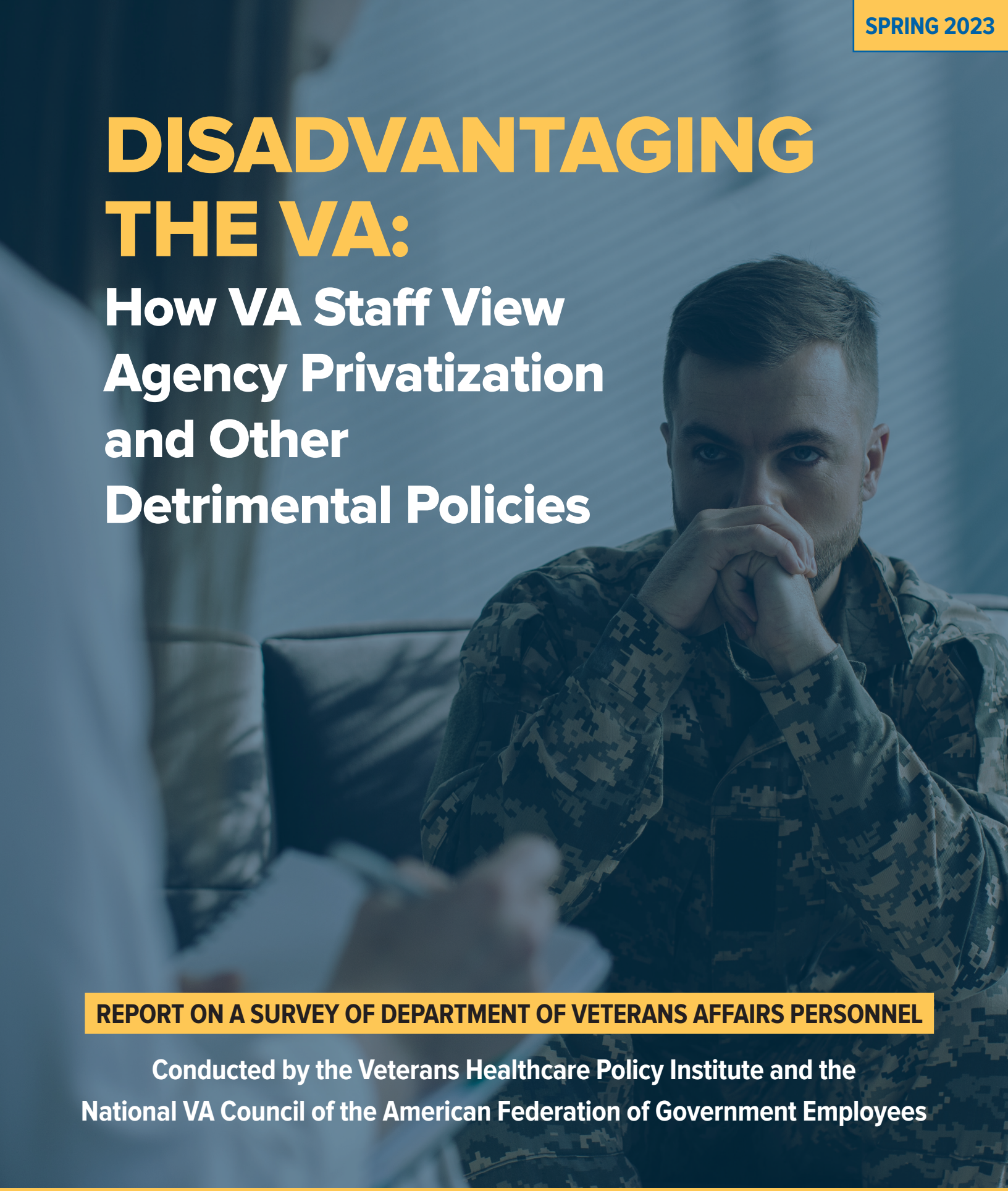
SPRING 2023

DISADVANTAGING THE VA:

How VA Staff View Agency Privatization and Other Detrimental Policies



REPORT ON A SURVEY OF DEPARTMENT OF VETERANS AFFAIRS PERSONNEL

Conducted by the Veterans Healthcare Policy Institute and the National VA Council of the American Federation of Government Employees

Veterans Healthcare Policy Institute
Strengthening Care for Veterans and the Nation

CONTENTS

EXECUTIVE SUMMARY

THE DEPARTMENT OF VETERANS AFFAIRS (VA) provides the best healthcare in the nation, benefitting not just veterans, but all citizens. During the COVID-19 pandemic, the VA continued to outperform private hospitals. The agency maintained and supported solid staffing levels, opened pandemic-specific units, and focused on patients over profits. The agency has emerged out of this public health crisis as the national leader in delivering quality healthcare outcomes. VA also consistently ensures that veterans receive their hard-earned benefits. The agency's excellence inspires the Veterans Healthcare Policy Institute (VHPI), as well as the American Federation of Government Employees (AFGE) and its National Veterans Affairs Council (NVAC) to maintain and improve VA services, while also fighting back against misguided privatization efforts.

In the spring of 2022, VHPI conducted a survey of Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) employees who are represented by AFGE, the union with the largest bargaining unit of VA employees. The survey posed questions about the impact of recent legislation and administrative actions related to healthcare for veterans and non-medical benefits for veterans and their dependents. The survey also inquired about job satisfaction, recruitment and retention, and other work-related problems. More than 2,000 employees nationwide completed the survey.

The survey's major findings include:

- **Ninety-six percent** of VHA respondents indicated their facility needs more frontline clinical staff. **Seventy-five percent** said their facility needs more administrative staff. **Seventy-seven percent** said that there are vacant positions for which no recruitment is taking place.

- **Seventy-seven percent** of those who responded to the survey reported that their VHA facilities have closed beds, units, and/or programs due to staffing and budget shortfalls.

- **Fifty-five percent** of VHA respondents said they have less time to deliver direct patient care and support services than they did four years ago.

