unimportant, or 'will pass.'"

Among Nabors' other findings:

As of June 23rd, 2014 the independent Office of Special Counsel, a government investigative arm, had more than 50 pending cases that allege threats to patient health or safety.

One-fourth of all the whistle-blower cases under review across the federal government come from the VA. The department "encourages discontent and backlash against employees."

The VA's lack of resources reflects troubles in the healthcare field as a whole and in the federal government. But the VA has been unable to connect its budget needs to specific outcomes.

The VA needs to better prepare for changes in the demographic profile of veterans, including more female veterans, a surge in mental health needs and a growing number of older veterans.

"No organization the size of VA can operate effectively without a high level of transparency and accountability," said Sen. Bernie Sanders, the Vermont independent who heads the Senate's Veterans' Affairs Committee. "Clearly that is not the case now at the VA."

The President asked Nabors to stay at the VA temporarily to continue to provide assistance.

The White House said that over the past month, the VA has contacted 135,000 veterans and scheduled about 182,000 additional appointments. It has also used more mobile medical units to attend to veterans awaiting care.

The report noted that there is a strong sentiment among many veterans and stakeholders that in general the VA provides high quality health care "once you get in the door" and that the current system needs to be fixed, not abandoned or weakened.

The report also noted:

The 14-day scheduling standard is arbitrary, ill-defined and misunderstood. It represents an unrealistic goal that may have in some cases incentivized inappropriate actions. It is a poor indicator of either patient satisfaction or quality of care and should be replaced with a more insightful measure.

The VHA needs to be restructured and reformed as it currently acts with little transparency or accountability with regard to its management of the VHA medical structure.

A corrosive culture has led to personnel problems across the VA that are seriously impacting morale and, by extension, the timeliness of health care.

The VA failures have generated a high level of oversight. The VA must be more agile and responsive in addressing legitimate oversight inquiries.

The technology underlying the basic scheduling system used by VA medical facilities is cumbersome and outdated. There is a need for more doctors, nurses and other health professionals as well as physical space and properly trained administrative support personnel.

Many of the resource issues VA faces are endemic to the health care field such as shortages of certain types of specialists, an aging patient base or geographical shortages around the country. Other issues include the slowness in the hiring process and the inability to compete with private sector wages. The report notes that VA has also demonstrated an inability to clearly articulate budgetary needs and to tie budgetary needs to specific outcomes.

The report also stated the VA needs to better plan and invest now for anticipated changes in the demographics of the veterans. This includes geographical changes, an increased number of female veteran, a surge in mental health needs, an increase in the special needs of younger veterans returning from Iraq and Afghanistan and specific needs associated with a growing number of older veterans.

VA Medical Appointment Delays Have Been Previously Reported To Congress

Access to timely medical appointments is critical to ensuring that veterans obtain needed medical care. Over the past few years, there have been numerous reports of VAMCs failing to provide timely care to patients, including specialty care, and in some cases, these delays have resulted in harm to patients.

In December 2012, GAO reported that improvements were needed in the reliability of VHA's reported medical appointment wait times, as well as oversight of the appointment scheduling process. Also in 2012, VHA found that system-wide consult data could not be adequately used to determine the extent to which veterans experienced delays in receiving outpatient specialty care. In May 2013, VHA launched the Consult Management Business Rules Initiative with the aim of standardizing aspects of the consults process.

In its December 2012 report, GAO found that VHA's outpatient medical appointment wait times were unreliable. The reliability of reported wait time performance measures was dependent in part on the consistency with which schedulers recorded desired date—defined as the date on which the patient or health care provider wants the patient to be seen—in the scheduling system. However, VHA's scheduling policy and training documents were unclear and did not ensure consistent use of the desired date. GAO also found that inconsistent implementation of VHA's scheduling policy may have resulted in increased wait times or delays in scheduling timely medical appointments. For example, GAO identified clinics that did not use the electronic wait list to track new patients in need of medical appointments as required by VHA policy, putting these patients at risk for not receiving timely care. VA concurred with the four recommendations included in the report and, in April 2014, reported continued actions to address them. For example, in response to GAO's recommendation for VA to take actions to improve the reliability of its medical appointment wait time measures, officials stated the department has implemented new patient wait time measures that no longer rely on desired date recorded by a scheduler. VHA officials stated that the department also is continuing to address GAO's three additional recommendations. Although VA has initiated actions to address GAO's recommendations, continued work is needed to ensure these actions are fully implemented in a timely fashion. Ultimately, VHA's ability to ensure and accurately monitor access to timely medical appointments is critical to ensuring quality health care to veterans, who may have medical conditions that worsen if access is delayed.

