


The VA scandal, explained

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Chip Somodevilla / Getty Images News

Update: This article is a preliminary explainer. For a more in-depth version, check out our card stack [here](http://www.vox.com/cards/va-scandal-explained/) (<http://www.vox.com/cards/va-scandal-explained/>).

The US Department of Veterans Affairs scandal is, at its heart, a fight over scheduling procedures.

Over the past few weeks, allegations have surfaced that the VA's shoddy scheduling practices at its medical facilities have put the lives of veterans in danger — and, in some cases, contributed to patient deaths. The problems all seem to stem from abuses of the scheduling system that the veterans' hospitals use — particularly, from hospital administrators hiding thousands of patients on secret waiting lists.

This is becoming a really big deal. Reports now allege that scheduling issues at the Phoenix, Arizona, VA hospital led to 40 deaths. President Barack Obama is [talking about it](http://www.vox.com/2014/5/21/5738446/obama-on-va-scandal-i-will-not-tolerate-it) (<http://www.vox.com/2014/5/21/5738446/obama-on-va-scandal-i-will-not-tolerate-it>). The White House and VA are both conducting investigations, and Congress is holding hearings about the issue.

What went wrong?

In short, multiple pressures have worked together to create perverse incentives and confusion at VA hospitals around the country:

- 1** The VA has always struggled to keep up with demand. Simply put, there are way too many veterans seeking care for the amount of doctors the VA employs.
- 2** The VA's scheduling policies, which aim to keep veterans from waiting for health care, are very ambiguous, yet they're also the basis for how VA hospitals are evaluated. The ambiguity and incentive create confusion at localized VA hospitals about how, exactly,

veterans should be scheduled, which further exacerbates the VA's struggles to keep up with health-care demands.

- 3 Fixing the VA's scheduling policies might not solve the VA's inability to treat all the veterans it cares for in short order. But since the policies push VA hospitals to treat veterans in a timely manner, changing the policies can eliminate perverse incentives for providers, like perhaps those in Phoenix, to hide the veterans who are waiting in line.
- 4 There's historically been little federal oversight over the VA's localized medical centers. That's allowed some hospitals and clinics to get away with shoddy, sometimes nefarious scheduling practices that left sick veterans waiting for necessary health care — and sometimes dying as a result.
- 5 Some advocates also point to funding problems. The VA already struggles to keep up with demand. If homecoming veterans increase demand for medical care and [health-care costs continue to rise \(http://www.vox.com/cards/health-care-spending/is-health-care-spending-growing\)](http://www.vox.com/cards/health-care-spending/is-health-care-spending-growing), the waiting problems could get worse if Congress doesn't allocate more funding.

What went wrong at the Phoenix hospital in particular?



Charles Ommanney / Getty Images News

It's important to emphasize that everything at the Phoenix facility is, for now, a series of allegations. It's not confirmed that 40 veterans died as a result of shoddy practices. The investigations will find out whether that's really what happened.

With that caveat out of the way, here's what we know so far: CNN reported (<http://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/>) that a secret wait list may have contributed to the deaths of 40 veterans and delays for as many as 1,400 to 1,600 sick veterans.

A preliminary report (<http://www.vox.com/2014/5/28/5758154/report-veterans-in-phoenix-wait-115-days-for-health-care>) from the VA's inspector general confirmed that at least 1,700 veterans were waiting for care outside the official system. The inspector general also found veterans waited an average of 115 days for their first primary care appointment — much longer than the 14-day goal set by the VA and the 24 days previously reported by Phoenix officials.

THE ALLEGATIONS HAVE GROWN BEYOND PHOENIX

How did Phoenix officials allegedly conduct this grand scheme? It's simple: they supposedly kept a secret wait list on paper, not on the electronic system that's used for federal oversight, which kept Phoenix's practices out of sight of federal officials. At the same time, Phoenix officials allegedly sent a different, doctored electronic wait list to federal officials that misleadingly showed the hospital tending to patients in a timely manner.

Since the initial reports, the allegations have grown beyond Phoenix. The American Legion, a veterans advocacy group, has tracked (http://www.legion.org/documents/legion/pdf/va_epidemic.pdf) scheduling issues in up to 18 states.

Epidemic of VA Mismanagement

Cheyenne, Wyo.

MAY 9, 2014

A VA employee is put on leave when an email surfaces on CBS News.

The email details specific instructions for "gaming the system" to "get off the bad boys list."

The employee is placed on suspension in May, when the story breaks, but another whistleblower in the Cheyenne office notes VA's Office of the Special Counsel was informed of the situation in December 2013, five months before VA response to the accusations.