- **Eighty-two percent** of VHA respondents said that their work referring, monitoring, and coordinating outside care has increased in the last four years.

- **Half of respondents** said that the VHA's Human Resources Modernization Project has exacerbated delays in hiring and is contributing to the hemorrhaging of staff. Just over **90 percent** said HR delays had deterred interested candidates.

- **Sixty-two percent** of VBA employees are considering leaving their job in the next few years, primarily due to understaffing and unrealistic work metrics.

- The VHA and VBA workforce remains deeply committed to caring for veterans and fulfilling the VA's many missions.

RECOMMENDATIONS

The report ends with a series of commonsense policy solutions that will improve and strengthen the VA so that it can continue to provide high quality services to veterans and the nation. These include:

1. Fully staff and fund the VBA and the VHA.

2. Eliminate internal VBA and VHA obstacles to hiring staff in a timely manner, and improve utilization of tools in existing law and policy that assure that VA provider compensation is competitive with local markets.

3. Rescind the Human Resources Modernization project and reassign HR staff to local facilities.

4. Adhere to 2022 end-of-year omnibus language that requires VA to develop detailed and accurate quality comparisons between VHA and private providers.

5. Reform VHA access standards, including by counting in-house telehealth as access to care under the VA MISSION Act.

6. Pass the Employee Fairness Act, which will enable certain VA medical professionals to grieve patient safety issues and improve working conditions.

7. Roll back so-called "talk time" requirements and other punishing productivity standards that hobble the ability of VBA staff to answer veterans' questions and accurately process their claims.

STRUCTURE AND FUNCTION OF THE DEPARTMENT OF VETERANS AFFAIRS

THE DEPARTMENT OF VETERANS AFFAIRS (VA), the second largest agency in the federal government, employs over 412,000 people—a third of whom are veterans. The VA runs the only publicly funded, fully integrated healthcare system in the country—the Veterans Health Administration (VHA). The VHA's healthcare practices and outcomes are some of the best in the nation and it leads the nation in the integration of mental health and primary care, geriatric care, suicide prevention, healthcare equity, and employee safety practices. In FY 2023, the VHA was allocated a budget of $118.7 billion to provide medical care. The VHA employs roughly 380,000 staff, including physicians, nurses, and other medical and mental health staff, as well as transport workers, plumbers, dieticians, groundskeepers, clerks, and other support staff.

The VHA has four major missions:

1. **Delivering clinical care to veterans**
2. **Teaching healthcare professional trainees (More than 70 percent of all American physicians have had training at a VHA medical center.)**
3. **Conducting medical research and producing innovations that benefit veterans and civilians alike**
4. **Serving as backup to the private sector civilian healthcare system in times of local, regional, or national emergencies**

The VHA offers medical, mental health, and other care and services to nine million enrolled veterans, about six million of whom visit the VHA for care at least once a year. Not all veterans are eligible for VHA care. The VA effectively limits access to veterans with proven service-connected disabilities and/or low incomes. The 230,000 veterans who use the VA each day are poorer, older, and sicker than private sector patients and

disproportionately black, younger, female, and unmarried. Many haven't attended college and have low household incomes. Veterans are cared for at 1,298 sites of care across the country, including 171 medical centers, plus scores of outpatient clinics, rehabilitation facilities, nursing homes, and inpatient residential programs.

The VA also runs the Veterans Benefits Administration (VBA), which acts as the largest benefits system in the country. The VBA operates 56 Regional Offices, usually one in each state. Collectively this network oversees 55 percent of VA's annual budget ($146.7 billion in 2023). Its staff of 27,000 process claims filed by veterans and their dependents seeking healthcare, pensions, disability compensation, and educational benefits under the G.I. Bill.

MAJOR FINDINGS OF THE SURVEY OF VA EMPLOYEES

ACROSS THE COUNTRY, INSIDE HUNDREDS OF VHA HOSPITALS AND CLINICS, PLUS DOZENS OF VBA OFFICES, staff members report mounting obstacles to fulfilling their organizational mission.

Dedicated staff want to help veterans qualify for and receive healthcare coverage and other Congressionally-authorized benefits. Instead, they report that their efforts to approve or deliver these critical services are being thwarted by chronic underfunding and understaffing. These two long-standing VA problems have been exacerbated over the last 15 years by incremental privatization. That on-going process of outsourcing patient care to private sector providers has, among other things, transformed many care-providers into monitors of care delivered by others—over whom they have little control, and whose quality they cannot guarantee. Many employees also feel unsupported by VA administrators at the local, regional, and national levels.

In the spring of 2022, the Veterans Healthcare Policy Institute (VHPI) sent a survey to ~90,000 VHA and VBA employees represented by the American Federation of Government Employees (AFGE). Within AFGE, this survey was supported by the National VA Council (NVAC), which works to improve VA employee wages and working conditions—and by extension quality of care and benefit services—through contract negotiation on the AFGE-VA Master Agreement and administration of that agreement at locations with represented members across the country.

VHPI posed questions about how employees and veterans are being impacted by a series of policies, including the VA MISSION Act, the VA Accountability and Whistleblower Protection Act, a Trump-era Human Resources Modernization project, VBA productivity standards, and the outsourcing of medical exams related to VBA disability claims.

More than 2,000 employees (VHA = 1,680; VBA = 359) completed the entire survey. Roughly 30 percent of all respondents served in the military. Every one of the VHA's 18 Veterans Integrated Service Networks (VISNs) had at least 50 respondents. They spanned a wide spectrum of clinical, administrative, and support roles including

physicians, nurse practitioners, physician assistants, registered nurses, nursing assistants, physical therapists, diagnostic radiologic technologists, police officers, plumbers, groundskeepers, clerks, and dozens of other occupations. Specifically:

- 33 percent were nurses
- 3 percent were physicians
- 25 percent were other health professionals
- 23 percent served in various administrative and other support jobs
- 16 percent were "other" positions, including VBA claims processors and other administrative support staff.