March 14, 2013 GAO provided testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives and issued GAO-13-372T, a VA HEALTH CARE Appointment Scheduling Oversight and Wait Time Measures Need Improvement.

The testimony noted that 0utpatient medical appointment wait times reported by the Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA),are unreliable. Wait times for outpatient medical appointments—referred to as medical appointments—are calculated as the number of days elapsed from the desired date, which is defined as the date on which the patient or health care provider wants the patient to be seen. The reliability of reported wait time performance measures is dependent on the consistency with which schedulers record the desired date in the scheduling system.

However, aspects of VHA's scheduling policy and training documents for recording desired date are unclear and do not ensure consistent use of the desired date. Some schedulers at VA medical centers (VAMC) that GAO visited did not record the desired date correctly, which, in certain cases, would have resulted in a reported wait time that was shorter than the patient actually experienced for that appointment.

VHA officials acknowledged limitations of measuring wait times based on desired date, and described additional information used to monitor veterans' access to medical appointments; however, reliable measurement of how long patients are waiting for medical appointments is essential for identifying and mitigating problems that contribute to wait times. While visiting VAMCs, GAO also found inconsistent implementation of certain elements of VHA's scheduling policy that impedes VAMCs from scheduling timely medical appointments. For example, four clinics across three VAMCs did not use the electronic wait list to track new patients that needed medical appointments as required by VHA scheduling policy, putting these clinics at risk for losing track of these patients. Furthermore, VAMCs' oversight of compliance with VHA's scheduling policy, such as ensuring the completion of required scheduler training, was inconsistent across facilities. VAMCs also described other problems with scheduling timely medical

appointments, including VHA's outdated and inefficient scheduling system, gaps in scheduler staffing, and issues with telephone access. For example, officials at all VAMCs GAO visited reported that high call volumes and a lack of staff dedicated to answering the telephones impede scheduling of timely medical appointments. VHA is implementing a number of initiatives to improve veterans' access to medical appointments such as use of technology to interact with patients and provide care, which includes the use of secure messaging between patients and their health care providers. VHA also is piloting a new initiative to provide health care services through contracts with community providers that aims to reduce travel and wait times for veterans who are unable to receive certain types of care within VHA in a timely way.

More recently GAO reported in its testimony on April 9, 2014, before the Committee on Veterans' Affairs, House of Representatives its preliminary work examining the Department of Veterans Affairs' (VA), Veterans Health Administration's (VHA) management of outpatient specialty care consults identified examples of delays in veterans receiving outpatient specialty care, as well as limitations in the implementation of new consult business rules designed to standardize aspects of the clinical consult process. For example, for 4 of the 10 physical therapy consults GAO reviewed for one VA medical center (VAMC), between 108 and 152 days elapsed with no apparent actions taken to schedule an appointment for the veteran. For 1 of these consults, several months passed before the veteran was referred for care to a non-VA health care facility. VAMC officials cited increased demand for services, and patient no-shows and cancelled appointments among the factors that lead to delays and hinder their ability to meet VHA's guideline of completing consults within 90 days of being requested. GAO's preliminary work also identified variation in how the five VAMCs reviewed have implemented key aspects of VHA's business rules, such as strategies for managing future care consults—requests for specialty care appointments that are not clinically needed for more than 90 days. Such variation may limit the usefulness of VHA's data in monitoring and overseeing consults system-wide. Furthermore, oversight of the implementation of the business rules has been limited and has not included independent verification of VAMC actions. Because of the preliminary nature of this work, GAO is not making recommendations on VHA's consult process at this time.

What Is Next?

Back on May 16th, 2014 the US Senate Committee on Veteran's Affairs held a hearing about the developing scandal concerning a potential cover-up of chronic delays in diagnosing and treating sick vets.

