CONCERNED VETERANS FOR AMERICA FOUNDATION'S GUIDE TO:

VA REFORM

Dear Reader,

My name is Chris Enget. I'm a veteran of the United States Army, a veteran of the war in Afghanistan, and a recipient of the Purple Heart from injuries received in combat.

Like millions of other veterans, young and old, I've relied on the Department of Veterans Affairs to provide medical care for my service-connected injuries.

And like many of those millions, I've been disappointed by the care I've received. I never felt truly cared for, heard, or even safe in the hands of the VA.

My experiences, just like those of other veterans, are exactly why reforms at the VA have been so important.

In this book, you'll learn about the Phoenix VA scandal, which opened the eyes of lawmakers and Americans about how bad the treatment of veterans was, not only in Phoenix, but at facilities around the country.

You'll also learn about major pieces of legislation that have made huge strides in fixing the glaring problem at the VA — little accountability for bad VA employees and too few options for veterans seeking needed care.

Those laws have (or should have) changed the way the VA operates, and the way we as citizens are able to demand better care for those who served.

We ask a lot of our men and women in uniform, and they don't hesitate to answer the call. The reforms you will learn about have gone a long way to make sure we keep our promise to veterans after they hang up the uniform.

Thank you for your dedication to learning more about veterans and our health care needs. I hope this e-book leaves you better informed and spurs you to ask more questions about what is being done, how things have changed, or what you can do so we can continue working to keep the promise to our nation's bravest.

Chris Enget
STRATEGIC DIRECTOR
Concerned Veterans for America Foundation

How the Phoenix VA scandal became a catalyst for

REFORMING VETERANS' HEALTH CARE

In early 2014, the media began reporting on delayed and mismanaged care at the Department of Veterans Affairs. The scandal shone a spotlight on VA failures across the country, revealing dozens of veterans had died or were dying from illnesses that might otherwise been caught and treated had the VA not delayed these patients' colonoscopies and endoscopies. But these delays in care were just the tip of the iceberg.

By April, news broke of more delays in care at the Phoenix VA Medical Center. The VA wasn't just delaying certain screenings and procedures; it was making a concerted effort to hide how long veterans were waiting for all kinds of care.

Efforts to hide veterans' appointment wait times

Phoenix staff were maintaining two sets of appointment wait lists: one that made it appear medical appointment wait times were within a reasonable, required range, and a second with actual wait times that were far beyond the VA's goals for timely care. Veterans languished for weeks and months waiting for care while the VA was making every effort to hide it from the public. The average wait for primary care was 115 days.

An Office of the Inspector General report would later confirm more than 3,500 veterans were waiting for appointments at the Phoenix VA Medical Center alone. The OIG identified 28 veterans with "clinically significant" delays in care, six of whom had died while waiting.

This news from Phoenix started an avalanche of reports from VA facilities around the country – manipulating wait time data was common practice at the VA, and veterans were dying while waiting to be seen by doctors.

Choice program for veterans gives more access to care

The Phoenix VA scandal became a catalyst for change and reforming the VA became a top priority for lawmakers and other advocates. Shortly after the scandal broke, Congress passed the Veterans Access, Choice and Accountability Act. This legislation created the Veterans Choice Program, an option for veterans to seek non-VA care if wait times or driving distances to the VA were too long.

The choice program was significant because it broadly introduced more flexibility to veterans' health care. Where many had been stuck in the VA's bureaucracy, leading to long waits like in Phoenix, the choice program would in theory allow those veterans to seek non-VA care in their communities.

The choice program was only meant as an interim solution to an immediate problem. The program had significant flaws that would require further reforms in the following years. But the law and Veterans Choice Program were major steps toward giving veterans more control of their health care and set the stage for the VA MISSION Act to further expand care in the years to follow.

The Phoenix VA scandal was a pivotal event in veterans care. It brought to light systemic problems at the VA and led the way for landmark legislation that would dramatically change how veterans receive their care. But most importantly, the Phoenix VA scandal started a conversation about empowering veterans to advocate for themselves and each other to get the care they earned.

The Phoenix VA scandal led to much-needed reforms at the VA. Read about changes to operations at the VA thanks to the VA Accountability and Whistleblower Protection Act.

