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Exposed By Phoenix: Veterans Health Care in the Age of Operations Enduring Freedom and Iraqi Freedom

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Exposed By Phoenix: Veterans Health Care in the Age of Operations

Enduring Freedom and Iraqi Freedom

by

Andrew Bogardus

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Table of Contents

Abstract.....3

Introduction.....4

Pressures on Veterans’ Mental Health Caused
by Operations Enduring Freedom and
Iraqi Freedom6

OEF/OIF: The Physical Casualties.....12

Barriers to Veterans’ Access to VHA Care.....15

Beneath the Surface:
VHA Issues Prior to the Phoenix Scandal.....25

Phoenix.....29

In the Spotlight: House and Senate Response
to the Phoenix Scandal.....36

The Veterans Access, Choice and Accountability Act
Summary and Conclusion.....42

Citations.....45

Bibliography.....50

Abstract

When the scandal at the Phoenix Veterans Health Administration facilities came to light in 2014, it exposed systemic problems throughout the VHS, some of which had existed for long periods of time and some more recent. This essay explores why the VHA was ill-equipped to handle effectively the challenges in veterans' health presented by Operation Enduring Freedom and Operation Iraqi Freedom, both of which were much more protracted than initially expected. Both conflicts generated more veterans with more challenges than anticipated by the U.S. government. The Veterans Access, Choice and Accountability Act of 2014, an example of motivated b-partisan negotiation and work, was designed to address the flaws exposed by the Phoenix scandal and this paper describes the lead-up to the signing of this act as well as its potential for success.

Introduction

In August of 2014, President Obama signed legislation designed to change forever the health care provided by the Veterans Administration. Only four months earlier, scandal had emerged at the Carl T. Hayden Medical Center in Phoenix which laid bare a nation-wide system that was itself sick. Veterans across the country were waiting dangerously, and in some cases fatally, long periods of time for primary and specialized appointments; their plights were then being masked by deceitful record keeping. Instead of readily accessible care, veterans who most needed it were often having to fight through frustrating layers of delay and ineptitude in order to get the care promised them. Meanwhile, veterans were returning from Operations Enduring Freedom and Iraqi Freedom having experienced unique pressures and with a complicated set of needs including high rates of polytrauma and mental health needs. As these conflicts continued to grind on, suicide rates remained high and were a terrible illustration of the urgency of many veterans' needs. Delayed, inconsistent and inaccessible health care was undermining the nation's ability to provide for its veterans. With the conflicts lasting significantly longer than estimated, the cost of care mounted and made solutions seem further out of reach. The extent of the issues was masked intentionally as administrators were focused more on minimizing the evidence of the problems than on collecting information that would provide true measurements. Administrators' bonuses were

largely based on how their efficiency was assessed and they therefore were motivated to provide information that would lead to the most favorable evaluations. Within a system that was already overtaxed by the needs of OEF/OIF veterans and the overall volume associated with being the largest health care provider in the U.S., these administrators served to exacerbate the problem.

Once the Phoenix scandal gained national publicity, the extent of the problems that came to light were shocking. Questions were numerous and intense as people grappled to understand how this point could possibly have been reached. In addition to the general public, members of both parties tried to answer questions about who and what were responsible and they quickly positioned themselves to present the most effective solutions. Was the VHA system resource deficient and simply unable to meet the huge demand for VA health care, even though less than half of eligible veterans were enrolled? Would the elimination of pervasive corruption and inefficiency allow for the savings needed to fuel the reforms necessary to cure the system? Were the goals of the VA unrealistic and did the provision of care for our veterans need to be a blend of private and VHA care? Everyone agreed that solutions needed to be enacted expeditiously. Members of both parties and the general public were all unified in intent. The result was an impressively bi-partisan piece negotiation and legislation designed to increase access, choice and accountability.

Pressures on Veterans' Mental Health Caused by Operations Enduring Freedom and Iraqi Freedom

Over time, the needs of the veteran community naturally evolved during periods of peace. However, the United States' involvement in Operation Enduring Freedom and Operation Iraqi Freedom created a new list of pressures and needs for returning veterans. There are aspects of both OEF Freedom and OIF that have led to consequences for members of the U.S. military and therefore a new set of responsibilities for the VA in caring for veterans. One characteristic of these conflicts is the kind of mental, emotional toll that they have taken on soldiers. In both arenas, soldiers have experienced kinds of trauma and stressors that are distinctive from previous wars. One significant source of mental and emotional stress was the fact that extreme violence has not been limited to combat zones. In both conflicts, there existed the constant possibility for soldiers to be subjected to, or witness to, violence at any point, not just while on patrol. There was a threat of attack during missions, while en route to or from missions, while on base or while conducting humanitarian work. There is also constant uncertainty with regard to the allegiances of the civilians even while these civilians also bear the brunt of much of the violence. American soldiers therefore witness atrocities that are visited upon civilians and yet they also have to live with the stress that every civilian is a potential threat to them. As a result, there is little chance to escape from the stress and a very high percentage of soldiers are exposed to scenes of violence. Upon return home, these veterans bear the burden of their memories; some are able to absorb them and even use them to their advantage, some are debilitated by them and some bury them. For today's soldiers in the U.S. military, the conflict is often not left behind in Iraq and Afghanistan. Instead, its

images live on in ways that are interfering with the lives of many veterans and their families. This leaves the military with many questions to answer. Why are so many soldiers suffering the effects of these memories and how can more effective supports be put in place for these veterans who have witnessed such violence? The topic is worthy of the highest priority since our soldiers and their families are being insufficiently prepared for their return from combat. This is a topic for the VA but also for society as a whole so that an environment can be created where the chances are maximized that veterans can live with their memories and successfully reintegrate and lead fulfilling lives. The U.S. armed services is at a critical juncture with regard to caring for, and sustaining, its troops who bring home painful memories from Iraq and Afghanistan at a rate that may be higher than any war in history.

While the effects of combat on individual soldiers are obviously unique, there are aspects of the warfare being conducted in Iraq and Afghanistan that affect all soldiers and that create a context within which the intensity of memories are exacerbated and often play a more significant role upon veterans' return to the home front. There are pressures involved in combat in both arenas that have created a consistency of strain on soldiers throughout deployment during combat operations and while at base. Today's technology allows, and necessity dictates, that operations are carried out at all times of day.¹ This, in turn, eliminates predictability, preventing proper rest and heightening the age old issue of sleep deprivation and exhaustion that soldiers have always faced. Other factors inhibiting rest and augmenting strain are the immediacy and constancy of life threatening situations. The methods of opposition to U.S. forces are not limited to the battlefield and they include improvised explosive devices, suicide bombing and mortar attacks, all of which are pervasive in a way that makes them nearly inescapable during a deployment. As a result, there is no safe form

of transportation, particularly on the ground. Routine operations such as checkpoints are dangerous in ways as never before, particularly with women posing equal threats as men and with the presence of children not being a preventative in these attacks. [Note: This is not to imply an absence of civilian casualties, including children, in U.S. and NATO operations] In fact, the overall combat situation involves target confusion such that members of the population can be potential attackers and yet also be the people whom soldiers are meant to help. And the situation can change with the time of day as friends in need of help during the day are attackers at night. Additionally, with the regularity of attacks on bases, checkpoints and transportation, there is no separation from the threat of injury or death anywhere inside the theater of war, even outside the actual combat zones. In effect, soldiers are still within a life threatening situation even when they step away from being directly involved in combat operations. Instead of only those soldiers on patrol, conducting missions or located at the outposts facing hostile fire, according to Eric Massa, the special assistant to former Supreme Allied Commander General Wesley Clark, "...nearly all our service members in Iraq are being exposed to constant fear... on a 24/7 basis for periods often lasting over a year at a time. The constant fear of dying is overwhelming and it is taking its toll".² In essence, this working environment, one that involves constant fear and proximity to extreme violence, creates a high likelihood of vivid, potentially damaging memories being created that will require attention and intentional processing at home.