Our queries were framed as multiple-choice questions. Respondents were invited to provide supplementary written comments, and hundreds did so. Our comprehensive survey data is expressed through graphs in Appendix A (for VHA) and Appendix B (for VBA). In these two appendices, we dropped "Not Applicable" answers when tabulating final percentages.

The survey results, which are contextualized and analyzed in this report, reveal a series of mounting challenges. Most relate to the outsourcing of care to the private sector through the VA MISSION Act of 2018 and Choice Act of 2014, which is hurting staff morale and negatively affecting veterans' health. Many employees have concerns about the VA Human Resources Modernization project, launched during the Trump administration and continued under President Joe Biden. Many also expressed concern and opposition to VA Secretary Denis McDonough's March 2022 recommendations to close dozens of facilities and units as part of the Asset and Infrastructure Review Commission (AIR) process, another MISSION Act mandate. McDonough was forced to retreat, at least temporarily, from these plans when key senators refused to confirm President Biden's AIR Commission nominees and Congress voted to defund the Commission. Nevertheless, the resulting job insecurity, and stress, has led many to reconsider their careers at the agency.

The survey's major findings, which were summarized in an interim report published in the summer of 2022, are as follows:

1. The VHA workforce is experiencing serious underfunding and understaffing. Tens of thousands of vital jobs are going unfilled. Sixty percent of respondents reported losing key resources, especially staff, over the last four years. Ninety-five percent said their facilities needed more frontline staff. Seventy-five percent said they needed more administrative/support staff. Seventy-seven percent said that there are vacant positions for which no recruitment is taking place.

2. Sixty-six percent of VHA respondents reported that beds, units, or programs have been closed in their facility due to staffing and budget shortages, even when there is patient demand for such services.

3. Almost 30 percent of VHA respondents have shifted a portion or a majority of their work to monitoring and coordinating private sector care. Fifty-five percent said they have less time to deliver direct patient care and support services because of outsourcing duties.

4. More than 40 percent of respondents said that, despite efforts to seamlessly coordinate private care with VHA services, staff often don't receive patient medical records from private sector providers. VHA respondents also report that private care is less integrated and more fragmented than VA care.

5. The VHA's Human Resources Modernization project—which was ostensibly designed to streamline the hiring process and improve working conditions—is failing. Forty-eight percent of respondents said the modernization project has increased delays in hiring. Respondents said facilities are hemorrhaging staff, with too few being replaced. More than 90 percent said that interested candidates were lost because of HR delays.

6. In scores of comments, VBA employees reported job dissatisfaction and burnout, due mostly to understaffing and unrealistic performance standards. Nearly 80 percent of VBA respondents said they faced work quotas, which in their comments, they described as entirely unrealistic. Of those, 83 percent said these quotas impeded their ability to assist veterans. Forty-seven percent said outsourced Compensation and Pension exams—which create crucial medical evidence for claims—make it more difficult for them to rate veterans. That's because they are often incomplete, incorrect, biased, or illegible.

7. Sixty-two percent of VBA respondents are considering leaving their jobs in the next few years. Their frustrations predated the passage of the PACT Act, which is now increasing their workloads and likely adding additional job frustration.

8. One of the survey's most important findings confirms what Secretary McDonough and countless VA patients have consistently noted: the VA workforce remains deeply committed to caring for veterans and fulfilling the VA's many missions. These sentiments suggest that, should the VA's serious challenges be addressed, VA workers will not only feel less frustration and burnout but will be able (and be enthusiastic) to provide even higher quality care and services to veterans.

The first section of the report discusses working conditions at the VHA. It begins with a description and analysis of the legislative and policy history that has produced adverse working conditions at the VHA. It then presents and analyzes the survey responses, along with selections from the hundreds of comments offered. The report then shifts to conditions inside the VBA.

In addition to survey data and written responses, this document includes profiles of patients and agency staff. (Additional patient profiles are in the appendix.) These stories make it abundantly clear why the majority of veterans, when surveyed, say they are satisfied with VA care. They do not want the VA to be privatized.

Our findings echo smaller surveys from VA staff—like the Association of VA Psychologist Leaders (AVAPL), the Nurses Organization of Veterans Affairs (NOVA), and the VA's Chiefs of Staff Advisory Council. It also mirrors findings published in peer-reviewed research papers, Congressional reports, VA Inspector General investigations, and VHPI's own extensive reporting and analysis, which are all summarized in the report.

The report concludes with an alternative agenda for the VA—a series of commonsense policy solutions to address staffing shortages, improve and expand services, end the outsourcing of VA work to the private sector, and ensure the integrity and vitality of both the VHA and VBA for generations to come.

VHA HISTORY

A LEGACY OF UNDERFUNDING

When President George W. Bush launched the "War on Terror," Republicans almost immediately pushed for deep and poorly timed VA budget cuts. In 2003, the House tried to slash nearly $15 billion worth of veterans' programs. At risk, according to the *Boston Globe*, was "money for disabilities caused by war wounds, rehabilitation and health care, pensions for low income veterans, education and housing benefits, and even—nice touch—burial benefits."

Democrats eventually thwarted this effort but were unable to bolster the overall VA budget so the agency could address current and future needs. In fact, that very same year, the VA announced it was forced to start turning away many middle-income applicants applying for new medical benefits.

Not long after, the Bush administration killed a bipartisan Congressional effort to add $1.3 billion for VA hospitals to the war and reconstruction budget. In 2004, Congressionally chartered Veterans Service Organizations (VSOs) like AMVETS, Disabled American Veterans, Paralyzed Veterans of America, Veterans of Foreign Wars, and Vietnam Veterans of America unsuccessfully pleaded for $3.7 billion more for the VA than the administration was requesting. Even Bush's own VA Secretary, Anthony Principi, publicly complained that the President was not adequately funding the agency. "I asked OMB for $1.2 billion more than I received," he testified.