Fort Collins, Colo.

MAY 2014

As mentioned in the Texas allegations, employees in Fort Collins, Colo., were directed to manipulate the books to conceal evidence of lengthy wait times for appointments.

Phoenix, Ariz.

APRIL 2014

Multiple whistleblowers in the Phoenix VA Health Care System step forward with allegations of two separate waiting lists, the public electronic list, and an offline secret list maintained to enable falsifying the electronic results to keep patient wait times within VA's acceptable guidelines.

As many as 40 veterans or more may have died while waiting to receive care.

MAY 2, 2014

In the aftermath of allegations, two VA employees are motivated to move to secure documents alleging that there was a systematic effort underway at the hospital to shred documents to eliminate evidence of the waiting list cover-up.

Construction and resource allocation concerns

2012-2014

In addition to preventable patient deaths, The American Legion has voiced concern over other mismanagement issues. In Orlando, Fla., New Orleans, Denver and Las Vegas, massive mismanagement of construction contracts result in four major projects that were \$1.5 billion over budget and were delayed an average of 35 months. Once completed, the Las Vegas hospital lacked an ambulance bay for their Emergency Room, requiring an additional \$16-25 million in funding to repair the grievous oversight.

In Hot Springs, S.D., The American Legion supports local veterans' protests against the shutdown of a VA medical facility which would require patients in rural areas to travel to a distant facility for care.

St. Louis

May 12, 2014

In an interview with AP, former St. Louis VA chief of psychiatry alleges that he was demoted for trying to improve productivity, prompting an investigation.

Chicago

May 13, 2014

A VA social worker details on CBS News how scheduling wait times are manipulated in order to protect pay bonuses.

Burlington, Vt.

May 14, 2014

Veterans suffering from PTSD dies in incident with son after long struggle to receive care from VA, frustrated by being shuttled between multiple counselors with maddening wait times.

Pittsburgh

November 2013, SWS site visit

Persistent management failures lead to a deadly Legionella outbreak that kills at least 6 veterans and harms over 20 more. The manager in charge of oversight escapes discipline and collects a \$63,000 bonus over Legion protests.

Charleston, W.Va.

May 19

A doctor employed at the Huntington VAMC from 2008 to 2010 claims she was told to put patients seeking treatment off for months on end – and that at least two of them committed suicide.

Durham, N.C.

MAY 12, 2014

Two Durham VA Medical Center employees are put on administrative leave pending review of "inappropriate scheduling practices" sometime between 2009 and 2012.

Columbia, S.C.

April 2014, SWS site visit

Six patient deaths linked to delayed screenings for colorectal cancer, investigation revealed the facility had only used ¼ of the \$1 million in funding they had been given specifically to eliminate the backlog in screenings over the course of the year.

Augusta, Ga.

March 2014, SWS site visit

Delayed gastrointestinal consults result in at least seven veterans adversely affected by the delays in care.

Gainesville, Fla.

May 20

An audit team sent to the Malcom Randall VAMC discovered a list of patients needing follow-up appointments that was kept on paper instead of in the VA's electronic computer system.

Albuquerque, N.M.

MAY 18, 2014

According to a doctor at the center, veterans with serious heart conditions, gangrene and even brain tumors waited months for care at the Raymond G. Murphy VA Medical Center.

Austin and San Antonio, Texas

MAY 8, 2014

A former staff member for VA is quoted in the Austin American Statesman accusing supervisors of forcing concealment of long wait times by manipulating the scheduling system.

The alleged falsification is said to have occurred in locations in Austin and the Central Texas Veterans Health Care System in San Antonio.

Jackson, Miss.

January 2014, SWS site visit

Multiple whistleblower complaints range from misdiagnosis of fatal illnesses to improper sterilization of instruments and failures in hospital management practices. After nearly 70% turnover in management, slow progress is now being made.

Atlanta, Ga.

January 2014, SWS site visit

Despite four preventable patient deaths, three of which were linked to widespread mismanagement, medical center director received \$65,000 in bonuses over four years over the protest of The American Legion and local veterans.

#NotJustPhoenix



THE AMERICAN LEGION

(http://www.legion.org/documents/legion/pdf/va_epidemic.pdf)

Who's been affected by these wait times?

At this point, all kinds of veterans from all over the country have been affected by the VA's scheduling problems. But cancer patients in particular seem to have been hit the worst in several cases.

