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Health Care In The US Department Of Veterans Affairs: Critical Issues And Strategic Progress

Kristin Nicole Sandoval
San Jose State University

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**HEALTH CARE IN THE US DEPARTMENT OF VETERANS AFFAIRS:
CRITICAL ISSUES AND STRATEGIC PROGRESS**

A Thesis

Presented to

The Faculty of the Interdisciplinary Studies Program

San José State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

by

Kristin N. Sandoval

May 2015

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CRITICAL ISSUES AND STRATEGIC PROGRESS**

by

Kristin N. Sandoval

APPROVED FOR THE INTERDISCIPLINARY STUDIES PROGRAM

SAN JOSÉ STATE UNIVERSITY

May 2015

Dr. William J. Reckmeyer

Department of Anthropology

Beth von Till

Department of Communication Studies

Larry A. Blitz

HFS Consultants

ABSTRACT

HEALTH CARE IN THE US DEPARTMENT OF VETERANS AFFAIRS: CRITICAL ISSUES AND STRATEGIC PROGRESS

by Kristin N. Sandoval

The United States Department of Veterans Affairs (VA) is one of the largest executive departments in the nation, providing essential financial and medical assistance to veterans and their families. As the VA continues to evolve and grow it is imperative to understand the department's current capability constraints and how they arose in order to propose effective methods for addressing current issues and overcoming future policy pitfalls. The most critical issues presently facing the VA concern appalling increases in wait-times and backlogs for services, which have emerged since 9/11 and are primarily the result of growing numbers of disabled veterans from the Global War on Terrorism (GWOT). Much of the information and proposals regarding veteran benefits claims and conditions at VA hospitals focuses on current aspects of these issues. This thesis examines the growth of the VA since its inception and evaluates the results of policies over the course of recent decades in order to analyze the causes of current issues and offer several policy recommendations for enhancing strategic progress in resolving those issues.

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HEALTH CARE IN THE US DEPARTMENT OF VETERANS AFFAIRS: CRITICAL ISSUES AND STRATEGIC PROGRESS

Introduction

Public support in the United States for disabled veterans began emerging in the early years of the American Revolutionary War, during which 25,000 soldiers were wounded, when the Continental Congress issued pensions as part of its efforts to encourage enlistments (Veterans Affairs 2015). Although the federal government established the first residential medical care facility for veterans in 1811, there was no concerted national effort to address their needs until widespread casualties (more than 476,000 wounded veterans) during the Civil War led to the establishment of state veterans homes throughout most of the country (Civil War Trust 2015). The growing variety of pensions and benefits for veterans was expanded even further during the balance of the 19th century to cover their widows and dependents (Veterans Affairs 2015).

Historical Context

The institutional origins of the Department of Veterans Affairs emerged shortly after the end of World War I when the special needs of 204,002 wounded soldiers from that conflict, such as the effects of mechanized warfare and mustard gas, prompted President Warren G. Harding to establish the Veterans Bureau in 1921 (Chambers 1999, 849; Cooper et al. 2004). However, due to corruption and ineffectiveness within the Bureau and other programs similar to it over the subsequent 10 years, President Herbert

Hoover consolidated the system into the Veterans Administration and elevated it to a federal agency in 1930 (Kizer et al. 2000, I-8; Veterans Affairs 2015). As a result of even greater casualties during World War II, which added 670,846 disabled veterans to the VA's responsibilities, President Franklin D. Roosevelt and Congress created the Servicemen's Readjustment Act of 1944 (Chambers 1999, 849; Cooper et al. 2004). That act, which is commonly known today as the GI Bill of Rights, significantly increased the size of the nation's middle class by offering low-interest home, education, and business loans; it also allowed veterans to attend college, receive unemployment benefits, and receive health care services (Kizer et al. 2000, I-8).