"We are facing a crisis today because we have underfunded VA healthcare," former Texas Congressman Chet Edwards said in 2005 remarks while serving on the House Committee on Veterans Affairs. "We should correct it before Congress takes one more day of recess or vacation."

"We are facing a crisis today because we have underfunded VA healthcare," former Texas Congressman Chet Edwards said in 2005 remarks while serving on the House Committee on Veterans Affairs. "We should correct it before Congress takes one more day of recess or vacation."

Funding issues hadn't been resolved by early 2014, when Senator Bernie Sanders (I-VT) worked with top VA and VSO officials on a legislative proposal called the "Comprehensive Veterans Health and Benefits and Military Retirement Pay Restoration Act of 2014." This would have authorized $24 billion for new VA hiring and infrastructure improvements. The bill would have also created an education and peer support program for military family members and caregivers with mental health disorders, expanded veteran dental care coverage, and secured new VA services for victims of military sexual assault. It was hailed in the press as "the most sweeping veterans legislation in decades." But because of Republican opposition, led by Senator John McCain (R-AZ), the bill never made it to the Senate floor.

Everything changed in the spring of 2014 thanks to management misconduct at the VA Medical Center in Phoenix, Arizona. Florida Congressman Jeff Miller, then the Republican chair of the House Committee on Veterans' Affairs, held a hearing at which a VA whistleblower from Phoenix revealed that a few hospital administrators had falsified paperwork to collect performance bonuses based on their false reports that they had met appointment-scheduling goals. The bonus policy created a pernicious incentive that undercut the VA's not-for-profit care model. Although Miller identified legitimate wait-time issues at the hospital, he inaccurately claimed that 40 Phoenix-area veterans had died because of delayed care.

Reducing wait times was a bigger challenge in Phoenix than at other VHA facilities for several reasons. In addition to an influx of newer patients from America's post-9/11 conflicts, Arizona already had a sizable year-round population of older veterans, plus a seasonal increase in patient loads during the winter due to visiting "snowbirds" from the Northeast and Midwest. In 2004, a Congressionally-chartered commission, known as the CARES Commission, was mandated to assess the capital asset needs of the VA in providing care for veterans over the next 20 years. Although the Commission recommended new construction of VHA facilities, no new medical centers or staff were added to handle the increased patient demand in Sunbelt cities like Phoenix and Tampa.

Rather than address the root cause of the resulting problems in Phoenix—or Congress' long history of underfunding veteran care and benefits—Miller and other Republican lawmakers turned a local scandal into a sweeping indictment of the entire system. The Koch-backed group Concerned Veterans for America (CVA) launched a nationwide media campaign that tarnished the VA's reputation, and, by extension, the public's confidence in government.

An extensive investigation by the VA's Office of Inspector General (OIG) later uncovered no evidence to support Miller's claims of veteran deaths. Due to Miller's efforts and the CVA campaign, however, mainstream media outlets like CNN and *The New York Times* published sensationalized reports about appointment delays and veteran deaths. As a result, McCain was able to pressure Sanders and Senate Democrats into supporting a three-year experiment in outsourcing veteran care, legislation he billed as a perfect fix for wait times. The law was called the VA Access, Choice Act and Accountability Act of 2014.

CHOICE MORPHS INTO MISSION

The Choice program the legislation created allowed veterans to seek outside treatment if they faced wait times longer than 30 days or lived more than 40 miles from a VHA facility. It allocated $10 billion to pay for private care, and just $5 billion to hire more VHA doctors and staff. (This in spite of the fact that VSOs and VA leaders believed that the agency needed at least $21 billion to address long-standing understaffing and infrastructure problems.)

Studies have documented that the Choice program failed to deliver on its main promise of ending delays in delivering veterans' health care. In its first year, private contractors only managed to successfully schedule 13 percent of all private sector appointments. Some veterans experienced frustrating and ludicrous glitches. In one case, a veteran in Idaho with a herniated disk was given an appointment with a primary care doctor in New York.

Although $5 billion had been set aside for hiring more staff, this was insufficient to tackle the VHA's existing staffing shortages. Nothing in the law addressed long-standing HR problems. The VHA was still unable to offer clinicians and other staff market-rate salaries and its internal hiring efforts were sluggish, with 13 percent of new hires dropping out during what was often a year-long onboarding process.

Despite its many flaws, the Choice program did not sunset after three years. McCain worked with Senators Jon Tester (D-MT) and Johnny Isakson (R-GA)—then the two top lawmakers on the Senate Committee on Veterans' Affairs—to secure a permanent extension and expansion of outsourcing via the VA MISSION Act of 2018. Air Force veteran Darin Selnick, a one-time CVA official, greatly influenced the content of the bill. According to his CVA bio, Selnick, who was a senior VA and White House adviser between 2017-2019, had a "major responsibility" for the "implementation of the VA MISSION Act."

The MISSION Act created the Veterans Community Care Program (VCCP). Two third-party administrators (TPAs) TriWest and Optum (part of UnitedHealth Group, Inc) were paid billions of dollars to assemble and administer a Community Care Network (CCN)—one comprised of more than a million private sector providers. In recent years the VA's OIG has conducted investigations that have documented that a significant number of these providers have fraudulently billed the VA. The TPAs were also tasked with training CCN providers about how to care for veterans as well as appropriately submit their invoices to the VA. (According to a report from the VA's OIG, they failed to do so.)

The MISSION Act established an Asset and Infrastructure Review (AIR) Commission, a provision that Selnick inserted into the bill. This nine-member body was tasked with recommending which VHA facilities should be closed, rebuilt, or repurposed, and where replacement facilities should be constructed. The AIR process mandated that the VA Secretary do a series of "market assessments." Consultants were hired to conduct studies of 96 VA "markets" to determine the relative capacity of private sector and VHA providers to care for current and future cohorts of veterans. Based on these data, VA would plan its future nationwide footprint.