Obviously it came as no surprise that VA officials told Senators how awesome the VA is. And everyone else had wonderful things to say about the VA too — including Dan Dellinger, the commander of the American Legion who was calling louder than anyone for the head of the head of the VA, Eric Shinseki. As Dellinger said in his testimony, "Overwhelmingly, our task force finds that veterans are extremely satisfied with their healthcare team and medical providers."

Healthcare policy experts have been praising the VA as a model of efficient, centrally managed healthcare for years. This spate of praise for the VA started in the mid-2000s and continued right through the middle of the debate on the Affordable Care Act (ACA) when health policy wonks were looking to the VA to see what could be done to improve everyone else's healthcare.

The VA appears to be a system that provides really good care that doesn't cost a great deal of money. Everyone — critics and supporters of the VA alike — agreed that the problem wasn't the health care; it was the wait to get it.

According to Carl Blake, who testified on behalf of the Paralyzed Veterans of America, "Many of the problems that the media continues to report are really access problems, not quality-of-care problems. While there are many detractors of the VA who would like to convince veterans and the public at large that the VA is providing poor quality care, that is simply not true."

The problem stems from a lack of doctors, nurse practitioners, and other clinical care givers.

Normally, this is the kind of thing that most people would solve by getting a bigger budget and hiring more doctors. And yet that does not appear to be the case with the VA. Here's an example:

While the total discretionary budget for VA has increased from $50.6 billion in 2009 to $64.2 billion in 2013, an increase of $13.6 billion (27%); the Total Medical Care Appropriation budget for the Wilmington VAMC during that time has decreased by $3.6 million, a 2% decrease.

At Wilmington salaries, wages & benefits have increased by $30,467, 201 a 46% increase from 2009 to 2013. Total employees have increased by 802. This includes 1 additional physician and a reduction of 38 Registered Nurses from 2009 to 2013. One additional physician, 38 less RNs while total outpatient visits have increased by 61,467, a 30% increase. Total unique patients have increased by 2,172, a 9% increase.

So who are the 802 new hires and what are they doing? Are they working in some facet of health care or are they among the too many paper-pushers at the expense of people doing actual healthcare? If the VA spent less time on paperwork — including the paperwork bureaucrats had to do to lie about patient wait-time lists — might it have more resources to devote to things like treating patients?

What kinds of paperwork are VA employees spending their time processing? A lot of it grows out of things any taxpayer expects out of any government-funded agency: oversight, accountability, and some basic competency. Representing the Disabled American Veterans organization, Joseph Volante said:

Unlike private providers and healthcare systems, VA is required by its own policy to admit and publicly report all medical errors and fully investigate all untimely deaths. VA uses the information from these investigations for self-improvement and to strengthen prevention protocols system wide. To be effective, VA must have sufficient internal monitoring and

reporting systems that detect and report problems rapidly through the chain of command in order to correct them and develop prevention strategies nationwide. These recent revelations indicate that there are troubling gaps in this reporting system that need to be addressed.

In other words, because it's a public agency, there should be more oversight and accountability. And that means more bureaucrats and more paperwork, which in turn, will result in studies, policies, guidelines, and all manner of corrective measures that very large government organizations use to try to change themselves. All of this puts the squeeze on care providers, exacerbating the problems that lead to the wait-time cover-ups in the first place.

Private hospitals don't have waiting list requirements or an Inspector General's office. They don't report to Congress. To be sure, that cuts down on staffing costs dramatically. So what? Just privatize the VA and be done with it?

Any suggestion that Veterans Health Administration is a fundamental failure which should be dismantled in favor of an alternative model serve only to relieve VA of its responsibilities, but fails to take into account the contributions that VHA makes to veterans, their families, and the medical community as a whole.

The American public wants and the veteran community deserves a way to provide high-quality, cost-effective health care to its veterans. However that comes with bureaucratic overhead, which is going to exact a toll. There is a need to address the wait times, however, without leading to lower-quality care and/or exorbitant costs. So while the VA has horrible problems with the duplicate wait lists, veterans dropping off the radar while awaiting appointments and the consequences for veterans caught up in this quagmire; dismantling the health care system that provides for millions of veterans and pushing them into a public health care system that may not be able to handle the sheer numbers or the unique needs of our veterans is not of itself a responsible solution to the problem.