A previous fact sheet from the VA (http://cdn2.vox-cdn.com/assets/4492093/VA_FactSheet.pdf) linked 23 patients' deaths to delays in gastrointestinal cancer tests and treatments. CNN tracked (<http://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/>) one particular veteran, 71-year-old Thomas Breen, who died of bladder cancer after waiting for months just to set up an appointment. By the time Breen's family got a call from the VA to schedule an appointment, Breen was dead.

How did all of this go so wrong?



Jeff Hutchens / Getty Images News

Ideally, the scheduling system would work much like a typical trip to the doctor's office: a patient and doctor's office would work out the time for an appointment, the appointment would be scheduled, and the patient would make the trip to the doctor on the scheduled date.

At the VA, there are rules to try to ensure patients are seen in a timely manner, typically within 14 to 30 days. If it takes longer than 90 days to schedule a patient due to overcapacity, waiting veterans are supposed to be entered into an electronic wait list that tracks patients and makes sure their appointments are prioritized.

But that's not how it works in practice. And since as far back as 2000, the Government Accountability Office (GAO) has been calling on (<http://www.gao.gov/products/HEHS-00-90>) the VA to adjust its scheduling policies. Most recently, the GAO reported problems in 2013 (<http://www.gao.gov/products/GAO-13-130>) and 2014 (<http://www.gao.gov/products/GAO-14-509T>).

"THE WAY THE SYSTEM IS SET UP, IF SOMEONE WANTED TO GO IN AND MANIPULATE IT, IT WOULD NOT BE HARD TO DO"

Debra Draper, health-care director at the GAO, points to the lack of oversight and ambiguous policies as the two main drivers of scheduling problems. As she explains it, the VA's policies make it unclear whether, for example, hospitals are supposed to prioritize physician's or patient's desired dates for appointments.

These issues, of course, might not explain nefarious cases like those alleged in Phoenix, where medical providers are accused of purposely gaming the system to mask long wait times. But it does explain some of the many other scheduling problems now popping up across the country, where confusion and ambiguity in policies have led schedulers to inadvertently do the wrong thing.

There is also weak federal oversight, which allows problems like those found in Phoenix to go on as no one checks in to ensure rules are being followed. One example of such lax oversight: the GAO, in one of its reviews, found three of four clinics certified themselves as in compliance with scheduling policies, but none of them actually were. The VA could, in theory, audit these facilities, but it rarely does — largely because the issues were out of the public spotlight until now.

"Certainly, the way the system is set up, if someone wanted to go in and manipulate it, it would not be hard to do," Draper said [a previous interview](http://www.vox.com/2014/5/14/5714574/what-the-hell-is-happening-at-the-va) (<http://www.vox.com/2014/5/14/5714574/what-the-hell-is-happening-at-the-va>). "But in some facilities, they just don't really understand what they're supposed to do, and sometimes they do things incorrectly. It really gets back to the ambiguity in the policies and processes, and on top of that the lack of oversight."

Why can't the VA just schedule patients in a timely manner?



Christian Petersen / Getty Images News

In short, the VA has more patients than it can take in.

"We were told by staff in some facilities that increased demand and shortages of some physician specialties contributed to the wait times," Draper wrote in an email.

"WE WERE TOLD BY STAFF IN SOME FACILITIES THAT INCREASED DEMAND AND SHORTAGES OF SOME PHYSICIAN SPECIALTIES CONTRIBUTED TO THE WAIT TIMES"