The MISSION Act was backed by all the major veterans service organizations. In exchange for that support, their members won significant expansion of the VA's Caregiver Program, which provides case-support services and stipends to caregivers assisting severely disabled veterans. This program previously excluded post-9/11 veterans.

Only five Senators, including Bernie Sanders, opposed the MISSION Act. In the House, just 70 members—all of them Democrats—voted against the legislation. Following MISSION's passage, House Democratic leader Nancy Pelosi warned that the law was set to "to dismantle veterans' health care."

Following MISSION's passage, House Democratic leader Nancy Pelosi warned that the law was set to "to dismantle veterans' health care."

LOSING PATIENTS AND ASSOCIATED FUNDING

After MISSION passed, the Trump administration's then-VA Secretary, Robert Wilkie, quickly drafted new access standards that would determine which veterans would be eligible for private care. These rules were written, as the Veterans of Foreign Wars (VFW) later noted, "without consulting with those who most intimately understand VA's mission and the needs of the veterans community."

Instead of basing outside referrals on the clinical needs of patients or the timeliness and quality of care available from private providers, Wilkie's rules tied access to wait and drive times. If a veteran had to wait more than twenty days for mental health or primary care, or twenty-eight days for specialty care, they could also seek care outside the VHA. Any patient who had to travel more than thirty minutes for a primary care or mental health appointment or sixty minutes for a specialty appointment could automatically choose private doctors and hospitals instead of the VHA. (In many heavily trafficked urban centers, as well as sparsely populated rural areas, drive times to the nearest VA medical center or clinic can easily exceed sixty minutes.) According to a report from the Congressional Budget Office (CBO), these drive-time changes alone meant that one-third of all VA patients were made eligible for the VCCP.

In January 2019, twenty-eight Senate co-sponsors of MISSION warned that the massive projected costs of outside referrals was not being "adequately assessed." In a similar letter sent a month later, a group of twelve Senators expressed concern that expanded outsourcing— ranging from $1 billion to $21.4 billion over five years— wasn't being properly funded. These lawmakers accurately predicted that the "designated access standards could cause too much care to shift to the private sector." Among the negative impacts of that shift would be offering the "false promise of faster private sector care" and "crippling the largest integrated healthcare system in the country for those veterans who rely on its services."

In 2022, Rep. Julia Brownley (D-CA) reported that "spending on community care has increased by 116 percent over five years while investments in direct staff of VHA medical facilities grew by only 32 percent." Between FY2017 and FY2020, the VA OIG estimated that payments just for non-VA evaluation and management services that were not supported by medical documentation jumped by about 350 percent, from $67.5 million to $303.6 million. One reason for this increase is that 84,000 VCCP providers have overcharged VA and fraudulently billed for millions of dollars in care that was never delivered. (According to a 2022 OIG report, some private providers have also double-billed VA and Medicare for their services.)

In FY 2021 alone, more than 33 million private sector appointments were completed. At a June 2022 Senate hearing, Secretary McDonough

disclosed that the budget for private sector care had increased from 26 percent of the VHA's total annual spending on clinical care to 33 percent in a single year. He predicted that the VCCP could soon consume 50 percent of the VHA's clinical care budget.

In a related report McDonough submitted to Congress, he acknowledged that outsourcing "threatens to harm the VA's training, research, and emergency preparedness missions." He warned that "certain VA medical facilities, particularly those in rural areas, may not be able to sustain sufficient workload to operate in their current capacity." McDonough also noted that there was only one way to stop this unsustainable drain on VHA resources: "My hunch is that we should change the access standards."

McDonough also noted that there was only one way to stop this unsustainable drain on VHA resources: "My hunch is that we should change the access standards."

So far, that hasn't happened. Absent any changes, the VCCP will continue to cannibalize the VHA's in-house care budget. Consider, for example, the FY 2023 Appropriations bill. It gives the VA $135 billion in funding which includes $128 billion for veterans' medical care. While this appropriation has been heralded as a significant increase—$34 billion more than in FY 2022—much of it will be directed to private sector healthcare.

Allowing VCCP growth to continue unabated has further ripple effects on how much money is available to regional and local VHA entities. One director of a large VA medical center told VHPI that it has become harder to reliably manage facility budgets—as well as argue for new hiring and expanding infrastructure—because the costs of private sector care are so unpredictable. Predicting a facility's budget for medical services—always a difficult but nonetheless manageable process—has become chaotic and variable due to rampant outsourcing.

STAFFING SHORTAGES FROM TRUMP TO BIDEN

In our 2020 Vacancy Crisis Report, we also documented serious staffing issues within VHA. At the time of its publication, the VHA had roughly 50,000 vacancies—a number larger than the workforce of the Departments of State, Labor, Education, and Housing and Urban Development combined. Despite pleas from overburdened VHA staff, then Secretary Wilkie made it clear that hiring staff was not a priority of the Trump Administration. This ignored the fact that the MISSION Act created major new administrative burdens, including routinely diverting staff from delivering or supporting clinical care to coordinating treatment by outside providers.

Registered Nurse Linda Ward-Smith has worked at the VA's Southern Nevada Healthcare System in Las Vegas since 2007. Before the MISSION Act, she spent her time caring for veterans with diabetes. She was proud to be part of a system that, according to many studies, vastly outperforms private sector providers in caring for this patient population.

Today, Ward-Smith works at her local Office of Community Care, alongside other nurses, psychologists, and clerks. She said employees in this office mostly "try to chase down documentation and paperwork from non-VA providers. There is no requirement that those providers give VA any record of what they have done with our patients. How can we take care of our patients if they come back to us, and we don't know what happened to them in the private sector?"

