hurry up and wait:

The VFW's Report on the State of VA Health Care

September 2014

VFW
VETERANS OF FOREIGN WARS
NO ONE DOES MORE FOR VETERANS.

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INTRODUCTION:

In April 2014, whistleblowers at the U.S. Department of Veterans Affairs Medical Center in Phoenix, Ariz., exposed rampant wrong-doing and potential criminal cover-ups through which veterans are alleged to have died waiting for health care, while VA employees hid the truth.

Since April, the House of Cards that held up the VA Health Care system as one of the top health care delivery networks in the country has toppled. The VA secretary and many of his top health deputies were forced to resign. Investigators may be pursuing criminal charges against those responsible for any cover-up or obstruction of justice that kept veterans and veterans' advocates in the dark.

The VFW knew that veterans needed immediate help, which is why on Friday, May 9, the VFW reintroduced its national helpline, 1-800-VFW-1899 (1-800-839-1899), asking veterans to call and share their health care experiences. The VFW also solicited comments from veterans through the vfw@vfw.org email inbox, as well as direct paper surveys at veterans' events and facilities across the country. For veterans with urgent care needs, such as cancer or mental health treatments, the VFW worked directly with VA Central Office to resolve their issues within 24 hours.

In the first three months of outreach, the VFW received more than 1,600 inquiries from veterans in every state, as well as the District of Columbia, Puerto Rico, and the Philippines. Nearly 60 percent of the veterans who contacted VFW reported negative health care experiences; more than 300 veterans reported critical concerns requiring immediate intervention; and nearly 800 more requested direct support.

The VFW sorted through all of the information gathered over the summer to develop the following report in which we identify national trends in VA care; develop a comprehensive analysis of the health care situation for today's veterans; and outline specific policy recommendations to fix the VA health care system and hold its leaders accountable.

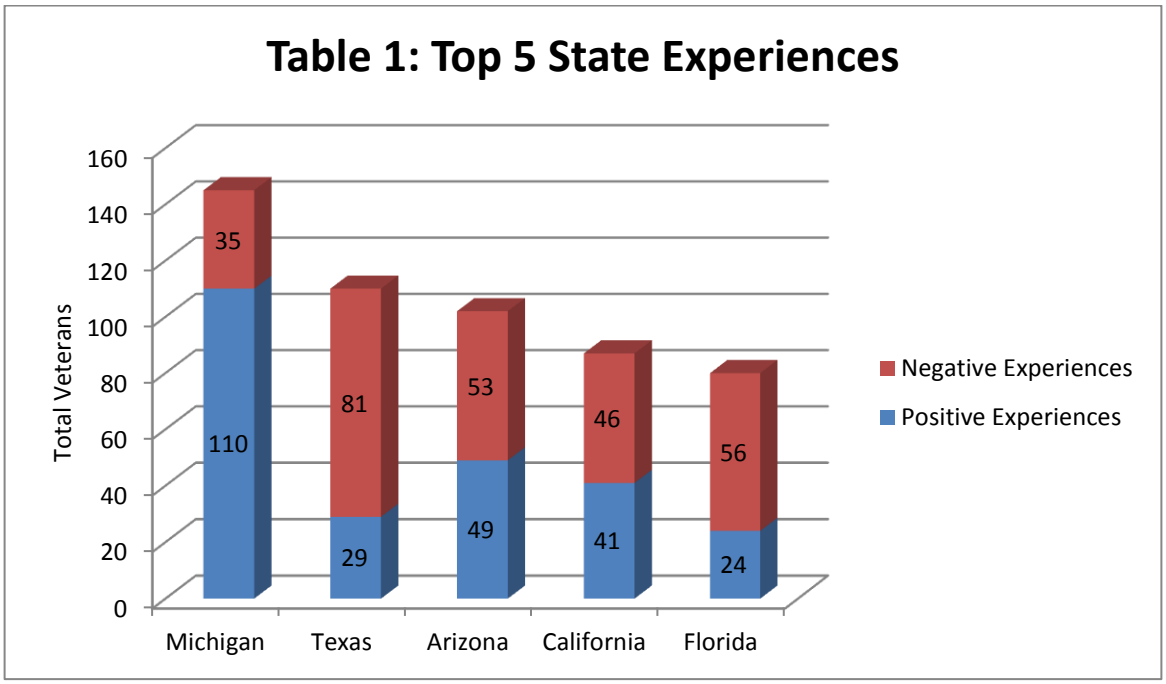
The VFW helpline will also remain in continuous operation, and the VFW encourages any veteran with questions or concerns about care or benefits to call.

FINDINGS:

By analyzing the data, the VFW determined that veterans' concerns over health care can be classified as related to access to care and appointments; quality and safety of care; and customer service at the VA health care facilities.

The VFW also learned that the areas with the highest concentrations of veterans generated the most inquiries, and many times, the most negative health care experiences. States like California, Arizona, Texas, and Florida all have some of the nation's largest concentrations of veterans, and each of these states presented the largest volume of inquiries and concerns. The exception to this was Michigan, which accounted for the most inquiries, and where most veterans reported favorable experiences.