SCANDALS

VA whistleblower claims drove major VA reforms

In 2014, Brandon Coleman was an addiction therapist at the Phoenix Veterans Affairs medical facility, providing much needed mental health services to veterans.

A veteran of the Marine Corps, Brandon was giving back to his brothers and sisters, helping them recover from addiction and live healthier, more prosperous lives.

So when Brandon raised concerns to leadership about suicidal veterans not being monitored while in the medical center's emergency room — and even being allowed to leave without treatment — he assumed his superiors would have the same level of care and concern for those veterans as he did.

But instead of taking the necessary steps to protect veterans struggling with their mental health, Phoenix VA officials retaliated against Brandon.

VA employees accessed his medical records without his consent, and he was threatened with termination for bringing up serious concerns about suicidal veterans' care.

Still determined to ensure suicidal veterans got the care they needed, Brandon went to the media.

The next day, Phoenix VA officials met to decide what to do about Brandon. They accused him of threatening another employee, shut down his addiction recovery program, and put him on paid administrative leave.

Brandon stated in an interview that after he disclosed mishandling of suicidal veterans, the facility director called him to a meeting where he was told, "you are not being terminated. Not yet."

"This has everything to do with me being a whistleblower," Brandon said of the way the VA treated him.

After being sent home and even being told he would need a police escort to visit the VA for his own care, Brandon made it his mission to get justice for himself and for other VA whistleblowers.

He did media interviews and joined advocacy groups to call for major reforms at the VA – in the way care is delivered and how VA handles whistleblower complaints.

After 461 days of administrative leave, Brandon was allowed to go back to his job helping veterans, albeit at a different facility.

VA whistleblowers consistently mistreated

Brandon wasn't the only whistleblower the VA punished for shedding light on serious deficiencies at its facilities:

- Dr. Katherine Mitchell was "transferred and harassed" after raising concerns about emergency room patients at the Phoenix VA.
- Physicians in Tomah, Wisconsin were fired for exposing "rampant overmedication of patients with painkillers".
- A food service worker in Pennsylvania was fired for allegedly eating expired food after reporting unsanitary conditions.

The poor behavior of those in power with consequences only for whistleblowers had become a mainstay at the VA. Leadership was more concerned with protecting themselves and their interests than serving the veterans they were meant to care for.

And the corruption and mismanagement went deeper than whistleblower retaliation.

VA reforms needed to hold staff accountable

The VA became notorious for story after story of VA employees' bad behavior. Not only were there few, if any, firings, but employees with poor employment records were rewarded despite the serious problems.

In 2014, the VA gave out more than $140 million in bonuses to VA employees, including to:

- Claims processors in the country's worst ranked benefits office
- Managers at a facility known for over-prescribing painkillers to the point that one veteran died of drug toxicity
- Executives who mismanaged a facility construction project that ended up $1 billion over budget
- Staff who drove mass resignations of health care workers

And if the bonuses weren't bad enough, the VA "solved" its leadership problems by simply shuffling its staff around to new facilities rather than firing deserving employees.

Then-VA Secretary Bob McDonald claimed in 2016 that 90 percent of VA medical centers had new leadership or new leadership teams. But a USA Today investigation found that the majority of new leadership were just existing VA employees that had been transferred from other facilities.

When the VA did attempt to discipline or fire employees it was often unable to, like in the case of Diana Rubens and Kimberly Graves.

Both were VA Regional Office directors who were operating under a hiring scheme to take jobs with less responsibility for the same salary.

Both women were reinstated in their jobs with six-figure salaries.

So why was the norm at the VA for bad employees to be protected and whistleblowers to be punished? Legally, the VA didn't have much recourse to fire or discipline its employees and acted vindictively toward those who exposed the department's flaws.

Legislation was needed to give the VA power to remove bad actors from employment and protect whistleblowers.

Why was the norm at the VA for bad employees to be protected and whistleblowers to be punished?