In January 2020, Ward-Smith, who serves as Local President of AFGE 1224, had to fend off an attempt to turn VA into a temp agency for three neighboring private sector hospitals. Las Vegas VA leadership proposed that VA staff—employed at the taxpayer's expense—leave the VA to work inside these hospitals to help manage VCCP patients, ensure discharge planning, and make them aware of their VA benefits. Two out of the three were owned by the nation's largest for-profit chain (HCA), which has a decades-long history of perpetrating health care fraud and abuse. "Not only are we paying hospitals these high dollars to take care of our veterans, but now hospitals want to take our scarce resources so they can get up to snuff," Ward-Smith vented. "It's completely crazy."

"Not only are we paying hospitals these high dollars to take care of our veterans, but now hospitals want to take our scarce resources so they can get up to snuff," Ward-Smith vented. "It's completely crazy."

A series of other unfunded executive orders added more burdens on to the shoulders of beleaguered staff. One mandated the VA check in with all newly discharged service members multiple times in the first year out of the military.

The refusal to prioritize new hiring coincided with clear warning signs of an impending staffing crisis. In 2016, roughly 40 percent of the VA's workforce was approaching retirement. On top of that, the number of veterans over 70—a population more reliant on VA services—is expected to jump from 30 percent in 2013, to 34 percent by 2046.

The vacancy problem the Biden administration inherited has not abated since 2021. Despite stepped up efforts to hire staff during the height of COVID, the agency is today struggling with an estimated 76,149 vacancies, according to VA's own numbers.

This statistic fails to capture the full extent of the Department's staffing problem. That's due, in part, to the VA's own vacancy formula, which, according to federal watchdogs, is opaque and unreliable. The metric only counts positions left unfilled after an employee has left a job. Excluded are the many new positions needed to address emerging needs, like the expected influx of veterans into the VA following passage of the PACT Act, which offers long-overdue care to veterans who have suffered due to toxic exposures dating back to World War II. The number of veterans exposed to burn pits during the conflicts in the Middle East alone could be as high as 3.5 million. The VHA has few staffing requirements noted in policy, and few oversight tools for when understaffed areas are identified. As a July 2022 report from the VA OIG stated, even units that may not have vacancies have severe shortages of physicians, nurses and other employees.

Adding to the challenges for the VHA are labor market impacts related to the COVID-19 pandemic. Before the pandemic, the nation already faced serious shortages of nurses, primary care physicians, mental health professionals, and many other kinds of healthcare workers. According to personnel estimates, one in five healthcare workers have quit since 2020 due to the trauma of working during the pandemic. There is today intense competition for those still willing and able to work. Private healthcare employers are offering higher salaries and signing bonuses, perks the VA has been slow to provide.

CLOSING BEDS, FACILITIES, AND PROGRAMS

The COVID-19 healthcare environment demands competency and creativity from the VHA when it comes to hiring and retention. Instead, VA leaders under Trump and Biden have responded by closing facilities, programs, and services. In our vacancy report, we noted that the Brooklyn VA's ear, nose, and throat clinic had recently closed, as had an outpatient clinic in Buffalo. PTSD support groups at the West Los Angeles VA hospital were shuttered. In Kokomo, Indiana, veterans praised a newly opened outpatient clinic because it gave them greater access to care. Less than a year after it opened, it was closed. The Trump administration also sought to quietly curtail services across the upper-Midwest, including a 29-bed nursing home in Miles City, Montana. (This effort was halted largely because of opposition from Senator Tester.) According to internal agency documents, efforts to increase capacity at the North Texas VA Health Care System, the second largest in the country, were quashed in 2019 despite internal projections that the patient population was set to increase by 12 percent in the next decade. Even a small veterans' woodshop program in northern New Jersey became a casualty of this Trump-era downsizing.

According to internal agency documents, efforts to increase capacity at the North Texas VA Health Care System, the second largest in the country, were quashed in 2019 despite internal projections that the patient population was set to increase by 12 percent in the next decade.

Just before Memorial Day 2021, the VA announced it would close its Troy, New York, outpatient clinic. That facility served over 1,000 veterans, all of whom were forced to seek care in neighboring Clifton Park or Albany. In spite of protests from New York state legislators, the VA has closed the facility.

Adam Pelletier, who was deployed to Kuwait and Iraq in 2003, is one of the many upstate New York veterans upset by this decision. He didn't know much about the VA after getting out of the Marines, in 2006. It was only after he suffered a mental health breakdown, around 2009, that he came to understand its importance. Pelletier suffered from what can best be described as a moral injury. He'd seen a series of explosive news reports about the use of the CIA's black site torture programs and couldn't escape some sense of culpability—even though he'd had no direct part in the atrocities. "It hurt to know that I had been some indirect piece of that situation," he said.

Pelletier was initially treated in a private psychiatric program, which he described as "not a very positive experience by any stretch of the imagination." Luckily, providers there quickly identified him as a veteran, and steered him to the VA system. "When I got to the VA and explained my circumstances, I wasn't looked at like a mad man complaining about the evil American empire. At the VA, it was just a completely different story. I didn't feel or get treated like I was a 'crazy' person."

"When I got to the VA and explained my circumstances, I wasn't looked at like a mad man complaining about the evil American empire. At the VA, it was just a completely different story. I didn't feel or get treated like I was a 'crazy' person."

"It's a much different, more understanding, medical environment," he added. He said he has continued to receive high quality care at the VA outpatient clinic he went to in the small town of Malone, as well as at the

larger VA medical center in Albany, and at the now-shuttered clinic in Troy. Luckily, Pelletier is relatively young, and has a driver's license and a decent car. But from his many experiences in VA waiting rooms, Pelletier has learned that the VA's patient population is often older, and generally faces real transportation challenges. "I'm convinced that a lot of people who used to go to Troy and must now go to Albany are either (A) not going—or (B) have been funneled into a private healthcare provider that's less effective, less efficient, and ends up costing taxpayers a whole lot more money."