Table 1: The top five states from where veterans reported their health care experiences, both positive and negative:



Of the negative inquiries, most veterans explained that appointment wait times were unreasonable, especially for urgent services like mental health or cancer treatment. Sometimes even veterans who had positive experiences to share about the care they received from VA would add the caveat that appointment wait times can be long. While many spoke highly of their doctors and nurses, others vocally chastised the professionalism and compassion of call center administrators and desk clerks at VA facilities. Others also criticized the effectiveness of VA's Patient Advocates, who serve as the central point of contact for veterans who believe they are not receiving proper care or treatment at a VA medical facility.

"Hurry Up and Wait," seemed like a proper military colloquialism to explain how some veterans are being treated when they try to access care. One glaring example of the "hurry up and wait" nonchalance of VA care came from a veteran who shared with the VFW his experiences trying to transfer into the Salt Lake City VA Medical System. The veteran was told that upon enrollment he would have to wait six months to see his primary care doctor. After six months was elapsed, VA informed him that he would need to wait another six months. The veteran then reported that VA dropped him from enrollment because he had not been seen by VA within the last year.

However, the VFW believes that focusing solely on access issues neglects the linkages among access, quality and safety, and customer service. During a May 2014 Senate Veterans Affairs Committee hearing, VFW Deputy National Veterans Service Director Ryan Gallucci clarified that when access suffers, other aspects of care suffer as well.[1] Over the past few months, many veterans who have contacted the VFW with health care concerns have reinforced this linkage, often pointing to delayed diagnoses, worsening conditions, and hurried screenings for potentially serious health conditions.

For example, a veteran who was receiving care in Alaska reported that after he was diagnosed with colitis difficile, the delays in follow-up treatment caused the condition to worsen into now-permanent ulcerative colitis. Another veteran in Kansas was diagnosed with cataracts by a VA optometrist, only to be told that a surgery consult would take up to six months. Since the veteran was going blind, he sought immediate civilian treatment out-of-pocket to remove the cataracts.

"Just so you know, I will be laughing when you walk away." – Sign reportedly seen on the desk of a St. Cloud, Minn., VA staff member

As the strain on the VA health care system continues to grow, the VFW's evidence suggests that staff attitudes are rapidly deteriorating as well, whether veterans are reporting doctors who shrug off their serious symptoms or phone operators who treat veterans with contempt. In one extreme incident, a veteran in St. Paul, Minn., reported seeing a sign on one staff member's desk that read, "Just so you know, I will be laughing when you walk away."

[1] The State of VA Health Care, Senate Committee on Veterans Affairs, http://www.veterans.senate.gov/hearings/the-state-of-va-health-care-051514

What the VFW found most disturbing when addressing the issue of customer service was frequent reports of apathy or ineffectiveness of VA Patient Advocates. Established in 1990, VA Patient Advocates are supposed to serve as the liaison between veterans receiving care at a facility and the service chiefs and hospital administrators responsible for coordinating that care. In its early days, the Patient Advocate was an administrative position that would simply triage complaints for further action by the facility. In recent years, Patient Advocates were supposed to be higher-level, experienced medical professionals capable of intervening on a veteran's behalf either directly with the care provider or senior hospital administration.

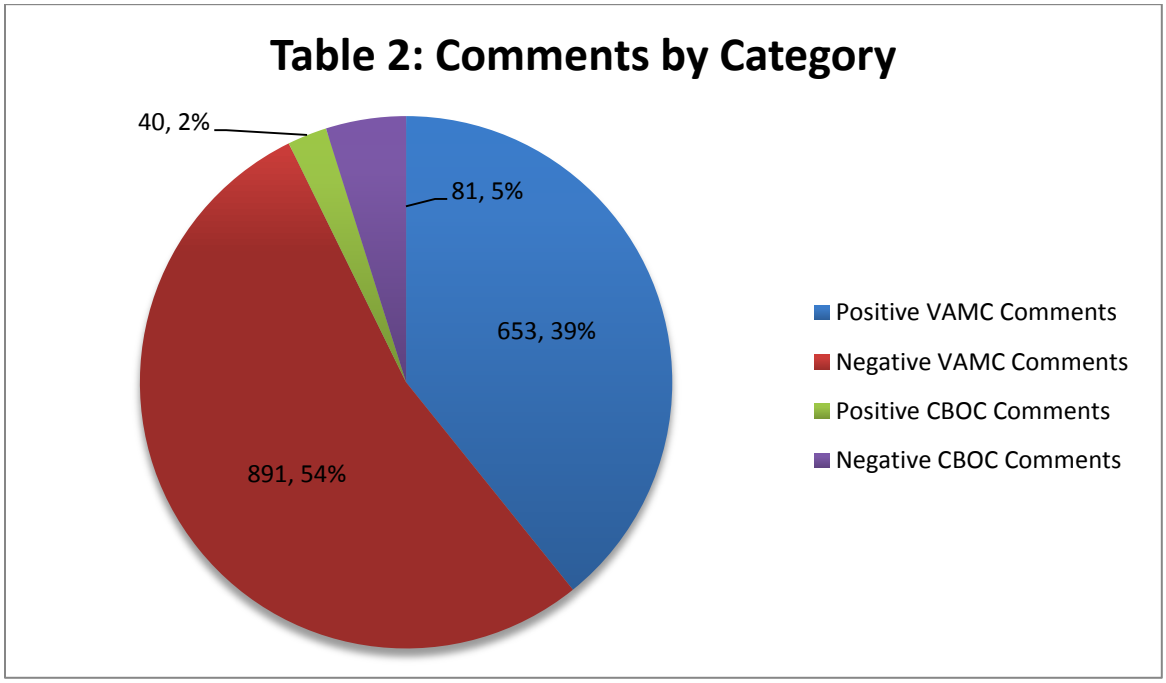
Unfortunately, veterans consistently reported to the VFW that Patient Advocates could not resolve even basic appointment scheduling conflicts at the lowest levels. In Atlanta, one veteran reported that a Patient Advocate told him to "keep his mouth shut" when he complained about physical therapy wait times. The veteran then reported that his physical therapy was cut off. Veterans also consistently reported that Patient Advocates seemed more interested in defending the status quo at their facility instead of intervening on the veteran's behalf. One veteran who contacted the VFW quipped that Patient Advocates do not advocate for the patients; instead they advocate for the staff.