The constancy of fear within each deployment is compounded by the fact that the duration of a "tour" is no longer clearly defined. With armed services that are voluntary and therefore limited in scope, and yet stretched thin across the world in multiple directions, soldiers often face multiple deployments or extensions. In addition, the span between these

deployments is often relatively brief. As noted in a study by the RAND Corporation, “Not only is a higher proportion of the armed forces being deployed, but deployments have been longer, redeployment to combat has been common, and breaks between deployments have been infrequent”.³ Inevitably, this leads to insufficient time for the veteran to recover fully from the initial deployment. Even worse, if an upcoming redeployment is expected, a soldier may never truly return home, in the sense of being present and reconnected.⁴ In essence, this can create a situation where fear of death is constantly heightened during deployment and then is not given time to dissipate effectively, or at all, in between deployments. Between the lack of a true front line in these wars and with longer, multiple deployments, there is heightened mental and emotional stress on veterans returning from Iraq and Afghanistan.

For the United States military, an additional hallmark of the conflicts in Iraq and Afghanistan has been the high number of National Guard and reserve troops that have been deployed, comprising 40% of U.S. fighting forces in Iraq (before combat troops were pulled out) and 50% of the force in Afghanistan.⁵ While facing many of the same traumatic experiences as other troops, reservists, National Guard members and their families are often less equipped to handle the burden of traumatic memories that accompany many of the returning soldiers. Not only is there less training ahead of time but the entire context of deployment is often more unsettling for those who are not full time service members as they, “...often experience greater levels of family and occupational disruption during deployments” (Erbes Polusny 973)⁶. Many families in this situation actually had not expected the spouse and/or parent to be deployed to a combat situation so there is an abruptness and lack of preparedness. With reservists representing a larger percentage of those suffering the effects of OIF and OEF, and with the characteristics of the kind of trauma

that all veterans face in these conflicts, there is a need for new types of planning and care for veterans to address what has been an increasing number of mental health diagnoses since the beginning of these conflicts in March 2003.⁷

The stresses that soldiers have faced during OIF and OEF have created an evolving, and growing, set of needs upon their return. Researchers at the RAND Corporation estimate that, of the 1.5 million returning veterans, fourteen percent have screen positive for post-traumatic stress disorder and fourteen percent for major depression.⁸ Veterans returning from OEF/OIF are two to three times more likely to suffer some level of PTSD and depression than were the veterans who returned from previous wars. Of course there higher levels of awareness and detection but regardless, there is an increasing need to provide effective care for these issues. Within the veteran community as a whole, there are sub-groups that have varying levels of need. A veteran under the age of 25 is twice as likely to suffer the effects of PTSD and yet reservists over the age of 40 are even more prone to this condition than are their younger counterparts. While reservists are at higher risk for mental health diagnoses, active duty veterans are at a higher risk for alcohol and drug issues, though there are significant levels of each present in both groups. Overall, from April 2002 to March 2008, new mental health diagnoses for all returning veterans increased from 6.4% to 36.9%. The percentage of mental health issues that included psychosocial and behavioral issues went from 9.1% to 42.7%.⁹ This creates a need for agile, targeted support and preventative measures since, “Targeted screening and early intervention with evidence-based treatments tailored to the problems of particular sub-groups of OIF/OEF may be the best defense against chronic mental health and social and occupational problems”.¹⁰ Given the high levels of diagnoses that have emerged since the start of the Iraq war, there is an

exacerbated need for ready access to care that can address immediate, urgent mental health needs and that can provide longer term, preventative care. A separate issue within the VA is that a number of veterans have been diagnosed with personality disorders instead of PTSD which consequently leaves them ineligible for VA treatment.¹¹ This can be rectified either by changing diagnosis codes or by establishing a connection between this issue and the pressures of combat and therefore leaving these veterans with access to VA care. The strains of OIF and OEF have created a new combination of needs in the veteran community and, as discussed below, the key element of successful care for this group is making care accessible in every sense of the word, such that veterans are aware of options and are able to secure appointments. As the 2014 scandal in Phoenix laid bare, access is exactly what was lacking.

OEF/OIF: The Physical Casualties

In addition to the mental health toll that OIF/OEF has taken on veterans, these conflicts have also changed the nature of the physical wounds that are accompanying returning veterans. This obviously changes the nature of the care that needs to be provided since, “The combat experience of U.S. military personnel in the irregular warfare of OIF/OEF presents unique challenges and paradigms that have not been encountered to such an extent in the history of American military medicine.”¹² The type of warfare in which U.S. forces are engaged, which lacks defined front lines, and often lacks uniformed enemies, means that most combat casualties are the result of ambush and frequently are the result of improvised explosive devices (IEDs), mortars, rocket-propelled grenades and landmines. This is significantly different than previous armed conflicts which were largely, other than parts of the Vietnam War, fought along the lines of traditional large scale warfare.¹³ The evolution in the way that the casualties have been inflicted, compounded by improvements in protective equipment since the Vietnam War, in turn has changed the casualty rates and wound patterns that have emerged.

The ratio of wounded in action to killed in action can provide some level of measurement of enemy effectiveness as well as the efficacy of combat medical care and the type of wounds being inflicted. With advances in evacuation methods, the ratio of wounded to killed, which can be called the survival rate, increased significantly from World War II to the Vietnam War and then continued to increase in OIF/OEF due to improvements in medical care and body armor.¹⁴ The case fatality rates for U.S. troops in World War II hovered at 19.1% and this was reduced to 15.8% in Vietnam and then between 8-10% in OIF/OEF.¹⁵ As a result of the change in the type of conflict, as well as the U.S. military’s protective technology, the type of