Challenges Facing the New VA Secretary

So now we know who is taking the helm of the troubled Veterans Affairs Department, assuming of course he is confirmed by the Senate.

President Obama has nominated Robert McDonald, a former CEO at Procter & Gamble who retired from the company in 2013. Veterans advocates and lawmakers alike hope that McDonald will be able to use the managerial skills he honed in the private sector to whip the department into shape, no small task in itself considering all that needs to be addressed.

First on the list will be the job of stopping the bleeding. The news media has reported one revelation after another as government investigators uncovered evidence of nationwide manipulation of data on how long veterans wait to receive medical care at VA facilities as well as allegations of veterans dying while waiting for care. With investigations still ongoing—including criminal allegations of fraud—there are more revelations to come.

There are no easy ways to attack the mess that has been uncovered and simply making sure things don't get any worse, if possible, won't be enough.

The focus on the VA culture, including a damning report released recently from White House adviser Rob Nabors and Acting Secretary Sloan Gibson—has spotlighted the manipulation of wait times by hospital staff as well as the widespread problems with personnel accountability. Fixing the "corrosive culture", as it was referred to in the report, will be a tremendous challenge.

There will be plenty of advice, much as there was plenty of advice as to who should have been the VA Secretary. Lawmakers, leaders from the major veterans organizations and a growing number of advocates will wade into the quagmire to call for the VA secretary to have greater firing power—particularly over senior officials, who they say have allowed the secret wait lists to exist for years as they faced pressure to meet deadlines handed down from the top. There will be calls for the VA to hire more doctors and increase veterans' access to private health care. There will be calls for increased funding.

There are a few things that should be remembered in the midst of all the calls to turn things around at the VA. First, the toxic problems are not new and they have gone unchallenged to the point of some of the poor practices being entrenched in a massive beauracracy. Although the Office of the Inspector General and the GAO have pointed out problems in the past, corrective actionS have not always brought the desired results. That will have to change.

The U.S. Office of Special Counsel announced last month that it will look into allegations of retaliation against 37 VA whistle-blowers, which could muzzle future complaints. The retaliation against whistleblowers is cultural problem that needs to be addressed. Passage of HR4580 and S1556 would help to address this problem.

H.R.4580 Improving Clinical Care Workforce for Our Vets repeals provisions excluding any matter or question concerning professional conduct or competence, peer review, or the establishment, determination, or adjustment of employee compensation from the applicability of collective bargaining rights for Veterans Health Administration employees.

S.1556 A bill to amend title 38, United States Code, to modify authorities relating to the collective bargaining of employees in the Veterans Health Administration repeals federal provisions that prohibit collective bargaining and related grievance procedures provided under a collective bargaining agreement for certain employees of the Veterans Health Administration of the Department of Veterans Affairs (VA) from covering any matter or question concerning or arising out of: (1) professional conduct or competence; (2) peer review; or (3) the establishment, determination, or adjustment of employee compensation.

The claims backlog will have to continue to be addressed with accurate reviews completed in a timely fashion. Again, this is not a new problem.

The goal to eliminate veterans homelessness will need to addressed with all the tools available to address this terrible situation.

Advance funding for the entire VA Department so that government shutdown will not effect the work that must be accomplished must be a priority.

The new Secretary should call for adoption of every law that will assist his efforts to resolve the many outstanding issues at the VA.

Building the trust with the veteran community and the veterans organizations will develop over time as improvements are developed and delivered to the stakeholders.

There is plenty of work ahead for the new Secretary, his staff, the many VA employees who have and will continue to do an excellent job of addressing the needs of the veteran community, our elected officials in Washington and the leadership of the veterans service organizations.

The VA - Moving Ahead

In the last month and a half or so the VA has been moving to get its ship righted. This has included changes in leadership at the top, a ban on executive bonuses, hiring more medical professionals, a freeze on hiring at the VISNs and central office levels and seeking help from the private sector to address waiting lines for medical services.

The VA, the VA Office of Inspector General and White House adviser Rob Nabors have all examined the scheduling problems. Additionally, the Office of Special Counsel, a federal watchdog advocate, announced last month that it is investigating allegations of retaliation against dozens of VA employees.