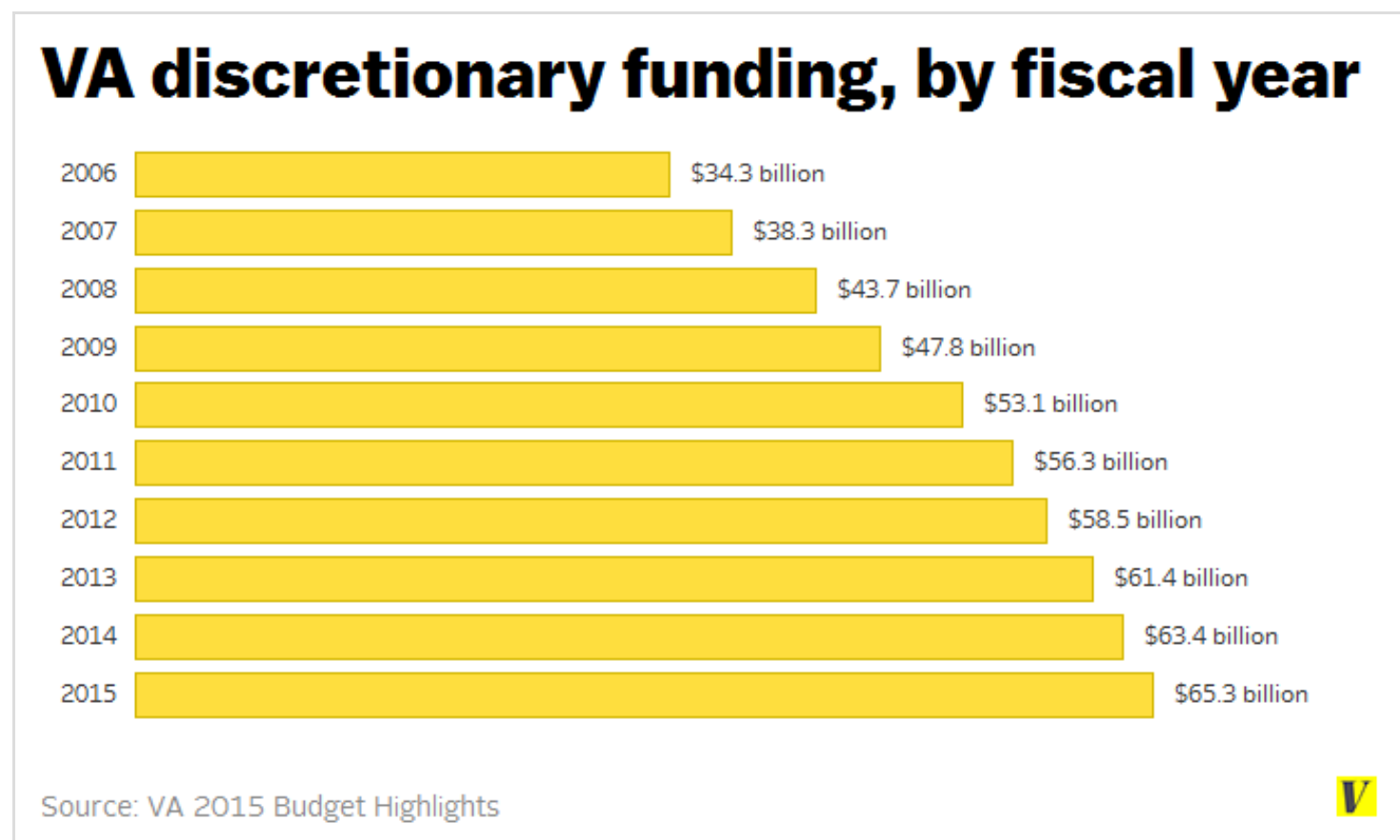
Some of those shortages represent a nationwide problem with doctor shortages (<http://www.vox.com/cards/south-obamacare-medicaid/southerners-report-the-most-trouble-accessing-affordable-health-care>), but part of the problem could be rooted in roadblocks put up by the VA. Right now, doctors need to get certified by the American Board of Medical Specialties and the American Osteopathic Association to work for the VA. The American Board of Physician Specialties (ABPS) has criticized (<http://www.abpsus.org/va-physician-shortage-and-abps>) this requirement: it argues that smaller boards like ABPS should be able to certify health workers and, therefore, speed up the approval process.

Increased demand is also a looming problem: thousands of military veterans have

come home from Afghanistan and Iraq in the past decade. That's kept the amount of veterans in the VA system up, and it could increase demand further in the future as veterans get older and, most likely, sicker.

Others blame the scheduling issues on funding problems. A whistleblower, for instance, [told \(http://washingtonexaminer.com/whistleblower-veterans-affairs-denied-delayed-tests-to-cut-costs/article/2548327\)](http://washingtonexaminer.com/whistleblower-veterans-affairs-denied-delayed-tests-to-cut-costs/article/2548327) the Washington Examiner that cost-cutting measures led to delays in life-saving cancer tests. Richard Krugman, a former VA doctor whose complaints were in part [verified \(http://www.osc.gov/FY2014/14-2%20DI-11-3558/14-2%20DI-11-3558%20-%20Letter%20to%20the%20President.pdf\)](http://www.osc.gov/FY2014/14-2%20DI-11-3558/14-2%20DI-11-3558%20-%20Letter%20to%20the%20President.pdf) by the VA, claimed his boss required patients to test positive in three successive screenings for bloody stools before they could get colonoscopies. As a result, Krugman estimated that 15,000 patients who should have gotten colonoscopies never did or had their care delayed.