casualties suffered, or wound patterns, have also changed. In World War I, 65% of all combat casualties were the result of gunshots. This decreased to 35% in Vietnam and now the latest studies of OIF/OEF indicate that ballistic trauma represents between 16%-23% of casualties with the remainder being the result of explosions.¹⁶ With the improvement in body armor, including body coverage and ability to deflect projectiles, thoracic injuries have dropped significantly while the incidence of head and neck injuries have doubled since the Vietnam War. The injuries that are due to explosives are often more complex, involving multiple entrance and exit points and require different care. These polytraumatic wounds often require both highly complex immediate care as well as rehabilitation. Accompanying the higher percentage of wounds resulting from explosives instead of ballistics is the increased prevalence of traumatic brain injuries, with 19% of casualties resulting in some level of TBI. In addition to complex care, there is the need for increased levels of research in order to better understand the most effective to provide care and rehabilitation. Finally, an emerging characteristic wound pattern is the increase in amputations and the need for prosthetics. Previously, thoracic bullet wounds were more likely to be fatal- therefore rendering amputation irrelevant- but with new body armor, most wounds are to the extremities. With the improvements in wound care, evacuation rates and hemorrhage control, soldiers are more likely to survive even if limbs need to be amputated.¹⁷ These new wound patterns among veterans, combined with the levels of mental trauma characteristic of OIF/OEF, create a new landscape of needs for the VA to consider, especially since it is younger veterans who are more likely to enroll and take advantage of health care provided by the VA. The combination of stresses on the personnel involved in OIF/OEF represent a new

formula of needs being created, not just on the battlefield but also, and possibly more dramatically, in the care provided at home.

Barriers to Veterans' Access to VHA Care

With the return of high number veterans enduring polytraumatic wounds as well as significant mental health concerns, the need for health care accessibility is as important as ever. Especially with the nature of the wounds, both physical and mental, there is a need for veterans to have ready access to care that is tailored to their needs. In order for the VA to provide the highest quality and most cost effective care, there is a significant benefit if veterans make exclusive use of VA health care since it allows for consistency of records and predictable utilization of services.¹⁸ For a complex set of reasons, however, a surprising number of veterans are either not enrolled in the VA health care system or do not make full use of the services provided.

At the beginning of OIF/OEF, only 23% of veterans meeting eligibility requirements were choosing to use VA health care. While some of these veterans choose to use other care, it is still an important question as to why so many do not use it even when it could notably benefit them. Since the actual quality of care is often, though certainly not always, of high quality, the significant number of people opting not to utilize it indicates the existence of preventative factors. Although the number of veterans availing themselves of VA health care on some level has risen significantly since 2003, it remains under 50% and there are still barriers that prevent a higher percentage of those eligible from using the services to which they are entitled. These barriers have more layers than might be apparent at first glance.

At the start of OIF/OEF, there were a number of significant barriers to veterans' full utilization of VA health care. A study published in *Military Medicine* focused on veterans' perceptions of the reasons behind these barriers in an attempt to discern whether they were

related more to accessibility or acceptability of service in the eyes of the consumer. Across veterans of all different conflicts and ages, distance to a VA health center was the most obvious barrier to use. For some segments of the veteran community, this was a very difficult obstacle, particularly those requiring specialized care such as that necessitated by spinal cord injury, which exacerbated the chances that distance from care would be a preventative factor.¹⁹ However, several other factors played significant roles as well.

Regarding the quality of the actual health care, there was a full range of opinions but there were consistent strains that emerged with regard to accessing that care. Waiting times and unreliability of appointments were consistently recognized as inhibiting factors, as they would continue to be for years to come. However, a stronger point of emphasis was the lack of accurate awareness and information about benefits and how to access entitlements. There was a strong perception that many of the veterans most in need of benefits were either unaware of how to access the benefits or whether they were eligible for them. In many cases, they were not even aware of the benefits in the first place. There was a consistent call, across all groups, for a central information clearinghouse and more of an effort to reach all constituents in need of care, especially those who might be more challenging to reach, such as the homeless. There was frustration with a perceived lack of effort on the part of the VA to assist veterans in accessing care. One veteran expressed a consistent opinion when he expressed his desire to be told, “Hey, these are all your benefits. This is what you can have.’ I would like to just see one person...be honest about how the system works... Because you’re constantly finding things by accident over there.”²⁰

While veterans may feel entitled to the care provided by the VA, there is often a perceived stigma about making use of it. Fear of stigmatization and the concern about being

perceived as abusing a form of welfare when using VA health care was a major factor. In order to ameliorate this, an important factor was the respect and care demonstrated not only by health care providers but also those involved in every step along the way. While this seemed to have varying levels of significance for different age groups and demographics, the acceptability of service was directly related to elements of customer service which were closely connected to respect. A perceived lack of respect would not just be undesirable but an actual barrier to veterans' access to care. In general, it was not just geographical proximity to care that presented a barrier but also lack of information, fear of stigmatization and lack of respectful assistance that were equally, if not more, to blame as barriers to great access to VA health care for veterans.²¹ By utilizing more effective outreach and creating a culture of respect and welcoming, veterans would in turn make more consistent use of VA health care.

As the needs of veterans returning from OIF/OEF have evolved, there is not just a need for access to care but often, due to a higher number of polytraumas as well as mental health issues, a need for specialized care. Hence, barriers to access become even more detrimental to the chances of veterans' exclusive use of VA care. With the existence of just one barrier, veterans were twice as likely not to use VA care exclusively and if distance were the barrier then the chances were seven times less likely.²² Ten years after the start of OIF, some barriers remain consistent and some have become magnified. In a study of veterans returning from OIF/OEF with polytrauma, the barrier most commonly identified was the frustration with wait times (26.7%) followed by concerns about staff reputation for care (15%), fear/stigma (13.9%), distance (12%), paper work (10.3%) and lack of information (9.5%).²³ Although this is not a direct comparison with the previous study, it appears that lack of

information diminished to some extent as a prohibitive factor. However, wait times were obviously creating a lack of faith in the system and a hopelessness about accessing care.

Since 2002, the enrollment in the VA of those OEF/OIF veterans eligible for its services has hit 42%, an historic high compared to the 10% of Vietnam veterans enrolled.²⁴ While it is encouraging to see such an increase in enrollment, there are associated pressures that were apparent since the early stages of these conflicts and which present mounting concerns and the need for planning as soldiers have returned as veterans. During the first six years of the conflict, the prevalence of mental diagnoses among OEF/OIF veterans increased from 6.4% to 36.9%.²⁵ The rate of psychosocial and behavioral problems that accompanied these mental health diagnoses rose from 9.1% to 42.7%. Not surprisingly, PTSD increased most significantly, followed by depression. Of note is that veterans were not necessarily receiving diagnoses immediately upon their return. As time passes and readjustment issues emerge for veterans, there is a rise in the percentage of those receiving new mental health diagnoses. In a four year study of a large cohort of returning OEF/OIF veterans, 14.6% received a new mental health diagnosis in the first year and the percentage went up to 20.3% after two years and then to 27.5% after four years. This is obviously concerning with regard to veterans' readjustment to life after these conflicts. While a surge in mental health diagnoses are predictable to coincide with the start of a major conflict, OEF and OIF are presenting new levels of pressure on the VA with regard to mental health issues. Is it possible that veterans feel less stigma in having their symptoms addressed? This is a possibility but there is also compelling evidence, as discussed previously, that these conflicts have been inordinate mental strain on U.S. soldiers, resulting in a high level of mental health issues. Paul Sullivan, a leading veterans advocate, summarizing the effects of OEF/OIF: "The signature

wounds from the wars will be (1)traumatic brain injury,(2)post-traumatic stress disorder,(3)amputations and (4)spinal cord injuries , and PTSD will be the most controversial and most expensive.”²⁶ Even with greater efforts being made at raising awareness about treatment options for these issues, however, there is a lack of availability to address the problem. In a 2006 edition of *Psychiatric News*, Dr. Frances Murphy, the Under Secretary for Health Policy Coordination at VA clearly laid out that many VA facilities simply did not have mental health and substance abuse care and the facilities that were equipped were rendered nearly inaccessible by waiting periods.²⁷