The Veterans Administration also had to serve an additional 245,437 soldiers who were wounded during the Korean War and the Vietnam War between 1953 and 1979, all of whom received fewer VA benefits compared to WWII veterans (Chambers 1999, 849; Clemmitt et al. 2007, 707). In 1970 the *New Yorker* and *Life* magazine published articles about poor VA hospital conditions and veteran health issues as a result of Agent Orange (Billitteri et al. 2010, 371-372; Whiteside 1970, 32). In response, the Pentagon banned use of the defoliant. Appalling VA hospital conditions remained unaddressed, however, so disabled veteran Ron Kovic launched a demonstration in 1973 to raise awareness by seizing Senator Alan Cranston's office (Billitteri et al. 2010, 371-372; Clemmitt et al. 2007, 707). Progress on these types of matters occurred in 1979, when Congress approved 92 veteran clinics to provide counseling for a range of combat symptoms that psychiatrists termed Post Traumatic Stress Disorder (PTSD) and was subsequently

included in the *Diagnostic and Statistical Manual of Mental Disorders* (Billitteri et al. 2010, 371-373).

During the 1980s damage from radiation and chemical exposure started being investigated, which enabled veterans to win multiple legal initiatives. Several of the key initiatives were 1) Agent Orange manufacturers agreed to a \$180 million settlement, 2) the U.S. District Court ruled that the VA could not exclude 400,000 veterans from claiming benefits, and 3) President Ronald Regan approved VA benefits for 13 types of cancer for WWII veterans (Billitteri et al. 2010, 371-374; Cooper et al. 2004). As more evidence accrued regarding the harmful effects of Agent Orange, the United States began fighting in the Persian Gulf War. The growing number of benefits claims from the Gulf War, combined with those from WWII through the Vietnam War, began to severely strain the VA's capabilities. In 1992, despite the Pentagon's insistence that no troops were exposed to toxic chemicals, approximately 100,000 Gulf War veterans began reporting physical and psychological symptoms that have been collectively termed the Gulf War Syndrome (GWS). In 1997 medical researchers reported that GWS was the result of pesticides and nerve gas (Clemmitt et al. 2007, 707-710; Cooper et al. 2004). This led the Pentagon to admit that soldiers had been exposed to nerve gas and the VA began paying disability benefits.

The terrorist attacks on September 11, 2001 spurred the United States into declaring a Global War on Terrorism (GWOT) that resulted in the deployment of more than a million troops to Iraq and Afghanistan since 2002 (Bilmes 2008, 84). The

enemy's use of Improvised Explosive Devices (IEDs) has resulted in a large number of disabilities that include the loss of limbs, traumatic brain injury, and PTSD. This new generation of disabled veterans has pushed the VA system to the breaking point. In 2003 the VA suspended health care benefits to 200,000 veterans just prior to the launch of Operation Iraqi Freedom. Approximately 27,000 veterans filed for benefits in 2004, but nearly 9,000 were not processed within the calendar year due to a backlog of 334,000 claims (Cooper et al. 2004). In 2007 the *Washington Post* published a series on the deplorable conditions of outpatient veterans at the Walter Reed Army Medical Center outside Washington, D.C. This led to the forced resignations of Francis Harvey, Secretary of the Army, and two medical officers, as well as recommendations by a presidential panel for a simpler disability rating system (Clemmitt et al. 2007, 707-710; Shanker & Stout 2007).

Despite these changes, the disgraceful delays in timely access to veterans' benefits continued. In 2008 the wait-time in processing VA disability benefit appeals reached 563 days. In 2010, the Institute of Medicine reported a shortage of mental health services for veterans and the VA technology chief called the claims management system "broken beyond repair" (Billitteri et al. 2010, 365-372). The scandal came to a head when reports confirmed accusations of widespread misconduct and the long-term systematic cover-up of these appalling wait-times throughout the VA's massive hospital system, which led to the resignation of VA Secretary Eric Shinseki in May 2014 (Shear & Oppel 2014). As of July 2014, 523,849 veterans were waiting to receive disability

benefits; 260,837 of those individuals were waiting more than 125 days; and 244,939 veterans had been waiting longer than a year for a response from the VA. As of August 2014, the average wait time for a claim response was 160 days and the average wait time to appeal a claim was 1,301 days (Anderson 2014).