Despite predominant reports of problems plaguing VA health care, the VFW maintains that the VA health care system must remain intact and must be capable of delivering and managing quality care for veterans. VA holds competencies that either do not exist or cannot be easily duplicated or scaled in the civilian health care sector for issues like combat-related mental health care, blast injuries, toxic exposure, and prosthetics. Moreover, the civilian health care system does not have the capacity to serve the needs of the millions of veterans now under the care of VA.

"I would be dead if VA had not found a blockage and put in a stent." – Washington, DC veteran

Fortunately, the VFW also received more than 600 positive comments from veterans about their health care experiences with VA. In states like North Dakota, Connecticut, Maine, and Michigan, veterans predominantly seemed happy with the level of service they received from VA. As VFW outreach has continued, more and more veterans have come forward to share their positive health experiences.

Table 2: Total numbers and percentages of positive and negative comments received on VA Medical Centers or Community-Based Outpatient Clinics.



In Washington, D.C., one veteran told the VFW, "I would be dead if VA had not found a blockage and put in a stent."

In Cannon Falls, Minn., another veteran told the VFW that he had major surgery with VA; that it was the best care he's ever received; and that he is tired of everyone bashing it.

Another veteran from Detroit, Mich., told the VFW that he has used VA since the 1970s; the care is great; and he has no real complaints. However, he went on to say that veterans might have to wait too long to receive that care. Consistently, wait times were still an issue for veterans who reported positive experiences.

While no VA health care service network was perfect, and gaps must be urgently addressed for certain kinds of specialty care, the VFW's data suggests that the national VA health care system has shown the ability to effectively deliver care when properly staffed and resourced.

HOW WE GOT HERE:

For years the VFW warned the Bush Administration, the Obama Administration, and Congress about the dangers of long appointment wait times and improper resourcing of VA facilities.

Just this past March, VFW Deputy Legislative Director Aleks Morosky warned the House Veterans Affairs Committee about ongoing access problems.

"Complicating the well-known deficiencies in VA appointment scheduling is the fact that VA is still in the process of establishing productivity standards to determine appropriate physician staffing levels at its facilities. Simply put, it is impossible to achieve the greatest level of access if too few providers are available to meet the demand for care," said Morosky. "Accurate appointment scheduling and proper physician staffing must both be achieved in order to solve the problem of long appointment wait times."[2]

In March of 2013, the VFW also warned a special joint hearing of the House and Senate Veterans Affairs Committees about the dangers of long appointment wait times, telling Congress "We must not fail to provide the care these heroes have earned in a timely manner."[3]

In fact, the VFW and its partners in the Independent Budget (IB) have warned Congress about the problems with access every year dating back to 2002, when the Veterans Health Administration's own survey acknowledged that 310,000 veterans were waiting longer than six months for care.

In the fiscal year 2013 Independent Budget, the IB said, "Timely access is crucial to the VHA health-care system's capacity to provide health care quickly after a need is recognized and is crucial to the quality of care delivered. Significant and recurring delays for appointments result in patient dissatisfaction, avoidable waste of finite resources, and possible adverse clinical consequences."[4]

[2] Witness Testimony of Aleksandr Morosky, Senior Legislative Associate, National Legislative Service, Veterans of Foreign Wars, March 27, 2014, http://veterans.house.gov/witness-testimony/aleksandr-morosky
[3] Legislative Presentation of Veterans of Foreign Wars, March 5, 2013, http://www.veterans.senate.gov/hearings/legislative-presentation-of-veterans-of-foreign-wars
[4] Timely Access to VA Health Care, Fiscal Year 2013 Independent Budget, p. 91, http://www.independentbudget.org/2013/IB_2013.pdf

Earlier IBVSO indictments went so far as to warn about VA "health care rationing," building more than a decade-long narrative about the dangerous combination of poor appointment tracking and the inextricable links between access and care quality.[5]

As a result of the ongoing VA health care scandal, VA recently conducted a system-wide audit of its scheduling systems and wait times, revealing that approximately 120,000 veterans were either waiting longer than 90 days to receive care or had never received a requested appointment at all.[6] Of these veterans, only 53,000 are being tracked by VA's electronic waiting list for the next available appointment. Some veterans among the remaining 67,000 waiting for care had enrolled with VA nearly a decade ago, but VA failed to contact them for an initial primary care appointment.