With the conflicts lasting much longer than predicted, the pressures on the VA have snowballed. At the same time, these conflicts’ protracted nature lays bare the need for the VA to eliminate as many as possible of the barriers to care that have impeded veterans from accessing the care for which they are eligible. While some veterans choose other care and there is a higher percentage enrolled than for Vietnam veterans, the fact that more than half of eligible OEF/OIF veterans are not enrolled for VA care is distressing. The persistently high level of mental health issues among those veterans who are enrolled is particularly troubling when one considers the high number of veterans who are not enrolled and therefore may or may not be receiving care for these critical issues. With this in mind, there is an exaggerated need for the VA to focus on the elimination of barriers to care as well as on outreach in order to ensure that as many veterans as possible are receiving necessary treatment. With the nature of the mental health needs being generated by the aftereffects of OEF/OIF, the benefits of reaching veterans is critical not only for the veterans themselves. Given the psychosocial and behavioral issues often linked with PTSD, depression

alcohol/drug abuse, effective care for veterans obviously has an immediate benefit for their families and avoids costs to society as a whole.

Inextricably linked with the increase in mental health diagnoses is a disturbing rate of suicide among veterans. With twenty two veterans committing suicide every day, the need for a comprehensive, collaborative approach is imperative. While the rates differ within groups of veterans from various conflicts, and therefore by age, the need is apparent across the board and the rate among OEF/OIF veterans has remained consistently higher than that of civilians.²⁸ Through 2007, the suicide rate for OEF/OIF veterans was 21% higher than for the general population.²⁹ This presents the need for both the study of underlying reasons and for implementation of effective preventative measures. The distinctive set of pressures on soldiers involved in OEF/OIF play a role in this high rate, as is reinforced by the fact that the highest risk category is for those soldiers who deploy. With the prevalence of multiple deployments of unpredictable duration, the risk rates only increase. Unfortunately, the irony of the higher combat survival rate in OEF/OIF is that it is to some extent offset by this higher suicide rate. Additionally, there is the distinct possibility that the military is exacerbating the risk of higher suicide rates in its attempt to conserve fighting strength, of greater importance in a volunteer army, with an elevated rate of psychotropic prescriptions.³⁰ This could temporarily mitigate conditions that would surface later, especially if not effectively monitored upon soldiers' return.

In order to address the issue of elevated suicide rates, there is a need for a comprehensive understanding of the scope of the problem in order to assess patterns and the efficacy of efforts to address the issue. Currently, there is no nationwide surveillance system for suicide among all veterans. The VA does not have information about the suicides of those veterans

not enrolled in VA, unless states provide it, which happens on a voluntary basis. In fact, it is the CDC that gets reporting on veterans not enrolled with the VA and currently, it only receives information from less than half of all states and even among this group the reporting is inconsistent.³¹ At this point, a true suicide database would require the collaboration, among other agencies, of the VA and VHA with the Department of Defense, Health and Human Services and the CDC. There are a multitude of reasons that suicide data needs to be centralized and studied. The rate itself needs to be verified, along with the associated risk factors, so that the most effective screening methods can be established.³² This would then allow targeted suicide prevention programs to be implemented and subsequently validated with regard to efficacy. In an effort to better understand suicide pattern, the VHA has instituted a Behavioral Autopsy Program for each veteran suicide of which the VHA is aware. Each report consists of an interview of the last clinician to see the deceased, a review of health charts and public records that might have been stressors (bank records etc) as well as interviews with family members.³³ While these reports would surely elicit useful information, thus far they have been not been consistently completed, or submitted, with a standard level of accuracy.

While there is much that the VHA can do to address this problem, starting with consistent gathering and assessment of information, inter-departmental collaboration is essential because of the number of veterans who are not receiving VA care and who might have critical need for it. As previously discussed there are a number of barriers to veterans enrolling for VA care or taking full advantage of VA care. However, there are also a number of veterans who are intentionally prevented from receiving this care because of counter-productive military policy. When veterans separate from the military under conditions

“Other than Honorable”, they are not eligible for the benefits that are often critical to their health needs and successful transition to civilian life. Often, the behavior that causes a veteran’s discharge to be classified as “Other than Honorable” is connected to issues stemming from PTSD or depression or TBI (traumatic brain injury).³⁴ These conditions can increase the likelihood of behavior considered to be petty crime. In the civilian world, behavior that would likely lead to the provision of mental health treatment, can result in a veteran being classified in a way that precludes access to the treatment. Most startling is the fact that suicidal behavior can be considered reason for a discharge that would disqualify the veteran from VA benefits. If an active duty service member attempts suicide and therefore receives a “bad conduct discharge”, then there are no subsequent benefits. Hundreds of service members have been discharged for “personality disorder” after seeking PTSD treatment and were subsequently ineligible for benefits. This happened to Army veteran Jonathan Town who testified to the House Veterans Affairs Committee in 2007 about his experience seeking treatment after suffering PTSD symptoms following a rocket attack in 2004. He was told by a doctor that he would be treated but after being discharged for the personality disorder, he did not receive benefits.³⁵ By displaying the behavior that actually provides evidence of an increased level of risk, many veterans are then denied access to treatment because of the rigidity of the classification system. If the discharge classification system is to remain unchanged, then a reasonable adaptation to this quandary would be for the VA to provide care to those veterans whose “Other than Honorable” discharge is for reasons, whatever they may be, that are connected to their service. The intensity of mental health stresses for service members involved in OEF/OIF creates the need for an agility on the part of the military in assisting veterans to have the healthiest, most productive return to

civilian life. Of the veterans who do use VHA services, more than 60% of those who commit suicide have a diagnosed mental health condition.³⁶ Preventing veterans from receiving benefits because of behavior that, while not desirable, is likely the result of service runs counter to the mission of the VA and is detrimental to veterans, their families and to society as a whole. There are already 950 suicide attempts per month among veterans receiving VHA care which can only mean that the numbers are very high among those not receiving care.³⁷

While insufficient in many ways, the VA has instituted a number of approaches in an attempt to address high suicide rates. The most prominent is the crisis line, which is available 24/7 to all veterans and has addressed over 20,000 active suicide situations. There are also two new centers devoted to research, education and clinical practice in suicide prevention. Each VA medical center has a Suicide Prevention Coordinator and system for flagging and tracking patients identified as high risk. In addition, the VA is engaging in increased levels of outreach. These efforts are relatively new and include public service announcements and display ads calling attention to the hotline and services designed to reach veterans earlier in the emotional crisis cycle.³⁸ This is a great improvement, considering the fact that prior to the Veterans' Benefits Improvement Act of 2008, there was a VA policy of not advertising benefits or services by television.