Critical Issues

Although the VA was originally created to treat combat-related injuries and to help rehabilitate veterans with service-related disabilities, it has expanded in both size and responsibility. It has “grown from the Veterans Administration with an operating budget of \$786 million serving 4.6 million veterans in 1930 to the Department of Veterans Affairs with a budget of \$63.5 billion serving nearly 25 million veterans” (*VA History* 2006). The result is that the VA is now one of the oldest, largest, and most managerially complex health care systems in the world. More specifically, it is our country’s leading centrally managed health care system and the principal unified provider of health care education for health care staff and physician residents (Kizer et al. 2000, I-8-I-9; *Department of VA Strategic Plan* 2014). The demand to meet the needs of service members and veterans continues to grow: the number of outpatient visits to VA health care facilities has grown by 26% over the last five years, and the VA system experienced an overall increase from 83.6 million to 94.6 million outpatient visits/fiscal year from 2012 to 2014 (Shear & Oppel 2014; *Trends in the Utilization* 2013).

Faced with continually expanding responsibilities and demands, the VA system must have the capacity to respond to growth and change in a timely way. Unfortunately,

the cultural issues associated with promoting privatization, coupled with logistical issues involved with staffing and IT infrastructure, have only hindered its success in meeting these needs. Furthermore, financial costs are a significant limiting factor given the need to restructure an antiquated system that already requires considerable funding to sustain its annual operations. All of these issues have had a long-standing influence on policy and on the organization as a whole. In an effort to minimize expenditures and increase productivity, which was spurred on by ideology and powerful lobbying efforts by the private sector, President Ronald Reagan initiated the movement towards privatization (McKelvey 2009, 20).

Twelve years later, as the George W. Bush administration created the momentum required to convince the American public that minimizing the role of federal agencies was best for the nation, it was able to secure political support for privatizing government operations. President Bush outsourced many services at the onset of the Iraq War and was able to influence the removal of individuals from key positions, including Congressman Chris Smith (R-NJ), Chair of the House Veterans Affairs Committee, based on his attempts to increase funding for the VA. In his stead, party leaders chose Steve Buyer (R-IN) in the belief that he would counter the VA's efforts to obtain more federal funding (McKelvey 2009, 21). Their confidence was confirmed in 2005, when Buyer scolded the VA for misusing funds based on their budget predictions and argued that "we have to think to be more like a business" (Stoffer 2006, 21). Their perception was that outsourcing would decrease government expenditures by promoting greater efficiencies

through corporate business practices. However, large-scale privatization has often been more costly and less effective. For example, IAP Worldwide Services was granted a five-year \$120 million contract for support services at Walter Reed Army Medical Center in 2006. Soon thereafter, in February 2007, the scandal regarding the abominable conditions at Walter Reed hit the headlines:

Government reports reveal a pattern of mismanagement in procurement and oversight of private-sector contracts through Veterans Affairs. “Their effectiveness is questionable,” Jon Wooditch, a deputy inspector general for the VA, told a House veterans’ affairs subcommittee on oversight and investigations in February 2008. There are numerous examples of contracts gone wrong, including a \$248 million contract for Dell computers that was “not necessary or in the best interest of the VA.” (McKelvey 2009, 21)

When the VA began outsourcing health care services, it set up a fee claim process to reimburse non-VA health care providers through the VHA Fee Care Program. Since its implementation, the fee process has experienced major problems with delayed and erroneous payments. Between 2008 and 2010, expenditures increased by 1.4 billion dollars, a 46% rise in costs, while the new patient base during this time increased by only 16%. In 2009 and 2010, the VA Office of Inspector General found that VA Medical Centers made duplicate payments and paid out incorrect amounts totaling hundreds of millions of dollars. The Chief Business Office estimated a 12% error rate per year, approximately \$500 million in 2011 (Pane et al. 2011). “Despite VA’s best efforts to automate the fee claims process through various pilot programs over the past 10 years, claims are still not automated and the current manual claims process places the VA at high risk for improper payments” (Jones 2012). Substandard IT infrastructure requires

more employees and produces less efficient and effective results. Adding insult to injury, the proposed solution to this problem offered by VA critics was to outsource claims processing; that is to say, their solution to the problems created by outsourcing services was to also outsource the billing for outsourcing services.