THE AIR COMMISSION DEBACLE

Another major threat to the VHA healthcare system was the Asset and Infrastructure Review (AIR) Commission, which was embedded in the MISSION Act. It mandated VA to consider which of its hundreds of facilities to improve, shutter, consolidate or repurpose. In March 2022, using data collected by Trump-era consultants, which VA Secretary Denis McDonough admitted was deeply flawed, VA released market recommendations to the AIR Commission.

In them, the Secretary proposed closing hundreds of VA facilities and programs, including mental health services, VHA outpatient clinics, and residential treatment programs for patients with PTSD and substance abuse problems. He also recommended closing many inpatient units and emergency departments across the country. (Because a hospital can't have an emergency room without an inpatient unit, this would mean shuttering even more ERs than were slated for closure.) In areas where VHA doctors and nurses would no longer have the capacity to do surgical procedures or provide other inpatient care, VHA clinical staff would be "embedded" in private hospitals. The Secretary thus recommended a national plan similar to what Ward-Smith fought against in Las Vegas—using VA as a temp agency for the private sector.

Critics noted the recommendations would not only impact rural hospitals and the health of rural veterans, but would also adversely impact VA's teaching, research, and Fourth Mission—to serve as backup to the non-VA healthcare system in times of national, regional, or local emergencies.

To win support for his plan, McDonough dangled the promise of new infrastructure construction to replace local VA facilities that would be closed, downsized, or repositioned. The Secretary, however, could not guarantee that any single new VA facility would ever be built. (At the time of the release of his recommendations, the Senate had yet to approve even the paltry $5 billion in VA infrastructure spending that was part of Biden's then-stalled Build Back Better Act.)

McDonough's recommendations triggered a torrent of objections from stakeholders, including patients, unions (led by AFGE), and public officials whose states and cities would suffer facility closures. A dozen Senators opposed the plan, which they said would "put veterans in both rural and urban areas at a disadvantage." They refused to hold hearings to confirm President Biden's nominees to the AIR Commission, which effectively ended AIR.

Although the commission was jettisoned, McDonough's plan has created continuing anxiety among VHA employees inside targeted facilities. One union representative in Coatesville,

"We have a big sign outside our facility saying, 'Now Hiring,' and then people are reading news in the paper that our facility is about to be shut down. Why would anyone come and work here?"

Pennsylvania said, “We have a big sign outside our facility saying, ‘Now Hiring,’ and then people are reading news in the paper that our facility is about to be shut down. Why would anyone come and work here?”

THE FAILURE OF HR “MODERNIZATION”

Human resources staff recruit new hires, vet their credentials, make employment offers, notify candidates of the status of their job applications, and, if they are hired, onboard them so they are ready to work. HR is also responsible for administering pay adjustments and providing employees with Personal Identity Verification (PIV) cards which, quite critically, grant access to federal facilities and their corresponding computer systems. HR staffers also handle labor relations, as well as applications for Family and Medical Leave and worker’s compensation benefits.

In our vacancy report, VHPI documented the VA’s long-standing difficulties in recruiting and retaining staff. Labor market conditions, like chronic shortages of primary care and mental health professionals, are, of course, beyond the VA’s control. It is also difficult to lure healthcare staff to move from large cities to work in rural areas, where over a quarter of the nation’s veterans live. Hiring is further complicated by VA’s own HR processes that can involve multiple offices and entities that work in a linear (rather than parallel) fashion. Because of this, it is common for the VHA to lose well-qualified, eager candidates who simply become tired of waiting months to hear about a job.

On top of all this is the fact that the VA is often unable to compete effectively with the private sector. Before the pandemic it was not easy to find clinical staff willing to take thousands of dollars less to work at the VHA. After the pandemic this has become even less likely. According to the VA-AFGE Master Agreement, the VA is supposed to launch a local review of wages offered by non-VA hospitals in a region to determine if VA pay is, or is not, competitive. But according to AFGE officials, VA leaders in many regions refuse to initiate these reviews, which further exacerbates vacancy rates. Another complicating factor—according to the agency’s latest vacancy data, the department is struggling with roughly 2,500 unfilled HR positions.

“It was always a challenge to get a position filled, now they have totally dismantled the whole HR process.”

President Trump promised to fix these and other issues when he launched a Human Resources Modernization (HRM) project in 2018. Instead, the initiative has made a bad situation even worse by crippling already-cumbersome VA hiring, on-boarding, and other HR functions. Trump appointees also compromised recruitment and retention efforts by attacking VA unions and undermining workplace rights. His VA leaders installed, promoted, and protected ineffectual managers, some of whom have flouted labor agreements, threatened employees, and instituted punitive management practices. The agency’s depersonalized approach to hiring has also undercut collective bargaining agreements—which lay out hiring and promotion rules based around merit that often reward internal candidates, including veterans.

The major goal of the modernization project was essentially eliminating local HR offices. Before the HRM project, local staff reported to facility directors, and understood local conditions. With the launch of the HRM project, local HR staff were replaced by a web-based system, known as HR Smart, which is also used in the VBA. HR inquiries are now directed to regional VISN entities, and, ultimately, VA’s Central Office, in Washington D.C.

In a previous investigation, VHPI found that the HRM project has crippled HR functions. “Imagine trying to find a suicide prevention coordinator in an online system when you can’t explain to a real person how urgently you need these positions filled and they won’t even respond to your emails,” one former VHA hospital director said. “Facilities may be short 75 or 100 nurses. How can shortages like that even be allowed to exist?”

“It’s absolutely abysmal,” vented a physician leader on the West Coast. “It was always a challenge to get a position filled, now they have totally dismantled the whole HR process. You used to have contact with an HR person who could handle the problem. Now we must use an anonymous email server group list. It now takes 6 to 12 months to hire. We couldn’t even get PIV cards.”

Nurses are also distressed about the new system. “If a nurse can no longer push beds around, and her doctor has confirmed the problem, she has to go through HR to process a request for a transfer to a different job,” Ward-Smith, the AFGE president from Vegas, explained. “HR are supposed to respond in 30 days. Now it takes months, and the nurse is forced to do the job in which she was injured or quit. The same thing is true with anyone who wants to take family and medical leave.”