Any efforts that direct veterans to an outlet like the hotline and that generate awareness about access to benefits are critically important. And yet, there are still myriad steps that need to be taken. Outreach needs to be targeted toward all veteran audiences including ones that might be more challenging to reach. For some groups, television might not be the most effective medium. Messaging should be visible in public areas and on public transportation

and in clinics and health centers and well non-VA hospitals. Expertise should also be gleaned from any source possible, such as Veteran Service Organizations and other community organizations. These smaller operations have more of an opportunity for creativity than the VA and analysis of the successes and failures can provide critical information for more evidence-based decisions and policies. Of critical importance is the information that can be yielded by developing a metric that would effectively measure suicide rates of veterans enrolled in programs outside the VA. This is the only way to measure comprehensively the success rates of different approaches. Although the rhetoric of the armed services would indicate that any one suicide is considered one too many, the issue is way too broad in scope to avoid a multi-faceted, adaptable approach. The VA has taken good steps but is still not sufficiently pro-active or creative enough considering the magnitude of the problem. At the same time, even if all this research were done effectively and there was good collaboration between government organizations and with VSO's, it is rendered ineffective if care is not provided in a timely fashion and with consistency. Long before the 2014 scandal in Phoenix, there were clearly identified issues with regard to delays in VA health care. In 2012, there were 911,000 veterans waiting for disability compensation or access to VA health care. With the urgency of many of the individual cases, these delays mitigate the effectiveness of the increased outreach and other measures recently be taken by the VA. The Phoenix scandal brought the effect of these delays to light.

Beneath the Surface: VHA Issues Prior to the Phoenix Scandal

While the 2014 scandal in Phoenix thrust VA health care into the national spotlight, there were a long list of issues that were well documented prior to this scandal. Most of the issues were seemingly related to the volume of casualties, physical and mental, that were emerging from two conflicts that were grinding on much longer than anticipated. As the costs mounted, and administrators looked to contain them, it became more difficult for soldiers to be rated at disability that would enable them to get support levels commensurate with their injuries. Sergeant Garret Anderson of the National Guard represented many others with his plight. He lost an arm, had a traumatic brain injury and significant shrapnel wounds and yet was only rated at 90% disabled which in turn meant that he received \$1,600 per month instead of \$2,600. This occurred because the VA said that shrapnel was not mentioned in his wound report and yet his rating was also most likely directly related to misguided cost containment. Meanwhile, other veterans had reenlistment bonuses withheld after their wounds prevented them from reenlisting.³⁹ As early as 2004, the Veterans Disability Benefits Commission, created by Congress, identified a strong incentive in the Department of Defense to minimize ratings in order to preclude the associate cost of ongoing support.⁴⁰ While praise for the care of serious injuries remained strong, access to this care was the problem, especially when cost concerns put it out of reach.

Even as early as 2006, it was apparent in numerous studies that DoD and VA were unable to manage the mental health service needs that were emerging out of Iraq and Afghanistan.

By 2006, veteran support groups had identified this as an issue of the highest order. Veterans for Common Sense filed a class-action suit in California on behalf of veterans in order, "... to increase capacity so that veterans see the doctor right away," and with the warning that, "If we don't fix that now, there will be a social catastrophe- alcohol abuse, drug abuse, DUIs, homelessness."⁴¹ Similarly, while the Government Accountability Office provided an estimate of returning troops at risk for PTSD that was relatively low, 22%, it still pointed to evidence showing that there was an inability to care for these soldiers since the, "Department of Defense cannot provide reasonable assurance that... service members who need referrals receive them."⁴² This was particularly problematic because of the two year window for automatic eligibility for care. If symptoms were not identified because of delayed appointments and only surfaced urgently after the expiration of the window, a veteran faced the possibility of being ineligible for VA care. This was a driving force for the window being extended to five years as part of the National Defense Authorization Act of 2008, which made eligible for care all veterans whose discharge was "other than dishonorable". By 2010, it did not appear that these problems were being alleviated, with a report on the long term costs of veterans' care stating plainly that, "... the largest unmet need is in the area of mental health care."⁴³ This problem meeting mental health needs was lodged with a general inadequacy of preparation for the waves of servicemen returning from Iraq and Afghanistan. Between insufficient claims processing capacity and a lack of available health personnel at clinics or financial preparation to cover the new entitlements, it was veterans with mental health concerns who were most likely to be at risk.⁴⁴ The fact that this was the case in an environment where suicide rates among veterans were remaining consistently elevated was all the more troubling.

While both government and non-government organizations were cataloguing the issues that were emerging in providing timely and effective care for veterans, there were also issues surrounding the question of how to measure effectively the services provided by the VA. With veterans often using a combination of health cares and with patients' needs varying so widely, the VA focused more on process measurement than on health outcome measurement. It was easier to measure the completion of procedures than to measure their effectiveness. This is one of the reasons for the VA's focus on tracking waiting times for appointments. While this kind of information should have been clear cut and straightforward, it was apparent as early as 2007 to the VA Inspector General (IG) that data on waiting times was not reliable.⁴⁵ In large part this was because the measurements would not be favorable, either to the VA as a whole or to the directors whose bonus payments were influenced by efficiency measurement, as discussed below.

Although there are countless examples of egregious VA inefficiency and lack of effective care for today's veterans, the institution as a whole has been in need of change and reform ever since its inception. After World War II, the VA expanded dramatically to the point where it was the largest health care provider in the United States. It was designed largely for inpatient treatment, and hence the accompanying explosion of hospital construction created a glut of facilities without the necessary trained medical personnel to allow them to function at capacity.⁴⁶ One infamous example was the superfluous hospital built by the Army in Honolulu when a Navy hospital already existed there that had enough capacity to handle the entire region. Meanwhile in the New York City region, there was such excess that it would have been possible to close four large Navy and Air Force facilities without reducing the level of care provided for patients.⁴⁷ As medicine shifted to more of an emphasis on

ambulatory care, the VA facilities were slow to adjust and maintained a high proportion of inpatient care, with unnecessarily long hospital stays, until the 1990's by which time a series of reforms had been introduced. However, the 21st century has brought with it new pressures that necessitate further evolution.