In addition to these financial issues, there are also cultural aspects that indicate it is ineffective to operate the VA like a private sector company. Senator Buyer was not the first person to promote the philosophy that government agencies would be more cost effective and efficient if they operated like private sector companies. Many attempts have been made to reinvent the VA system over the years. Examples of new programs to improve the quality of delivered health care starting in the mid-1990s include the Quality Enhancement Research Initiative (QUERI), the Veterans Integrated Service Network (VISN), and the Veterans Equitable Resource Allocation (VERA) (Kizer et al. 2000, I-11-I-14). Other authors found that reengineering efforts, which included a systematic approach to measuring and managing for quality, significantly increased the overall quality of care (Jha et al. 2003).

The VA's performance management program sought to fulfill its missions and visions by associating tracking measures with goals, including the development of quality indicators that reflected private sector performance measures. This created a system whereby accountability was encouraged by the awarding of bonuses when management met specific goals (Kizer et al. 2000, I-14; Jha et al. 2003). Not unexpectedly, this approach resulted in personnel concealing delays and falsifying reports to show delivery

of care within the 14-day goal in order to receive bonuses. The *Washington Post* reported that VA claims processors and union representatives frequently ignored complicated claims in order to retain their positions, meet performance standards, or receive bonuses (Shinn et al. 2013). Since 2000, more than 18 reports have disclosed efforts by VA personnel to conceal extensive wait-times (Jaffe & O’Keefe 2014).

In January 2009, the US Senate approved Eric Shinseki to serve as Secretary of the Department of Veterans Affairs. He attempted to change the leadership culture within the VA by holding quarterly meetings with all VA hospital directors to assess current issues, which had never happened under the direction of previous administrators (Jaffe & O’Keefe, 2014). Despite Shinseki’s efforts to change VA hospital operations, though, reports began circulating in 2012 that revealed management misconduct. In April 2014, the Chair of the House Committee on Veterans’ Affairs, Jeff Miller (D-FL), held a hearing to examine evidence that the Phoenix VA kept one set of records to demonstrate timely delivery of care and another set that illustrated significant deferrals (Gold 2014). Later that month CNN aired “A Fatal Wait,” which revealed internal emails showing that top-level management condoned the act of shredding veteran appointment requests to distort wait-times (Gold 2014). After the report attracted national attention, President Obama and Secretary Shinseki ordered a full investigation into the allegations. The VHA conducted a systematic audit of scheduling procedures and found that staff had been instructed to alter the requested appointment dates at least once in 64% of its 258 facilities (Veterans Health Administration 2014).

Since then, more federal reports have surfaced, according to Shinn et al (2013), which detail the extent of the backlog cover-ups and the amount of money received by those responsible:

According to salary data from the Office of Personnel Management, in 2011, a year in which the claims backlog ballooned by 155 percent, more than two-thirds of claims processors shared \$5.5 million in bonuses... Those complex claims now make up much of the VA's widely scrutinized disability claims backlog, defined by the agency as claims pending more than 125 days.

In response to the revelation of this scandal, President Obama mandated that all backlog claims would need to be completed by 2015. With over 1 million claims processed annually already, this mandate drives a process focused on quantity over quality that will most probably result in an abundance of errors (Shinn et al. 2013). Many of those claims will likely need to be reprocessed, thereby costing the VA more man-hours and money. Thus a system that was intended to increase productivity and cost-saving measures via a private sector model has proven to be quite the opposite; not only were millions of dollars in bonuses received fraudulently, but the errors created in response to the result of this system will be less cost effective and less efficient over the long term.

Compounding these financial and cultural issues are several logistical issues that impede the internal effectiveness of the VA and significantly compromise the practicality of outsourcing services. First, many experts state that the shortage of physicians, nurses, and other medical professionals directly influenced lengthy wait-times and the resulting scandal to cover it up. Last July, for example, the VA told Congress that there were a total of nearly 46,000 vacancies throughout the country's VA health care system, a

vacancy rate of 15.5% (Oppel 2014). These vacancies are attributed to salary discrepancies, making VA positions less competitive in relation to equivalent positions in the private sector.

Second, outdated electronic scheduling systems (some of which have been in use since the 1980s) hinder the ability of employees to track patients and prevent VA officials in Washington from obtaining accurate data (Jaffe & O'Keefe 2014). The Veteran Affairs system is a vast network of facilities spread across the nation that encompasses 820 community-based outpatient clinics, 151 hospitals, and 56 regional offices. As of 2013, there are 300 Veterans Centers in the United States (*Trends in the Utilization*, 2013). These centers help guide veterans through the lengthy and convoluted disability claims process in order to receive benefits.