The VA Inspector General also recently released its findings on appointment wait times in Phoenix, outlining specific problems that led to at least 45 "unacceptable and troubling lapses in follow-up, coordination, quality, and continuity of care."[7] The Inspector General also determined that veterans seeking to establish care and veterans temporarily relocating to Phoenix faced significant problems accessing care. The culprit? Rampant improper scheduling practices and erroneous reporting on patient access and wait times – practices that reportedly even the top levels of facility leadership knew about.

The report went on to acknowledge that improper scheduling practices were not isolated to Phoenix, but rather rampant across VA, with the Inspector General substantiating many of the 650 allegations lodged at more than 93 facilities. The Inspector General made 24 specific recommendations in the report, many of which focus on accountability, reporting, training, care coordination, business ethics, quality control and customer service. The casual observer may wonder how 67,000 veterans could slip through the cracks in appointment-scheduling, or how dozens of VA facilities could all easily game the scheduling system with near impunity. However, VA's antiquated appointment-scheduling system coupled with lax oversight among VA's top leadership made it quite easy.

For years VA has worried publicly that its 26-year-old scheduling software was woefully inadequate. Built and implemented in the 1980s, VA's appointment-scheduling software has not changed much fundamentally – except for the occasional patch or software work-around designed to gather new information.

VA also acknowledges that this antiquated, patch-work system does not allow for VA to adhere to private industry wait time standards, making appointment scheduling highly susceptible to fraud and manipulation. This also makes it nearly impossible for VA to manage workload for its clinicians, meaning that some may be overworked, while others may be underperforming. In

[5] "Access Issues," Fiscal Year 2007 Independent Budget, p. 47, http://www.independentbudget.org/pdf/IB2007.pdf
[6] http://www.va.gov/health/docs/VAAccessAuditSystemWideFACTSHEET060914.pdf
[7] "Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System." VA Office of the Inspector General. August 26, 2014, http://www.va.gov/oig/pubs/VAOIG-14-02603-267.pdf

either case, care for veterans suffers. The IBVSOs have also been vocally critical of this antiquated system, and repeatedly called for modernization.[8] However, the Independent Budget has also consistently pointed out VA's inability to manage and execute large-scale IT initiatives.[9]

Since the scandal broke, a new leadership team has taken control of VA, implementing significant cultural changes that the VFW hopes will take root at all levels of the organization. The VFW is optimistic that VA Secretary Robert McDonald can succeed in modernizing business practices within the agency that foster quality veteran experiences and candid, competent leadership.

Secretary McDonald has started to leverage his authority to fire executives. He has also instituted new whistleblower protections for employees who witness wrong-doing, and called on every VA medical center to host regular town hall meetings to hear directly from veterans under their care.

Sadly, even the goal of establishing a public forum for veterans to interact with local VA leadership has been met with cultural opposition on the ground level. In late August, the Philadelphia Inquirer reported that employee training slides for one such town hall at the Philadelphia VA Medical Center presented veterans as the curmudgeonly Sesame Street character, Oscar the Grouch. VFW Public Affairs Director Joe Davis told the Inquirer that the negative stereotyping of veterans "slams the door" on VA's efforts to rebuild trust with the veterans' community.

"There are some people at the VA who forgot who their ultimate boss is, and that's the veteran." – VFW Public Affairs Director Joe Davis on negative stereotypes in VA training

The scandal that has rocked the veterans' community over the past few months clearly demands decisive action. The VFW's outreach directly to veterans affected by the health care crisis has already yielded significant results in helping veterans receive the timely care to which they are entitled.

In early August, Congress successfully passed the *Veterans Access, Choice, and Accountability Act of 2014* with the support and insight of the VFW. This emergency veterans' reform bill provides resources and guidelines to ensure veterans receive timely care from private health care providers when VA cannot meet the demand. It also ensures that VA executive employees can be held accountable for poor performance. The VFW worked very closely with leaders in the House and Senate to craft these reforms, but VFW leaders acknowledge that this was just the first step in restoring confidence in the VA system.

[8] Timely Access to VA Health Care, Fiscal Year 2015 Independent Budget, p. 89, http://www.independentbudget.org/2015/IB_2015.pdf
[9] Information Technology, Fiscal Year 2015 Independent Budget, p. 183, http://www.independentbudget.org/2015/IB_2015.pdf

Expanded access to non-VA care was the cornerstone provision of this act, and helps ensure that veterans who either wait longer than 30 days or live further than 40 miles from a VA health care facility can choose to receive their care from a non-VA provider. VA has until November to codify final regulations for these expanded access provisions. However, veterans must also remember that should they elect to receive care from a non-VA provider, the law dictates that such care must still be approved by their VA health care facility of-record, and any documentation, including the newly-commissioned Veterans Choice Card, will only entitle the veteran to non-VA care pre-approved by VA.

At a time when the more and more veterans are seeking to enter the VA system due to the Global War on Terror and expanded presumptions for service connected conditions, the VFW believes it is an issue of national conscience to get this right.

ANALYSIS:

In the view of many veterans who contacted the VFW over the past two months, the major issue facing the VA health care system is not the quality of the health care they have received; but access to care and unreasonably long appointment wait times.

VFW data suggests that veterans who receive care from VA in a timely manner are generally satisfied with that care, but veterans are understandably frustrated by the roadblocks they encounter trying to receive timely appointments. Moreover, the VFW worries that as access to care suffers, customer service, quality, and safety suffer as well.