A May report from the VA's independent inspector general confirmed that many of the department's medical centers had falsified records to hide the amount of time veterans had to wait for medical appointments. It described the crisis a "systemic problem nationwide." Official VA data showed that a sampling of 226 patients had waited just 24 days on average for their first primary care appointments, but the actual average was 115 days. The false wait times were used to determine bonuses and employee awards, the IG report said.

On June 9th, the VA released results from its nationwide audit of scheduling practices, showing that 57,000 patients were still waiting for their first appointments and that about 13 percent of VA schedulers were instructed to falsify appointment-request dates. The report also said that complex scheduling practices contributed to the problems by creating confusion among clerks and supervisors, and that the VA's goal of providing appointments within 14 days of any request was unattainable because of the growing demand for care.

White House Advisor Nabors conducted a broad review of the VA health network, reporting back to President Obama that the VA lacks accountability and suffers from a host of other problems, including a "corrosive culture" of employee discontent and management retaliation against whistleblowers.

The Office of Special Counsel issued a letter to Obama reporting the agency was reviewing more than 50 complaints of retaliation against whistleblowers and that it had already referred 29 of the cases for further investigation, meaning they had merit. Acting VA Secretary Sloan Gibson has vowed to stop reprisals against employees who report wrongdoing. "I am deeply disappointed not only in the substantiation of allegations raised by whistleblowers, but also in the failures within VA to take whistleblower complaints seriously," he said in response to the letter.

There have been drastic changes in leadership at the highest levels of the VA. There have changes in some of the VISN and medical center leadership posts, with more to follow.

Outreach to veterans has increased with more than 100,000 veterans who were on unofficial wait lists contacted to discuss their medical needs and begin scheduling appointments.

The VA has shifted more than $390 million within its budget to help provide care for veterans who have experienced extensive wait times. The money will be used to contract with private-sector hospitals and government clinics that do not belong to the VA. The agency has also deployed "mobile medical units," essentially clinics on wheels, to help improve access.

The VA has terminated its goal of seeing patients within 14 days of appointment requests. Nabors said in a summary of his findings that the target was "arbitrary, ill-defined and misunderstood," and that it may have "incentivized inappropriate actions." He also suggested that it was unrealistic given the VA's resources and the growing demand for care.

The VA has begun posting twice-monthly updates on wait times and other access-to-care data. The goal is to provide the most immediate information to veterans and the public.

Acting Secretary Gibson has said repeatedly since becoming interim VA chief that he will not tolerate retaliation against employees who report wrongdoing. He also ordered a comprehensive review of the department's Office of Medical Inspector, to include its handling of whistleblower complaints. The analysis is expected to be finished soon.

VA Fired 2,247 People Last Year

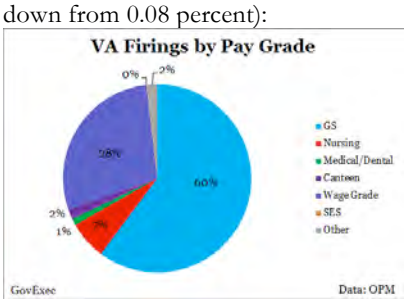
There have been numerous calls for firing folks at VA. Outgoing VA Secretary Eric Shinseki said in a speech just before he resigned that he would support such measures. He also told Congress he had sufficient authority to fire any worker when necessary, noting he forced out 6,000 employees in the last two years.

In fact, VA fired 2,247 employees for disciplinary or performance reasons in fiscal 2013, more than any other Cabinet-level agency, according to data from the Office of Personnel Management. That amounted to about 0.7 percent of its workforce, the third highest percentage of any Cabinet agency after the Homeland Security and Commerce departments.

According to Government Executive, VA fired just two Senior Executive Service employees for discipline or performance in fiscal 2013, and terminated a total of three senior executives since fiscal 2008. The

data do not include forced transfers or retirements.