In 2014, the VA's health care system was facing an ongoing challenge in accommodating its patients with timely care. The system had never fully, or at least successfully, made the shift from its initial inpatient design to one where primarily ambulatory care could be given efficiently and effectively. There were a number of pressures that were mounting within the VA. As veterans from the Vietnam War were aging, their needs were shifting to more of an emphasis on chronic care and cancer treatment. On the other hand, younger veterans were returning from OEF/OIF with needs that were specific to those conflicts, including high rates mental health needs, polytrauma and amputations from explosions. Many of these younger veterans required ready access to the VA in order to transition successfully to civilian life, especially if symptoms only manifested upon their return or if their wounds required significant support in order to function in civilian life. The combination was stretching a system that had never been able to adapt sufficiently in order to address efficiency issues. This said, the lengths that were taken by officials at the VA facility in Phoenix in 2014 exposed not only systemic inefficiencies but also the disturbingly unethical lengths that people were willing to go to in order to mask the delays and backlogs that were not only frustrating but were dangerous to veterans' health.

Phoenix

By the end of 2013, Dr. Sam Foote, an internal medicine physician and long-time employee at the Phoenix, retired. He did so in order to go public with his extensive list of allegations about the VA's intentional manipulation of scheduling records in order to mask wait times that were exceedingly long and were significantly damaging to the health care being provided. Doctors and medical personnel were working overtime but were unable to keep up with caseloads. Hospital administrators, on the other hand, were motivated to mask the issues because they would endanger their compensation bonuses that were based on demonstrating scheduling efficiency. Over the years, the VA's tendency to measure process instead of outcome had evolved to an extreme level. In Phoenix, and across the country, these process measures were used in determining extensive pay bonuses for administrators. These bonuses had been questioned over the years and the VA OIG even investigated their appropriateness in 2010, ultimately questioning the appropriateness of 80% of them.⁴⁸ Given the well documented extent of waiting time issues, it was predictable that these compensation bonuses exacerbated administrators' desire to mask wait times. Sharon Helman, the Phoenix VA Health Care System director, implemented the Wildly Important Goals program, for which cutting wait times was at the top of the list. The irony of this would become apparent when the litany of waiting time issues were illuminated. While Dr. Foote had lodged complaints previously, they did not get any traction and if anything, he felt that they had negative consequences for him and therefore he decided to make them more public. Without faith that the Office of the Inspector General would go far enough, he contacted *The Arizona Republic* and offered to help with an investigative project.

The extent of issues that were uncovered by the newspaper and by the VA Office of Inspector General was staggering. A CNN investigative report reported that there had been 40 veterans who had died while waiting for appointments. They had been placed on a secret waiting list and when they died, they were simply removed from that list with no record that they had been waiting. This represented a common ploy where patients were placed on waiting lists that were off record and outside the federal electronic tracking system until an appointment slot became available and then they were moved onto an official list within fourteen days of the appointment in order to give the appearance of staying within the target wait time from the time of the initial request for an appointment. The VA acknowledged at least 18 of these deaths and subsequently the FBI initiated a criminal investigation into whether or not hospital officials lied about wait times in order to receive performance bonuses.⁴⁹ As the Inspector General dug deeper, it was discovered that at least 1,700 veterans were waiting for care on lists that were outside the official system and that veterans were waiting an average of 115 days for their first primary care appointment, significantly longer than the 14-day goal set by the VA and the 24 days reported by the Phoenix administrators.⁵⁰

As Dr. Foote's allegations gathered national attention, individual incidents came to light that reinforced the broad based problems that he was describing. In one extreme case, a Navy veteran was sent home from the emergency room even though his case was noted as urgent. His family called repeatedly but he was not given an appointment and was told that the waiting list was seven months with other critical situations ahead of him. He died of stage 4 bladder cancer on November 30, 2013 and the VA returned phone calls to schedule an appointment on December 6th, one week after his death.⁵¹ This shocking example was one of

many at the Phoenix facility and unfortunately this kind of flaw in the system was soon uncovered at facilities across the country. While the former Phoenix director Sharon Helman was a common link between some of these facilities, such as Chicago where secret lists and falsified wait times were ‘everyday practice’⁵² and Walla Walla where a nurse was terminated under Helman’s watch for not supporting the falsification practices, the issues went far beyond her influence. As Dennis Wagner outlined in his article for the Arizona Republic, there were issues of falsification, alteration of request dates and overall unhealthy cultures surrounding these issues in San Antonio, Cheyenne, Fort Collins, Albuquerque and the list grew from there.⁵³ It was clear that measures were routinely being taken to mask underlying issues that were indicative of a system severely compromised in its ability to function at a rate that would allow it to provide necessary services for all its constituents. With almost 9 million veterans accessing VA care in 2014, the extent of the problem was of astounding magnitude.

The VA Office of Inspector General (OIG) soon took over the investigation and had produced a full report with twenty four recommendations. Having been accused previously of producing soft investigations that minimized VA issues, this was a much more substantial report designed to stand up to national levels of scrutiny. The team of investigators included physicians, auditors, special agents and health care inspectors. In addition to exhaustive interviews, the group reviewed the medical records of patients who died while on waitlists or whose deaths were alleged to be related to delayed care, analyzed statistical samples to assess the accuracy of patient wait times, and reviewed over one million emails, 1900,000 files as well as eleven encrypted computers.⁵⁴ The problems uncovered were only surprising in their scope.

The interviews of staff members clearly established a culture of deceitful record-keeping practices. Thirty staff member said they used the wrong desired date of care in order to show a false wait time. Eleven staff said that “fixed” or were told to “fix” wait times that were longer than fourteen days. Twenty-eight staff stated that they had printouts of patient information for scheduling purposes that they held for days or weeks before veterans were actually scheduled, at which point the information was entered onto the official electronic, and trackable, waitlist, referred to as the EWL.⁵⁵ As a result, it was extremely difficult for patients new to the Phoenix system to get any care and, even more disturbingly, there were significant difficulties with continuity of mental health care and psychotherapy services. For more general services, while there were 1,400 veterans waiting for primary care of the official EWL, there were 3,500 veterans on unofficial wait lists, all of whom were at risk for never receiving the care for which they were waiting.⁵⁶ While these findings emerged only from the Phoenix investigation, the national media attention that they sparked then led to 445 allegations of manipulated wait times. This in turn led the OIG to open investigations at 93 sites which uncovered practices that were similar to Phoenix and with the same goal in mind, to mask the true extent of wait times for service, primary and otherwise. The system was so deeply flawed that the OIG made 24 recommendations to address the Phoenix situation and all of them were accepted by the VA Secretary for implementation.⁵⁷ Part of the reason that the Phoenix OIG findings were so significant were because of the level of urgency that it created to tackle the issues plaguing VHA healthcare. By mid-August 2014, just before the full OIG report was released, the new Secretary of VA, Robert McDonald, put out a memorandum which apologized for what it termed as a “very serious crisis.”⁵⁸ In addition to apologizing, it established its priorities: “1) to get Veterans off waitlists and into clinics 2) to

address VA's cultural issues, which includes holding people accountable for willful misconduct or management 3) to use our resources to consistently deliver timely, high quality health care to our Nation's Veterans."⁵⁹ While establishing these priorities was very significant in that it established the national level of the issues and also the urgent nature of the need to fix them, it was not as strong in its emphasis on oversight or methods of implementation. It also mentioned that the OIG was unable to verify Foote's allegation of forty deaths of veterans on waitlists. This served to dilute the charges a bit but the memorandum was still as surprisingly strong notice of change, especially considering that the OIG was previously thought to be soft in its investigations. What was readily apparent was that the VA health care system was not providing an sufficient amount of care for the veteran community as a whole and was showing no signs of being able to keep up with the new set of demands being place on it by returning OEF/OIF veterans that required urgent and timely attention.