If a veteran sustains multiple disabilities, each disability must be processed through a separate claim. The Developmental Phase consists of gathering all documentation necessary for the regional office to determine the patient's disability rating, which may include documents from non-VA health care providers. During the developmental phase, the Veteran Center submits the disability documentation to the regional office, which processes the application. The regional office, in turn, sends the hospital information that determines which kind of doctor or specialist the veteran needs to see. It may take 6 months before an appointment is scheduled. The physician, upon examination, may then decide to treat the patient directly or may recommend other specialists. The physicians then submit paperwork back to the regional office, which

uses that information to determine the patient's level of disability. The regional office then schedules an appointment for the patient to review the medical file and submits that information to the rating board. On average it takes 10 weeks for the board to make a decision.

In the Notification Phase, the regional office sends the patient a letter explaining what medical information and regulations were used to determine the patient's disability rating and encloses a fact sheet about the patient's right to appeal. If the veteran chooses to pursue the appeals process, he or she has two options depending on whether or not there is new evidence to submit for reconsideration. The patient must write a letter explaining why he or she disagrees with the disability decision and completes a form. Then an experienced VA official reviews the case and mails a notification letter to the patient. If the veteran still disagrees with the decision, a teleconference or a travel board hearing is scheduled. Technically, an appellate case can continue to be reviewed until the Supreme Court makes a decision.

When a veteran submits a request to a regional office for an appointment there is no tracking process to determine whether the office received the letter. Since there is no internal data system, the Veteran Center cannot give the veteran a status update regarding a claim. Once an appointment is made the regional office sends a notification via mail. This process is the same for active duty members; however, if the soldier is stationed at a base and his or her family is located at a different address, often times the letter is sent to the family's address. If the soldier misses the appointment, because he or she is never

informed directly, the VA either places him or her on the waitlist again. Alternatively, in case a disability or appeals claim decision is pending, the VA either denies the appeal or finalizes a disability claim.

Third, in addition to lacking the technology infrastructure that enables internal communication between departments, there currently is no method to track and monitor the care that veterans receive in the community. Moreover, there is no single department that incorporates civilian health records into the VA health care system. Clinical information often does not return to the VA in a timely manner or does not return at all. The lack of coordinated care and digitized data also leads to problems of inconsistency (Jones 2012). It is much more difficult and time-consuming to access, compile, and analyze hundreds of thousands of claims that are handwritten on paper forms and mailed than information that is entered into a digital system. Without a comprehensive digital system, it becomes nearly impossible to determine if patients with similar symptoms are being treated in a similar way and receiving similar disability rates. “In addition, the lack of care coordination hinders VA’s ability to optimize its resources because there can be duplicative and conflicting treatment regimen. This not only results in wasted resources, but also can cause adverse medical outcomes” (Jones 2012).

In 2010, under the direction of Secretary Erik Shinseki, VA Chief Technology Officer Peter L. Levin began implementing pilot programs for a technology overhaul with a deadline of 2015 (Billitteri et al. 2010, 372). As of August 2014, though, the VA is still heavily reliant upon paper documents and postal mail instead of using an internal

database or an internet-based system to complete and transmit information from one department to another. For over 14 years the VA has intended to create and implement a new scheduling system, but a chronic lack of funding and ever more pressing matters continue to delay progress. Levin summarized the root of the problem when he observed that “It’s a simple question of bandwidth and priorities” (Jaffe & O’Keefe 2014). In sum, the VA’s use of antiquated communication methods is clearly responsible for missed appointments, errors in tracking appointments, delays in processing claims, and redundant or inconsistent treatment.

Levin’s initiative has demonstrated that attempting to overhaul one component of the VA is very time consuming and difficult, even without regard to securing the finances required to fund such a project. A comprehensive overhaul would require considerable financial support from the US government, which might be difficult to approve given current budget issues and the amount of money already being spent on treating veterans. The department’s \$154 billion annual budget has more than doubled since 2006; this includes approximately \$12 billion dollars spent each year on disability benefits for the veterans of the Vietnam War that ended almost 40 years ago and more than \$4 billion each year for veterans of the Gulf War (Bilmes 2008; Shear & Oppel 2014). Bilmes (2008) states that since the beginning of the invasion of Iraq “more than a third of 750,000 troops discharged from the military so far have required treatment at medical facilities, including at least 100,000 with mental health conditions and 52,000 with post traumatic stress disorder.”