VA health care access has been a subject of rigorous debate for more than a decade. Meanwhile, whistleblowers assert that transparency was effectively stymied within VA, meaning proper protocols could never be implemented to deal with the real challenges the agency faced in delivering timely care to veterans. When failures like these are identified, they must be swiftly corrected with better oversight, sufficient funding, and accountability of those responsible.

Congress and the American public must also resist any suggestion that VA health care should be dismantled in favor of an alternative model. The narrative that VA is a failed or flawed system could potentially be more disastrous for veterans who need care than any cover-up we have already exposed. Such suggestions not only serve to relieve VA of its responsibilities, but fail to take into account the contributions that VA makes to veterans, their families, and the medical community as a whole. Rather, it should be the goal to ensure that as many veterans as possible are able to receive quality VA care in a timely manner; they are owed as much.

ACCESS & QUALITY: The principle problem facing the VA health care system today is access. Access has clearly been hindered by inadequate appointment scheduling systems and rampant manipulation. For years, VA has been tracking appointments with a system that relies on outdated software and has produced unreliable wait time data. In some cases, employees have manipulated schedules to mask the amount of time veterans were actually waiting to receive care. The VFW believes that it is impossible to ensure timely access unless wait times are accurately captured. VA must implement an updated appointment scheduling system which accurately measures wait times, is not susceptible to data manipulation, and is

focused on the individual needs of the veteran. All employees must be fully trained and the policy must be adhered to at every VA facility. VA recently issued a request for proposal to acquire a new appointment scheduling system, and the VFW has participated in a series of briefings on the proposed new system to ensure it has the capabilities veterans need.

A new scheduling system alone does not solve VA's scheduling problems. VA's current methods for measuring timeliness are arbitrary and do not reflect the care needs of veterans. Arbitrary wait time deadlines of 15, 30 or 45 days do not necessarily correlate to quality health care outcomes. A veteran's "desired date" also does not necessarily reflect the clinical needs of a patient. At worst, desired date is a subjective timeline that has been proven to be highly susceptible to manipulation and misrepresentation. VA must have the ability to determine reasonable wait times based on the care needs of individual veterans, and use these wait time standards to determine whether or not a veteran needs expedited access to non-VA care. If VA must track appointment wait times, they must be tracked from the date on which a consult is created or a veteran contacts VA seeking care, rather than tracking from a subjective desired date.

VA must use all available tools to provide timely access to care, including non-VA care when necessary. This is why VA and the Administration must submit budget requests that accurately reflect the needs of the veterans' community. Congress must then act on these requests to ensure VA receives the timely and sufficient funding necessary to accomplish its mission. While legislators are quick to point out that the VA health care crisis struck amid record budget increases, the VFW knows that these increases were still insufficient for meeting the need. An analysis of the Independent Budget recommendations for increased VA funding over the past few years shows that VA's request for $17 billion in emergency supplemental funding matches the shortfall between actual VA appropriations and the Independent Budget's funding requests.

Serving veterans is a cost of war no different than funding to support overseas contingency operations. Under no circumstances will the VFW allow legislators and policy-makers to make distinctions between the two, as we saw when eight lawmakers voted against the *Veterans Access, Choice, and Accountability Act*.

Ideally, VA would have the capacity to provide timely, quality direct care to all those who need it. We know, however, that they currently do not. The VFW supports expanding VA infrastructure and hiring enough health care professionals to meet demand at Department facilities, we recognize that these improvements will not happen overnight. Veterans cannot be allowed to suffer in the meantime, and non-VA care must be used as a bridge between full access to direct care and where we are now.

It is vitally important that VA remains the guarantor of care, wherever that care is provided. This means that VA facilities must refer veterans to community providers

using a system that requires full coordination and guarantees access and quality. Under the old fee basis system, VA would issue veterans in need of non-VA care authorization letters. It would then be up to the veteran to shop this letter around, searching for a community provider who was willing to accept the authorization and could schedule an appointment in a timely manner. Following the appointment, the veteran would be responsible for returning any records to VA, in order to have them included in the veteran's VA medical record. This system was entirely uncoordinated, failed to guarantee access or quality, and was highly susceptible to improper billing of the veteran, instead of VA. At times this system even exposed veterans to unnecessary financial hardship as a result of VA's unwillingness to pay for services erroneously billed to the veteran that should have been fee-based, or unreasonable delays in payment to private providers.

The dangers of uncoordinated care are well documented. An April 2013 Office of the Inspector General (OIG) report revealed the mismanagement of non-VA care at the Atlanta VA Medical Center in which approximately 4,000 veterans were referred to non-VA mental health providers without an adequate tracking system. OIG found that this led to an average wait time of 92 days, with 21 percent of veterans receiving no care at all, and never receiving any follow up from VA. Even VA staff admitted to OIG that, due to the large number of referrals, many veterans had "fallen through the cracks." The lesson from Atlanta is clear: VA must not be allowed to push large numbers of veterans to outside providers without proper coordination simply to create the appearance that access is being provided.