Soon after Dr. Foote's allegations surfaced nationally and Wagner's article was published, Sharon Helman was suspended, and later fired for not acknowledging receipt of improper bonuses, and Eric Shinseki, Secretary of Veterans Affairs, had stepped down. There was condemnation from all corners of the country. The anecdotes from around the U.S. were disturbing, such as the veteran who transferred into the Salt Lake City system and was told that he needed to wait six months for an appointment and after this time had passed was told that he needed to wait another six months. At that point he was dropped from system because he had not yet been seen by a VA doctor.⁶⁰ While cases like this earned unanimous condemnation, there were obviously many differing viewpoints on what were the most significant issues and what were the necessary next steps. In addition to egregious wait

times, the VFW was strenuous in its criticism of the VA's Patient Advocate system.⁶¹ Established in 1990, the program was designed to provide veterans with assistance in navigating the system and yet more frequently, the VFW's research found, they were either inept or disinterested in the well-being of veterans and were, "...more interested in defending the status quo at their facility instead of intervening on the veteran's behalf."⁶² This said, the VFW argues that the VA should remain intact because it is best suited to be able to support the specific needs of veterans as well as their sheer volume, even though this volume is part and parcel of the current problem.⁶³ The VFW's reaction may have displayed less shock than other organization but that was because it has been warning of physician staffing and waiting periods since before OEF/OIF started producing veterans. As far back as 2002, the VFW warned congress about these issues and the fact that, as the VHA even acknowledged after one of its surveys, 310,000 veterans were waiting more than six months for services.

Reacting from a different angle, and in some ways even more forcefully, was Senator Tom Coburn from Oklahoma who put together a massive catalogue of both grievances and suggestions. He went to great lengths to explain that, "As is typical with any bureaucracy, the excuse for not being able to meet goals is a lack of resources."⁶⁴ Instead, Coburn identified waste and mismanagement as the driving factors. From wasteful renovations to needless construction to improper payments, fraud and lavish conferences, Coburn identified countless opportunities for savings. In addition, he outlined a host of opportunities to improve the mismanagement, negligence and lack of accountability that existed within the VA.⁶⁵ In order to start to remedy the situation, he wanted veterans to have more choice for their care, to have veterans with combat related disabilities prioritize, protection for good employees and more latitude for the firing of bad employees and more transparency with

regard to performance measures.⁶⁶ Coburn saw in the VA a poorly run behemoth with enough opportunities for increased efficiency that the savings would in turn allow the VA to give veterans more choices and better care.

The issue of how best to respond to the systemic issues illustrated in the Phoenix scandal quickly became politicized and Coburn's response was largely representative of a Republican perspective. On the other side of the aisle, Democrats were more focused on the areas that were under-resourced and therefore unable to handle effectively the volume of care. What received bi-partisan support, however, was the need for more agility in the system so that veterans could exert more control over their own care and be able to make choices that would increase access to care, timeliness of services and would shift the focus to health outcomes instead of working solely within the constraints of the system. This need for greater flexibility, in addition to greater efficiency and reforms, was an area where veterans and politicians were largely in strong agreement and a driver for the Veterans Access, Choices and Accountability Act (VCAA) of 2014.⁶⁷

In the Spotlight: House and Senate Response to the Phoenix Scandal

The strength and unanimity of the national response to the Phoenix scandal put immediate pressure on the House, Senate and both parties to take action without delay. In a striking example of effective collaboration, it took less than four months from the time when the scandal broke on April 9th for Congress to produce a new law.⁶⁸ Even with agreement across the board on the need to act decisively and on the fact that the VHA was not being operated as efficiently or effectively as possible, there was an underlying tension to the ways that Republicans and Democrats approached this crisis. It was a tension that reflected the, “.... ongoing polarization in Congress. As usual, the two sides were divided over conflicting core philosophies of government and wary and suspicious of the side.”⁶⁹ Many democrats were quick to position veterans’ care as a cost that should have been taken into account when the wars were undertaken and therefore current spending needed to adjust in order to accommodate the higher than expected expenses. Republicans were more focused on the opportunities to cut wasteful spending and redirect the savings and on allowing private health care to play more of a role instead of the VA being a direct, and often sole, provider for veterans.

This background made the negotiations that led up to the VACAA impressive, especially when considering the strong willed players who were at the center of the discussions. From the start of the legislative debate, Senator John McCain and Congressman Jeff Miller thought that Senator Bernie Sanders would use the entire event as a way to take steps to prop up the VA and even use it as a model for a future one-payer health care system. Meanwhile,

Senator Sanders was concerned that McCain and Miller would use problems at the VA as a means of dissolving it. These differences were only exacerbated when Senator Sanders requested 17.6 billion in additional funding and framed it as part of the real cost of the wars. “Planes and tanks and guns are a cost of war,” Sen. Bernie Sanders said. “So is taking care of the men and women who use those weapons and fight our battles.”⁷⁰ The costs that he initially laid out were viewed as over the top by Republicans who in turn were viewed by Democrats as uncompromising.

While their views differed drastically on what they wanted for the future of the VA, it quickly became apparent that both were motivated to find compromise that would move forward. They found the Phoenix revelations equally dismaying and were determined to take a pragmatic approach. There were boiling points during the negotiations, and the players’ motivation to work through their differences was fueled in part by the intensity of national scrutiny, but it was also simply a case of lawmakers approaching a topic from different angles while collaborating for a common goal. On one of the central issues surrounding the choice of private care for both scheduling and distance reasons, Sanders compromised while McCain agreed to limit it to a two year trial period. Both agreed on expanded firing authority and they compromised on how much due process to allow for those who were dismissed. There were also other areas which they found easier to agree on, including the decision to classify the bill as emergency funding, a cost of the war, so that it would not have to be offset by cost cuts elsewhere.⁷¹ In the end, all this work led, in an incredibly compressed time frame, to a comprehensive bill that was presented in Congress and passed with monumental levels of support.