There are 15 wounded soldiers for every fatality in modern conflicts, largely because medical technology has made it possible for significantly more soldiers to survive battle-inflicted injuries than in previous wars (Bilmes 2008). As the WWII and Korean War veteran population decreases over the next 20 years, the overall number of veterans is projected to decrease from approximately 21 million to approximately 14 million by 2040 (*Veteran Population Projections* 2013). During this same time period, however, medical care expenditures are expected to continue rising significantly – as they did between 2000 and 2009, when the veteran population decreased by over three million people but medical care expenses almost doubled (*Trends in Geographic* 2010). Bilmes states that “even using conservative estimates, the long-term cost of providing medical care alone to Iraq and Afghanistan war veterans over their lifetimes could approach... \$390 billion” (2008, 85).

Strategic Progress

Deciding how to resolve the issues surrounding the backlog of claims will ultimately be hashed out in Congress. This will probably be very difficult at the present time, given the extreme partisanship characterizing national policy-making, for both political parties can't even agree on what the problems are – much less on what the solutions might be. As Shear & Opper (2014) note, “Republicans say the problem is not a lack of money, but rather inefficiencies in the delivery of care. Democrats say that the problem is a serious shortage of doctors and not enough hospitals.” Regardless of which issue is addressed first, any attempts to make effective changes will be futile without

clear directives on how to achieve each goal. John A. Boehner (R-OH), Speaker of the United States House of Representatives, said after President Obama's acceptance of Secretary Shinseki's resignation that "until the president outlines a vision and an effective plan for addressing the broad dysfunction at the V.A., today's announcement really changes nothing" (Shear & Opperl 2014).

The new Secretary of Veterans Affairs, Robert McDonald, recently released the *Department of Veterans Affairs Strategic Plan Framework* (2014), which is a one-page summary of goals and objectives for the agency. *The Department of Veterans Affairs FY2014-2020 Strategic Plan* (2014) is a 45-page document that discusses those goals and objectives in more detail, but it fails to address how anything will be accomplished. In a press release on September 8, McDonald announced a 90-day plan that includes holding meetings 2-3 times per month, hiring tens of thousands of new medical staff, retaining them through competitive pay plans that are comparable to the private sector, streamlining access to VA websites, and flattening the power hierarchy within the department (Wax-Thilbodeaux 2014; Opperl, 2014). While hiring more staff is a direct approach to handling issues that affect wait-times, it is not clear why the other two projects were placed as top priorities and the Secretary did not go into detail about how they will be accomplished or what goals they will address.

Considering that the Veterans Health Administration conducted a thorough investigation in May of 2014, a few months prior to McDonald's appointment as secretary, it would have been more logical to set priorities based on system weaknesses

detailed in the investigation's findings (Veterans Health Administration 2014). The audit identifies issues that fall into both short-term and long-term solution categories. For example, it suggests that the appointment process based on a veteran's desired date be reevaluated and revised to reflect more standardized scheduling practices. Altering the approach to scheduling appointments by basing it on a verbal negotiation between the patient and the clinic to set a specific date and time would eliminate the need for staff to change request dates or use alternate forms of record keeping for appointment requests (Veterans Health Administration 2014, 2). It would eliminate the need for the 14-day policy because the process would no longer be based upon appointment requests. It would also not require changes in the IT infrastructure or the use of different interfaces, meaning that this change could be implemented immediately. Moreover, VA personnel would receive immediate modified scheduling training, which the audit report suggested would need to occur nonetheless (Veterans Health Administration 2014, 2-5).

The report also lists the need for the creation and implementation of a long-term software update to integrate systems and departments (Veterans Health Administration 2014, 4). This is a much more extensive and involved process than what the Secretary proposed. Adjusting the interface of exist-ing websites to allow individual access to all sites using one username and password does not change the disjointed nature of the separate websites or increase staff's ability to manage records. The VA needs to develop a detailed plan that addresses how to update the IT infrastructure, for the problems related to claims processing and integrating non-VA health records will not be resolved until

there are updated software programs in place – ones that can integrate digital information from various sources and allow access to records by different departments. The challenge is that the IT infrastructure has not been updated to support the bandwidth required to use new software simultaneously across all facilities. Resolving the lack of appropriately capable software and IT infrastructure should be at the top of the priority list because they directly affect problems with claims processing, records integration, and interdepartmental communication.