In order to address the problems of non-VA care, VA developed a new contract care model, Patient-Centered Community Care (PC3). Under this program, networks of specialty care providers were created to provide care at pre-negotiated rates in a well-coordinated manner. VA also recently expanded PC3 to include non-VA options for primary care. However, the networks are not yet fully operational nationwide. According to VA, veterans will be referred to PC3 providers if direct care cannot be readily provided due to lack of available specialists, long wait times, or geographic inaccessibility.

In theory, this program should help solve the access problems that have been plaguing many VA facilities. The program cannot succeed, however, if individual facilities are not open and honest about access to care issues and appointment wait time data continue to be unreliable. The VFW believes that VA must develop and implement wait time standards that would trigger PC3 referrals, and enforce those standards at each facility. Rather than an arbitrary number of days, these wait time standards should be developed based on the type of care being provided and the immediacy of the individual veteran's need for that care, based on a physician's medical opinion.

Although the VFW supports PC3, VFW will be watching its progress closely, and we ask Congress to conduct robust oversight to ensure it is being utilized to its full potential. Specifically, we will want to know which

facilities are using PC3 properly to reduce actual wait times, and which are not. If it appears that certain facilities are not making proper referrals due to improper training, lack of standards, or institutional resistance, VA must move swiftly to correct those problems. If PC3 is not being used effectively due to insufficient funding at the local level, we will call on VA and Congress to work together to get them the resources they need.

The PC3 program is new, and we recognize that the capacity of its networks may not immediately be sufficient to provide timely access for all specialties. In addition, PC3 is not currently set up across the board to provide primary care. Consequently, it may be necessary for some facilities to enter into local contracts for specific services. Under no circumstances should veterans be expected to coordinate their own care or be held responsible for record sharing when receiving care outside of VA. The VFW believes that all contracts should include provisions that ensure the same level of coordination, access, and quality as the PC3 contracts. Anything less would not only fail to address the access problems many VA facilities are facing, but would also represent a huge step backwards in the evolution of non-VA care.

Finally, VA recently implemented a new method through which non-VA care would be coordinated at each facility. VA facilities have now been directed to establish Non-VA Care Coordination (NVCC) teams responsible for determining whether care should be delivered through the newly-commissioned Veterans Choice Card, PC3, or traditional fee-basis models. NVCC is also supposed to ensure that the veteran will not be billed for coordinated non-VA care. The VFW insists that veterans must never be held financially liable for authorized non-VA care.

The VFW agrees that centralizing the referral process has the potential to cut down on red tape for veterans who need non-VA care, but in order to succeed, NVCC teams must be adequately staffed to competently process timely referrals and payments for care. If NVCC is improperly staffed, veterans will likely face referral backlogs and persistent billing problems, exacerbating access issues.

While care access remains the primary concern for veterans, the VFW cannot neglect the second- and third-order effects that inadequate access can have on the quality of care delivered and the level of customer service veterans receive. If a veteran has to wait too long for an appointment, conditions can become dire. Even if VA hospitals are brimming with the latest technology and the best doctors, if veterans wait too long to receive cardiovascular, oncological, or mental health care, it can be the difference between life and death. This nexus between care access and quality care delivery only reinforces the need for improved infrastructure, proper investment, and responsible non-VA care coordination.

ACCOUNTABILITY: The medical community readily acknowledges that staff attitudes and proper bedside manner have an undeniable impact on health care outcomes. An environment in which patients are

belittled or degraded naturally does not foster recovery. Civilian hospitals know this and strive to cultivate an environment conducive to healing.

The VFW believes we need to hold VA to a higher customer service standard, considering VA's clientele. This is why poor customer service demands more specific actions to address accountability, staff competencies and morale. The VFW has long been concerned about accountability of employees at all levels of VA from the highest executive offices at VA Central Office to the orderlies and part-time clerks at VA medical centers. Sadly, the VFW believes that managers do not have the ability to easily sanction poor-performing employees, and that VA does not have adequate leverage to quickly hire new employees to close gaps.

During the May 2014 Senate hearing on VA health care, then-VA Secretary Eric Shinseki noted that VA had reprimanded, moved, demoted, retired or terminated 3,000 VA employees for poor performance. However, when senators pressed the secretary on exactly how many had been terminated, the secretary acknowledged that very few were fired; but instead were moved, demoted or sent into retirement.

As a result, Congress gave the VA secretary broader authority to fire executive-level employees on the spot for poor performance, meaning poor-performing executives can now immediately be sent home and allowed to appeal the personnel action from there.

Understanding that positive staff attitudes and proper work ethic both can impact health care outcomes, the VFW now wants to see all employees held to the same high standard. To the VFW, the goal is to ensure that poor-performing employees cannot continue to detract from the workplace and that VA can move swiftly to improve its workforce.

However, strict firing authority is not a silver-bullet solution to accountability. VA must offer robust training to employees at all levels to promote quality customer service. All employees who interact with veterans must understand that their primary function is to serve the needs of those veterans in a considerate and compassionate manner. Those employees who cannot serve veterans properly must only work in jobs where they do not interact with veterans.

Next, when an employee leaves VA, whether they are fired or choose to leave for another opportunity, VA acknowledges that it can take from six months to a year to fill vacant positions – and this is if they have a viable pool of candidates interested in the job. The VFW believes that this presents a dilemma for VA through which the agency may accept or even reward poor performance out of fear that a vacancy would make the situation worse.