But the VA hasn't been doing so bad when it comes to funding in recent years. President Barack Obama has [bragged \(http://www.washingtonpost.com/politics/transcript-obamas-remarks-on-va-allegations/2014/05/21/b7116db2-e0f6-11e3-9743-bb9b59cde7b9_story.html\)](http://www.washingtonpost.com/politics/transcript-obamas-remarks-on-va-allegations/2014/05/21/b7116db2-e0f6-11e3-9743-bb9b59cde7b9_story.html) about increasing VA funding during his time in office. Indeed, [the VA's budget numbers \(http://www.va.gov/budget/docs/summary/Fy2015-FastFactsVAsBudgetHighlights.pdf\)](http://www.va.gov/budget/docs/summary/Fy2015-FastFactsVAsBudgetHighlights.pdf) show discretionary spending — most of which goes to medical services — rising over the years.



Still, some groups think more funding is needed. Veterans advocates previously pushed Congress to pass a \$24 billion bill that would expand education and health

services for veterans, but Senate Republicans blocked the bill (<http://www.reuters.com/article/2014/02/27/us-usa-veterans-congress-idUSBREA1Q26O20140227>) due to budget concerns.

Whether the ongoing scheduling problems would be fixed with more money is, however, a matter of debate. Draper argued that, based on the GAO's findings, many of the issues are strictly about the policies and how they're set, not funding.

What could be done to fix these issues?

The first step, obviously, is to find out what's actually happening on the ground. For that, the VA has launched (<http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2541>) its own investigations, and the White House sent a top aide to Phoenix and promised (<http://www.vox.com/2014/5/21/5738446/obama-on-va-scandal-i-will-not-tolerate-it/in/5488789>) to hold anyone involved in the scandal accountable.



Mandel Ngan / AFP via Getty Images

The next step, critics argue, is to ensure these issues don't happen again in the future by fixing the underlying problems.

Along with its findings, the GAO recommended VA administrators take steps to impose more stringent scheduling standards and regularly check if they're being enforced through increased oversight at both the federal and local levels. But, years

later, the VA is still looking into how to apply many of the suggestions instead of actually implementing them.

Beyond these measures, Draper says the VA's inadequate scheduling system, which is now more than 25 years old, is in dire need of upgrades. But upgrading these systems would presumably require more funding, which might not be able to make it through a dysfunctional Congress (<http://www.vox.com/cards/congressional-dysfunction/what-is-congressional-dysfunction>).

THE NEXT STEP IS TO ENSURE THESE ISSUES DON'T HAPPEN AGAIN IN THE FUTURE BY FIXING THE UNDERLYING PROBLEMS

Several veterans groups regularly put out a dream budget (<http://www.independentbudget.org/>) with policy and funding proposals that usually calls for more funding than Congress and the White House ultimately allocate. The latest budget in particular told lawmakers to avoid cutting funding to the VA's medical services in the future, because it could cripple the system as more veterans from Iraq and Afghanistan demand care.

The right-leaning advocacy group Concerned Veterans for America also has some suggestions (<http://vaaccountability.com/>). One proposal to increase accountability would allow top VA officials to more easily fire underperforming VA managers and employees — something that is reportedly very difficult today. The House of Representatives already approved (<http://www.washingtonpost.com/blogs/post-politics/wp/2014/05/21/what-is-the-va-accountability-act/>) a bill doing just this, but it's uncertain if it will make it through the Senate.

Another suggestion would let veterans, particularly those in parts of the country where no well-run VA facilities are available, get VA-funded care at non-VA hospitals and clinics. That would, of course, present a radical departure from the centralized health care the VA currently provides. But it also might ease wait times and demand at current VA facilities, while letting veterans get the best care they can possibly obtain.

What else should I read about this?

- Vox's previous explainer (<http://www.vox.com/2014/5/14/5714574/what-the-hell-is-happening-at-the-va>) gave an early look at the issue.
- Since the allegations in Phoenix broke, the Arizona Republic has been on top ([http://www.azcentral.com/story/news/nation/2014/05/14/veterans-affairs-scandal-va-illnesses/2014514001001](#)).

<http://www.azcentral.com/story/news/arizona/politics/2014/04/25/pheonix-va-health-care-meet-reporters/8176785/>) of the scheduling problems.

- The Washington Post also put up [its own explainer](http://www.washingtonpost.com/blogs/federal-eye/wp/2014/05/15/a-guide-to-the-va-health-care-controversy/) (<http://www.washingtonpost.com/blogs/federal-eye/wp/2014/05/15/a-guide-to-the-va-health-care-controversy/>) of the political angles behind the issue.
- The American Legion, which advocates for veterans, has [a great page](http://www.legion.org/dyinginline) (<http://www.legion.org/dyinginline>) on the issue.

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