Lack of funding isn't the limiting factor here, for the agency has the financial resources to make these improvements. If no software currently exists that can meet VA needs, then the department should use its resources to create the necessary software. Likewise, it should use those resources to install the necessary IT infrastructure to support modern software. The Secretary should propose a comprehensive plan that details the steps necessary to execute a system-wide technology overhaul. Then, within that overarching plan, he should set a series of goals with deadlines that can actually be achieved and specify the steps required to complete those goals.

For example, one goal might be to increase Internet speed and capability for all facilities. The steps necessary to execute the goal would be divided into an Assessment Phase, a Completion Phase, a Maintenance Phase, and a Monitoring Phase. The Assessment Phase would consist of [1] determining the cost of installing a high speed | high capacity internet system for all 1327 VA health facilities within a one year period of time by requesting a contracting bid from a variety of civilian companies; [2] comparing those

bids to the cost assessment of using military/government services, if using the military as a service provider is a possible option; [3] comparing the system's cost of maintenance with those of different civilian services and the military/government service options; [4] determining if the service to install the new system will be outsourced or completed through military/government services; [5] creating a process to oversee the completion of the project; and [6] constructing a plan if the system becomes faulty or ever fails.

The Completion Phase would entail [1] securing the funding; [2] methodically installing the service in facilities with the highest demand first; [3] overseeing the process and reporting to top VA officials on the progress towards completion; and [4] completing the project by the contract's deadline. The Maintenance Phase would consist of [1] verifying that the system is working as intended in all facilities; [2] routinely confirming that the system continues to operate as intended; [3] implementing all updates as required to optimize the system's functionality; and [4] assessing whether additional modifications need to be made.

All of the steps within all of the phases would require details about the specific actions (or sub-steps) required to implement those steps. Parsing one large goal into many specific goals with phases and steps to achieve each of those goals would enable directives to be well defined and the process to be transparent. This is one example of a much larger initiative to overhaul the system that is, in turn, part of solving a problem that requires a systems approach. By effectively implementing high-speed and high capacity internet, the VA can set the foundation for complex computer software to run

optimally across all facilities, which will allow for interdepartmental communication and integration of digital claims and health records across multiple interfaces.

CONCLUSION

In closing, it is clear that the Department of Veterans Affairs has been unable to adapt to changing conditions that were triggered by 9/11 and have been amplified by the country's pursuit of a Global War on Terrorism. The increased number of American soldiers actively engaged in asymmetrical conflicts, combined with the advent of new medical technology, has enabled more soldiers to survive traumatic injuries that would have been fatal in previous wars. These soldiers are now depending on the VA to provide new and more varied forms of health care and rehabilitative services to meet their medical and financial needs. As the VA has evolved and expanded to assimilate these soldiers into the system, policies have been developed and implemented to improve the department's efficacy. However, many of those policies have proven to further hinder the VA's ability to handle increasing numbers of claims and health care costs. The result has been dramatic increases in wait-times and backlogs that make it difficult, and in many cases, impossible for disabled veterans to receive timely and appropriate care.

Efforts initiated by the second Bush administration to promote privatization and outsourcing as the solution to VA problems have led to a perfect storm of unintentionally adverse consequences, characterized by significant decreases in overall quality of care and significant increases in financial costs. Unfortunately, internal cultural factors have fostered fraudulent activity, abuses by civilian contractors, and a systemic failure to

properly process medical claims. Shortages in staffing and an outdated IT infrastructure, along with wasteful expenditures and increasing health care costs, have pushed Veterans Affairs to the breaking point. In order for the VA to thrive in the future, it is imperative that policies focus on addressing the critical issues identified in this thesis. These are fundamental weaknesses that permeate the entire VA system and cannot be resolved without an effective plan with clear directives that focus on achieving both short-term and long-term goals to directly enhance system-wide capabilities.

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