Here is a breakdown of VA terminations in fiscal 2013 by pay grade (the 0 percent slice on the chart represents SES employees, rounded down from 0.08 percent):

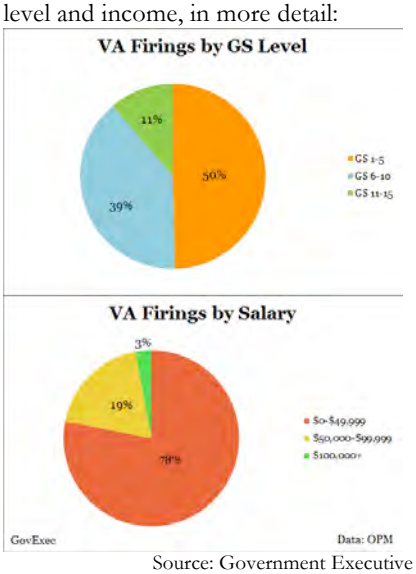


Currently, SES employees being demoted or fired for misconduct have the right to know the charges against them 30 days prior to the action, to respond in a meaningful way and to see the evidence the agency used to make its decision. The VA Management and Accountability Act would strip senior executives of these rights.

A senior executive can only be removed for three reasons, according to Debra Roth, a partner at Shaw, Bransford and Roth and general counsel for the Senior Executives Association: misfeasance, or poor performance; malfeasance, or misconduct; and nonfeasance, or the failure to take an assignment outside of the employee's duty area.

Employees must be removed from the SES if they receive two "unsatisfactory" ratings within five consecutive years, or two "less than fully successful" ratings within three consecutive years. The Merit Systems Protection Board can review the action and make a non-binding recommendation to the agency; however, employees cannot appeal the actual performance rating.

It been rare that VA fires senior executives. With the rest of the department's workforce, terminations based on discipline or performance have tilted heavily toward the lowest grade levels and lowest earners. Of those fired on the General Schedule pay scale, only 11 percent were GS-11 through GS-15. The rest were lower level GS employees. 78 percent of those fired in fiscal 2013 made less than $50,000 a year. The following two charts show the firings based on GS level and income, in more detail:



Source: Government Executive

Bonuses – Good Or Bad?

Bonuses in government are in the news, again. The House recently voted to eliminate performance bonuses at the VA and Acting Secretary Gibson has suspended all performance bonuses. Two reports—one by the VA's inspector general and another by the VA secretary—suggest that employees may have manipulated wait times in order to meet employee performance goals needed for bonuses. Some have pointed to poor leadership and a corrupt culture as explanations for this behavior

Bonuses are common in for-profit businesses to suggest that they play an important role in providing useful incentives for shaping worker behavior. The questions now is; are bonuses for achieving performance targets an appropriate way to provide incentives in government?

With regard to the VA, it appears that specific objectives that would earn a bonus were not met and the facts and figures were manipulated to earn a bonus that was not actually earned. Any specific measures with regard to the outcomes were not accurate and this was known by some in the system. Those involved in the manipulation chose to put in a false effort only for the purpose of achieving the objectives. The continued employment of these individuals should be examined.

Does Congress have a role in this matter? First, the political process makes it difficult to specify an appropriate set of objectives. Not only must Congress figure out what objectives in fact are achievable, it must specify all the objectives to be achieved. Achievable objectives require either detailed knowledge of the job and person's ability, or a way to experiment and actively adjust the incentive as they learn what is achievable. Congressional leaders, even with best intentions and the best staff, rarely can access enough knowledge to figure out appropriate and achievable objectives.

We have seen in the past where bonuses were awarded for saving money. Staff was reduced, vacancies were not filled; the number of veterans seen was reduced resulting in less treatment, less diagnostic testing and reduced pharmacy costs. This may have worked well for the cost savings produced, but it had tragic results for the veterans who were denied the care they have earned. Do we really want to reward neglecting our veterans?

This brings out another point; to pay out bonuses, objectives must be measured. All too often some objectives are easy to measure while others are difficult. For instance, measuring profit or stock price is relatively easy, however measuring ethical behavior is difficult.

Incentives encourage some to focus on what is easily measured and put less effort into the objectives that are more difficult to measure. Indeed, large bonuses lead to accomplishing easy-to-measure objectives whereas difficult-to-measure objectives will fall by the wayside as workers shift their attention from one (like behaving ethically) to the other (like earning the bonus).

Measuring the objectives for government jobs, especially for senior leaders, is inherently difficult.

Blaming leadership and culture for bad behavior may not be wrong, but it may not tell the whole story. Government is different from business and even from not-for-profit organizations. Borrowing best practices from one domain—like bonuses in business—and grafting them onto another—like bonuses in government—can have problematic and deeply troubling consequences.

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