Moreover, the VFW is also concerned that when VA seeks to replace its health care professionals, the bureaucracy simply cannot compete with nimble private health care systems. Private health care systems can easily fill vacancies in a matter of weeks. While doctors, nurses and nurse practitioners may have noble intentions of working for VA and serving veterans, many will likely forgo the year-long hiring process

to pursue timely employment opportunities elsewhere. This is why the VFW asks Congress to carefully review VA's hiring authorities, internal credentialing processes, and common practices to identify ways to streamline the process. Far too often the VFW heard from veterans who could not be seen because of staffing shortages. If VA cannot quickly fill its vacancies with top talent, we cannot expect VA to deliver timely, quality care those who need it.

Next, the VFW is concerned that an overburdened VA health care system that has been shrouded in secrecy has created low morale among employees who genuinely wanted to serve the needs of veterans. If doctors are forced to hastily see patients, they will not only miss diagnoses or botch a procedure, they will also either burn out or leave VA – especially if hospital administrators downplay or neglect the legitimacy of their concerns. As whistleblowers have come forward, many have reinforced the narrative of low morale, unrealistic expectations, and incentives to cut corners. The VFW believes that this can first be remedied by properly aligning resources within VA to ensure that employees have a responsible workload both for patient safety and for employee well-being. However, VA must also ensure that employees feel comfortable asking for help.

Finally, the VFW is concerned that the central system designed to address patient concerns at the facility level – the VA Patient Advocacy Program – faces fundamental challenges that have made it ineffective at many VA facilities. When a veteran has a complaint about access, care, or customer service, their first line of defense at a VA facility is the VA Patient Advocate. Unfortunately, many veterans reported to the VFW that VA Patient Advocates remain ineffective in influencing health care decision-making at facilities either due to improper staffing or a lack of authority. VA must ensure that all facilities are properly staffed with Patient Advocates that have direct reporting authority to VA Central Office. This direct conduit to the secretary means that Patient Advocates will have the authority to intervene directly on behalf of veterans without having to first placate the interests of hospital directors, VISN directors or the VA Undersecretary for Health.

RECOMMENDATIONS:

- Ensure VA and the Administration propose accurate budget requests for Department of Veterans Affairs health care accounts and ensure Congress acts on such requests to provide timely and sufficient funding for VA that aligns with the recommendations of the Independent Budget.

- Provide proper investment in VA capital infrastructure to ensure that facilities remain modern and capable of delivering safe, quality service to all veterans who need it.

- Modernize the VA appointment scheduling system so that it accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veteran.

- Develop and implement wait time standards based on quality care outcomes and the clinical needs of veterans that would trigger non-VA care referrals, and ensure such standards are enforced at every facility.

- Ensure that VA facilities understand how to deliver non-VA care through either PC3 or traditional fee-basis care models and that Non-VA Care Coordination (NVCC) teams are properly staffed to make timely outside referrals.

- Ensure that contracted non-VA care provider networks have the tools and resources to deliver timely care to veterans upon receipt of VA referrals.

- Strengthen accountability protocols for all VA employees -- not just VA executives -- to ensure that poor-performing employees can be held accountable.

- Implement comprehensive training for all VA employees that focuses on quality customer service and positive health outcomes.

- Ease federal hiring protocols for VA health care professionals to ensure that VA can compete with private industry to hire and retain the best health care providers in a timely manner.

- Implement proper whistleblower protections for VA employees who seek to expose improper practices in VA facilities.

- Ensure that VA Patient Advocate teams are properly staffed and report directly to VA Central Office, ensuring they can make decisions that best serve the health care needs of the veteran.

METHODOLOGY:

This is a non-scientific report built off of internal VFW data compiled through various means of constituent outreach. VFW staff analyzed two months' worth of inquiries from veterans via the VFW health care helpline, 1-800-VFW-1899; the VFW general email inbox, vfw@vfw.org; and paper surveys conducted on-site on the National Mall in Washington, D.C., over Memorial Day weekend, May 24-26, 2014; during town hall meetings conducted on June 9, 2014 in Rossville, Md., and Kansas City, Mo.; and at VA health care facilities that would allow access to VFW advocates.

Inquiries collected via in-person directed survey were predominantly positive (72 percent) compared to inquiries collected via telephone or email, which skewed predominantly negative (69 percent).

By close-of-business on Monday, August 25, 2014, the VFW had received 1,655 health care inquiries, 969 of which conveyed negative experiences with VA health care.

VFW advocates were allowed to conduct their surveys in the following VA health care facilities:

Phoenix VA Health Care System, Phoenix, Arizona
Southern Arizona VA Health Care System, Tucson, Arizona
VA Central California Health Care System, Fresno, California
Dwight D. Eisenhower VA Medical Center, Leavenworth, Kansas
Robert J. Dole VA Medical Center, Wichita, Kansas
VA Ann Arbor Health Care System, Ann Arbor, Michigan
Battle Creek VA Medical Center, Battle Creek, Michigan
John D. Dingell VA Medical Center, Detroit, Michigan
VA Marquette Clinic, Marquette, Michigan
VA St. Louis Health Care System, St. Louis, Missouri
Oklahoma City VA Medical Center, Oklahoma City, Oklahoma
VA Puget Sound Health Care System, Seattle, Washington

VFW advocates were turned away at the VA facilities in:

VA Long Beach Health Care System, Long Beach, California
VA Northern California Health Care System, Mather, California
Samuel S. Stratton VA Medical Center, Albany, New York
Cincinnati VA Medical Center, Cincinnati, Ohio

Appendix I: State-by-state breakdown of positive and negative comments received:

State	Positive	Negative	Total
Alabama	2	17	19
Alaska	2	5	7
Arizona	49	53	102
Arkansas	3	17	20
California	41	46	87
Colorado	7	21	28
Connecticut	4	3	7
Delaware	2	3	5
District of Columbia	10	5	15
Florida	24	56	80
Georgia	2	23	25
Hawaii	2	2	4
Idaho	6	8	14
Illinois	8	22	30
Indiana	9	8	17
Iowa	7	5	12
Kansas	22	16	38
Kentucky	6	13	19
Louisiana	3	14	17
Maine	4	3	7
Maryland	8	31	39
Massachusetts	8	7	15

Michigan	***110****	35	***145****
Minnesota	15	13	28
Mississippi	4	6	10
Missouri	21	28	49
Montana	1	5	6
Nebraska	9	3	12
Nevada	3	14	17
New Hampshire	4	2	6
New Jersey	4	9	13
New Mexico	1	11	12
New York	22	27	49
North Carolina	14	35	49
North Dakota	3	1	4
Ohio	12	19	31
Oklahoma	24	11	35
Oregon	11	23	34
Pennsylvania	20	28	48
Philippines	4	3	7
Puerto Rico	0	1	1
Rhode Island	1	0	1
South Carolina	1	13	14
South Dakota	5	4	9
Tennessee	2	15	17
Texas	29	***81****	110
Utah	5	3	8

Vermont	4	3	7
Virginia	11	17	28
Washington	23	36	59
West Virginia	10	13	23
Wisconsin	11	7	18
Wyoming	2	5	7
No State	71	120	191
Total	**686**	**969**	**1655**

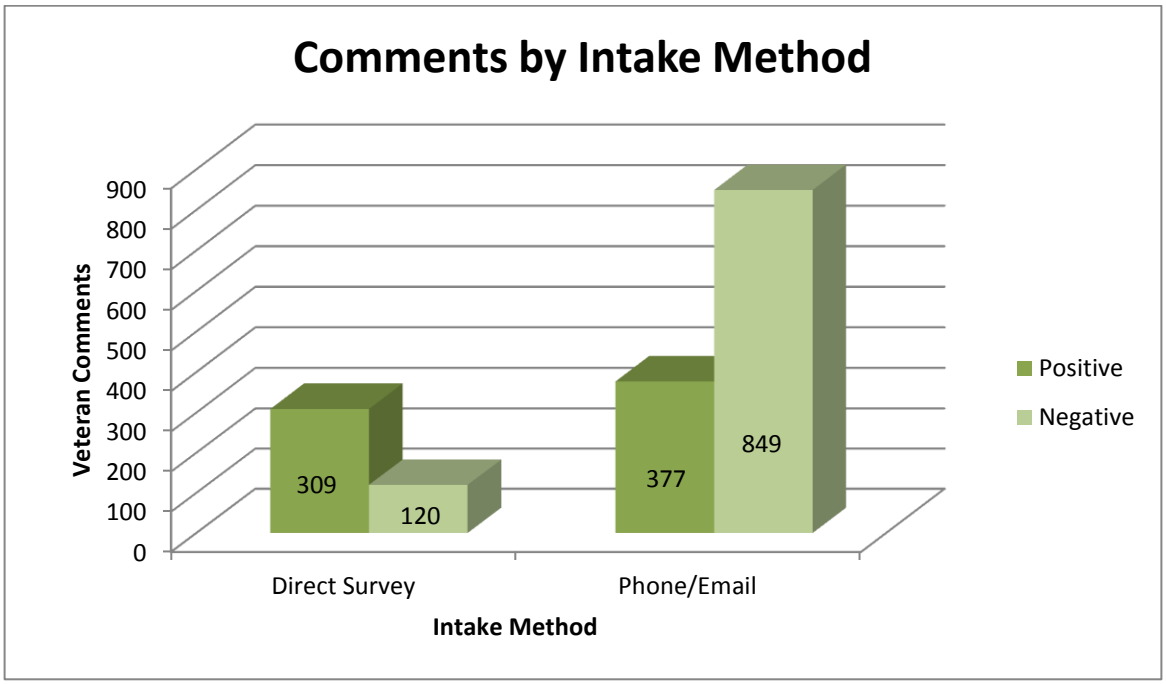
Negative-Leaning States

Positive-Leaning States

*** Highest Comment Volume**

Survey data as of August 25, 2014

Appendix II: Ratio of positive and negative comments based on intake method as of August 25, 2014. In-person directed surveys yielded more positive comments. Data comparison included below:



Intake Method	Positive	Negative	Total
Directed Survey	309 (72%)	120 (28%)	429
Phone/Email	377 (31%)	849 (69%)	1226

Survey data as of August 25, 2014

Hurry Up and Wait:
The VFW's Report on the State of VA Health Care

September 2014

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www.vfw.org

Washington DC Office
200 Maryland Ave., N.E.
Washington, D.C. 20002
202-543-2239

National Headquarters
406 West 34th St.
Kansas City, MO 64111
816-756-3390