VA Accountability and Whistleblower Protection Act

In 2017, the VA Accountability and Whistleblower Protection Act became law, changing the dynamics at the VA. The law gave the VA broader authority to:

- Remove, reprimand, or suspend employees for misconduct or performance issues
- Only pay demoted individuals on administrative leave under certain circumstances
- Recoup awards, bonuses, or relocation expenses under certain circumstances
- Better train supervisors on whistleblower rights and best practices
- Better protect whistleblowers

The VA Accountability and Whistleblower Protection Act was a huge win for veterans and advocates who wanted the VA to work for veterans, not for unions and the bureaucracy.

As a government entity tasked with caring for those who served, the VA should be accountable to the people and transparent about what is going on behind the scenes. This law was a monumental step toward making the VA more veteran-centric rather than VA-centric.

The VA Accountability and Whistleblower Protection Act made huge changes to operations at the VA, but veterans still needed more health care options. Read about the VA MISSION Act – the landmark legislation that expanded choice.

THE VA MISSION ACT

Offering much needed health care reform for veterans

In 2014, Congress responded to the Phoenix VA scandal with much-needed legislation — the Veterans Access, Choice and Accountability Act.

This law created the Veterans Choice Program, which sought to give veterans more options over where they access their health care. If the drive times to a VA facility or wait times for an appointment fell outside standards set by the VA, veterans would have the freedom to choose non-VA doctors.

But the Veterans Choice Program was an interim solution to address an immediate need for health care flexibility. The program had many flaws, including its arbitrary criteria for accessing non-VA care and difficulty in paying non-VA providers.

More was needed to build on the ideas and successes of the Veterans Choice Program while addressing its pitfalls.

VA MISSION Act gives more veterans more options than the Veterans Choice Program

The 2018 VA MISSION Act took veterans' choice over their health care much further, expanding access to non-VA care and creating avenues for the VA to modernize and streamline its services. Major tenets of the law included:

- New standards for accessing non-VA care that expanded community care options to more veterans
- Urgent care changes that gave veterans quicker, easier access to urgent care facilities
- Establishment of the Asset and Infrastructure Review Commission, whose job it would be to study VA facilities and services to find ways to streamline and improve the department

Most significant among the VA MISSION Act's components was the creation of new eligibility standards for accessing non-VA care.

Under the Veterans Choice Program, the standards for accessing community care were restrictive and impractical. Vets could only access non-VA care if:

- They had to wait longer than 30 days to get an appointment at a VA facility, for any type of care
- They had to drive more than 40 miles to the closes VA facility. This standard was particularly burdensome because the closest VA facility might not offer the services a veteran was looking for, but the veteran would still be locked in to being under 40 miles from a VA.

The VA MISSION Act required new access standards which would expand care out to more veterans by shortening the wait time and distance thresholds and focusing on specific kinds of care. Now, veterans can access non-VA care if:

- The wait time for a primary or mental health care appointment is longer than 20 days
- The wait time for a specialty care appointment is longer than 28 days
- The drive time to a primary or mental health care appointment is longer than 30 minutes
- The drive time to a specialty care appointment is longer than 60 minutes
- The VA does not offer the services the veteran needs
- Community care is in the best interest of the veteran

The VA MISSION Act and these new eligibility standards empowered veterans with more flexibility and choice over

where they could seek their medical care. But that doesn't mean there haven't been hurdles in adhering to the law.

VA MISSION Act & Veterans Health Care Reform Under Threat

At the onset of COVID-19, the VA essentially shut down access to non-VA care in violation of the VA MISSION Act. The VA canceled or delayed nearly 20 million appointments in the first year of the pandemic. Many of those appointments didn't have any indication in the VA's records that they had been rescheduled.

Meanwhile, the VA continues manipulating wait times, attempting to keep vets from seeking the non-VA care they earned. Americans for Prosperity Foundation found through a Freedom of Information Act request that the VA is using confusing and inaccurate calculations for determining appointment wait times, meaning veterans aren't being offered community care they are legally entitled to.

But despite all the attempts to skirt the VA MISSION Act, it remains a landmark piece of legislation focused on giving more veterans access to much needed health care options.

The VA MISSION Act expanded access to care for veterans, including to community care providers. Read more about a veteran who found care that worked for him in the community.

Empowering veterans with the tools to defend freedom at home.

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