The Veterans Access, Choice and Accountability Act

On August 7th, 2014, President Obama signed the Veterans Access, Choice and Accountability Act that was the result of the intense negotiations that were under the spotlight of, and accelerated by, national attention. The pillars of the act were intended to increase health access for veterans, to increase internal VA capacity and to allow the Secretary of the VA broader powers to fire executives expeditiously. Increasing access to care for veterans would be accomplished in two ways. First, efforts would be made to increase the VA's capacity to provide direct care in a timely manner. This would be accomplished by focusing largely on staffing and space. Resources would be made to attract larger numbers of qualified physicians and other health professionals to provide both primary and specialized care and relieve some of the backlogged burdens that were now gaining so much publicity. Additionally, VHA facilities would either be expanded or new ones leased in order to be able to handle greater volume or bring care closer to the veterans. In recognition that this would not be sufficient to address all the current issues, another major change was the introduction of the Veterans Choice Card, which would allow veterans waiting more than 30 days for an appointment to seek care from a private physician, community health center, a DOD health care facility or an Indian Health Center.⁷² Those living more than 40 miles would also be eligible without the 30 day wait limitation. The intent was to alleviate two very significant barriers to access, distance and wait time, while giving veterans a great element of control over their health care and also introducing a level of private care into the system that might ultimately increase efficiency. With regard to increasing the overall quality of the VHA and to avoid scandals like the one that was exposed

in Phoenix, the VA secretary was given broad authority to immediately remove senior authorities based on job performance or poor job performance. The appeals process would then be expedited through the Merit Systems Protection Board and whistle blowers would be protected.⁷³ Eventually, there would need to be much more work done on the performance evaluation protocols but the enhanced ability to remove problematic employees was an important first step.

With both sides in agreement that the funding would largely be emergency spending and hence be incorporated into the cost of OEF/OIF , the total estimated cost would be \$16.3 billion. Of this, \$10 billion would be allocated to providing health care outside the VA, while \$5 billion would be used to improve capacity and quality of care in the VHA. An additional \$1.3 billion would go toward helping the families of wounded or killed veterans with college benefits and scholarships etc. These expenditures would be offset to some extent by \$6 billion in savings cuts from other programs under the purview of the Senate and House Veterans Affairs Committees.⁷⁴ Similar to their agreement on the Veterans Choice Card part of the act, the proposed funding for this plan represented an impressive compromise between political parties.

The VACAA was an accomplishment noteworthy for the speed of its creation and its enactment as well as for the enormity of the scope of its goals. It was essentially an attempt to reform the largest health care delivery system in the country in response to systemic problems affecting the 9 million under VA care. Given the circumstances, there were bound to be areas that would require ongoing adjustment and reform. One such adjustment was the change in distance requirement that would automatically allow veterans to choose private care. Initially, the measurement was forty straight line miles but this obviously represents

wildly divergent driving times dependent on roads etc, so requirements were shifted to reflect the amount of time that the travel would represent. While surprising that this adjustment was even necessary, it was an example of the VA taking ownership of an issue and initiating a solution.

Since the timeline for implementation of the overall program was as aggressive as possible, there were concerns that the Choice Program could be fully implemented within the 90 day target. Early feedback from VA and private care leaders was that the timeline was too compressed and therefore unrealistic. While the rollout of the program went quite well, there were significant ongoing concerns about the ability of community health centers to coordinate and provide timely access to high quality mental health care given the high number of veteran with diagnoses requiring this care. In addition to concerns about the lack of sufficient facilities and personnel in certain parts of the country, the hybrid VA and private services would require integration of records in order to track services and work flow.⁷⁵ Given the enormous scope of VA operations and the number of moving parts that private care would introduce, there were well founded concerns about the coordination of care given that there were already, prior to VACAA, plenty of examples where, “Badly coordinated care, duplicated efforts, bungled handoffs, and failures to follow up result in too much care for some patients, too little care for others, and the wrong care for many.”⁷⁶ While Veterans Choice presented a significant challenge, it also was an important opportunity to consider new organizational frameworks, such as that used by Accountable Care Organizations like the Mayo and Cleveland Clinics where primary care physicians serve as coordinators of patient care.⁷⁷ While this level of organizational change has not yet occurred, VA health care reform is still at a stage that requires the consideration of all existing models that can be

incorporated into the system that has the distinction of being the largest health care provider in the country.

Summary and Conclusion

The VACAA was signed into effect less than two years ago but how successful has it been in effecting change? This is a challenging question to answer since official VA data prior to the Phoenix scandal was deeply flawed. Hence, answers to question about progress vary significantly. The VA portrays the progress as substantial, such that wait times for first time appointments were reduced by 18% in 2014 and private-care appointments increased by 45% in the first half of 2015 while 97% of all veterans' appointments nationwide were completed within 30 days. The Associated Press on the other hand assessed VA appointment data and concluded that there had been negligible, if any, improvements.⁷⁸ While there have certainly been improvements, the enormity of the task makes incremental change more likely in the short term, although the VACAA was founded on calls for wholesale change. Phoenix is representative of some of the worst of the problems in the national program and Interim director of the Phoenix VA Health Director Glen Grippen described the needs of the system under his care as a, "... giant ship trying to change course after getting lost in a storm."⁷⁹ Even with the addition of 305 employees and some improvements in transparency and wait times, there remain a host areas for improvement. In addition to the large scale of the reforms, much of it is geared toward cultural change since the VA lost, according the Senator McCain "...all credibility on maintaining accurate wait- time records."⁸⁰ Cultural change requires not only change in personnel and resources but changes in relationships, perspectives and motivations. This made it all the more concerning when Rep. Ann Kirkpatrick, a year after the act was signed, described a system still plagued by whistleblower retaliation since this was one of the central issues sickening the system in the first

place. Part of the reason for the delay in implementation is tied to the scandal itself. Interim Director Grippen described challenges in recruiting medical workers because of the combination of residual effects of the public-relations damage done by the scandal and the challenges presented by the VA's archaic, inefficient hiring system. The Phoenix system has also been faced with an exodus of second-tier administrators which would eventually be an opportunity for leadership improvement but which in the meantime has remained a void.⁸¹ Other measurements of progress at this point are largely subjective and anecdotal, and represent a range of experiences. In large part, there has been evidence of change but also opportunity for continued growth and improvement. Given the amount of operational as well as cultural change necessary, the end point of this process might be as difficult to gauge as the conflicts in Afghanistan and Iraq.

As the VA health care system grew into the largest provider in the country, there were consistent complaints about delayed, inconsistent levels of care. As the needs of the veteran community evolved along with the protracted and unique nature of the OEF/OIF conflicts, the issues within the system became even more dire. Administrators were eager to mask the problems, particularly when their compensation was at stake. Within many parts of the VA system, a culture was reinforced where the efficient delivery of care was not the primary focus. The reality was that this efficient delivery was out of reach for the encumbered system but instead of addressing the issues at stake, they were often denied or buried. When the extent of the situation was illuminated by the Phoenix scandal, the public outrage was strong enough to fuel an intense bi-partisan effort to create legislation aimed at reforming the entirety of the system. The Veterans Access, Choice and Affordability Act of 2014 was an incredible piece of work that was passed almost unanimously by Congress in an attempt to

address the inefficient use of resources, delayed delivery of care, and corruption as well as the need for veterans to have more control of their health care. Confidently measuring the progress that has been made particularly challenging by the fact that much of the data prior to the VACAA was corrupted or inconsistent. Not surprisingly, there are unresolved issues and it will be critical for the VA to keep the goals of the act in the spotlight. A culture needs to be created that perpetuates a spirit of transparency and allows the necessary levels of investment and creativity to be applied to maintaining a quality of care for our veterans that is commensurate with this issue's importance.

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