The situation became so dire that, in the fall of 2021, the VHA Chiefs of Staff Advisory Council—which represents medical leadership in VA medical centers—conducted an internal survey to catalog the consequences of the HR reorganization. Ninety-two percent of respondents said the HRM project had made things worse or much worse. Most said the project had led to a “tremendous drop in access to care.” One wrote: “The current system could not be more dysfunctional and unhelpful if it tried.”

The Chiefs of Staff survey also found that HR staff didn’t make job offers in a timely fashion, which often resulted in applicants finding other work: “Delays in HR extending a formal offer led to the annual loss to competing offers of 5 or more interested candidates in 69 percent of facilities and more than 10 candidates in 37 percent.” As the veteran suicide epidemic persists, chiefs reported bed closures due to lack of nursing staff, including a need to reduce inpatient mental-health beds. They also said that roadblocks to hiring resulted in more veterans being sent to private-sector providers, which, according to one chief, are “now saturated and cannot take on more vets.” Another chief warned that “this is increasing the number of veterans who are dying due to lack of care from not being able to fill positions in a timely fashion.” Another begged: “This is a patient safety issue. HELP US!!!”

“This is a patient safety issue. HELP US!!!”

FRAGMENTATION OF CARE

Care fragmentation has been among the most serious side effects of America’s market-driven healthcare system. As Einer R. Elhauge explained in his book “The Fragmentation of U.S Health Care,” “the current payment system perversely provides *disincentives* to invest in coordination of care that might lessen the needs of patients for health care, because such investments result in fewer patients for medical or hospital services.” Elhague explains that these issues arise in systems that suffer from “excessive disintegration that worsens outcomes.”

According to Elhauge, the “costs of fragmentation” include “uncoordinated care, low adherence rates, and variations in sources of care.” Fragmented care also increases the likelihood of duplicative or redundant testing

and over-prescribing. A 2018 study of VA patients being cared for in the private sector noted that "recent federal policy changes' attempt to expand veterans' access to providers outside the [VA] may increase the risk for unsafe prescribing, particularly in persons with dementia."

These dangers were further highlighted in a 2020 *JAMA* article on VA outsourcing: "Without well-defined mechanisms for 2-way flow of information, it is unclear how easier access to private sector care, potentially at the expense of increased fragmentation, could translate into safer higher-quality care, regardless of the cost implications."

Before the MISSION Act, almost all VA patients were cared for in a system in which both financial incentives and decades of innovation aligned to encourage care coordination through various well-oiled mechanisms. These include a shared electronic healthcare record, the integration of primary and mental healthcare, and Patient Aligned Care Teams (PACT), which focus on coordinating care across all departments and among all clinicians and staff.

"The current payment system perversely provides disincentives to invest in coordination of care that might lessen the needs of patients for health care, because such investments result in fewer patients for medical or hospital services."

Research shows that superior outcomes result from better coordination. Perhaps the best evidence came in a 2021 study published in the *British Medical Journal*. Author David Chan and his colleagues reviewed the experiences of 583,248 veterans who were enrolled in both the Medicare and VHA programs. During medical emergencies, these veterans were quasi-randomly taken by ambulance to either a VA center or a private sector hospital. In the 30-day period after their ambulance ride, veterans who were taken to private ERs were twice as likely to die than if they were treated at the VA. (The cost of their care was also 21 percent higher.) Chan and his colleagues suggested that this so-called "VA advantage" was due chiefly to care coordination.

A former member of the National Faculty of the American Heart Association, Dr. James Martin is an emergency physician who, since 2006, has worked at the VA's James A. Lovell Federal Health Care Center in North Chicago. (He's also an AFGE leader.) He believes that MISSION outsourcing is eroding the "VA advantage." By way of example, Martin spoke about a 70- year-old veteran who had visited his Emergency Department. Two weeks before, the patient was experiencing chest pain and went to the ER at a nearby private sector hospital. He was admitted and had an extensive cardiac evaluation. Then he was discharged from that hospital. Two weeks later, he came to Martin's facility with chest pain.

Martin immediately wanted to know what had happened to the patient in the private sector. If he'd been previously admitted to any VA hospital, this information would have been at his fingertips. But because the patient had come from the private sector, Martin was flying blind. In this case, the private hospital had scanned the patient's file into a pdf. The problem was, it was 82 pages long, and difficult to quickly read on a computer. Martin printed out the entire document, sat down, and leafed through it. Some of the information he needed was there, but Martin didn't have EKG images or a chest X-Ray.

When a patient comes to the emergency room with chest pain—a signature symptom of a heart attack—the motto is: "time is muscle." That's because every minute that goes by, more heart muscle dies. "Here I was wasting precious minutes printing a pdf and trying to find relevant sections," Martin exclaimed. "Believe me, this was not a good feeling."

"We know that the VA delivers care that is far superior to the private sector, particularly when it comes to emergency care," Martin continued. "So why are we sending so many patients out to the private sector? Why is my job caring for them becoming harder? The VA is a model for the private sector. They should be learning from us. Instead, our model of coordinated care is being contaminated by the kind of care fragmentation that I experienced all too often in my earlier career in non-VA hospitals. Enough is enough."

"The VA is a model for the private sector. They should be learning from us. Instead, our model of coordinated care is being contaminated by the kind of care fragmentation that I experienced all too often in my earlier career in non-VA hospitals. Enough is enough."

PROVIDER BURNOUT

Scholarly literature defines burnout as an emotional reaction to multiple sources of stress at work. It's a problem that affects many across America's healthcare workforce. It's fueled by a number of factors, from chronic understaffing, punitive management, and unreasonable productivity measures that impede effective performance.

Burnout, as one study points out, leads to "emotional exhaustion, cynicism and depersonalization, and reduced professional efficacy and personal accomplishment." Researchers have also confirmed the link between burnout and decreased care quality, including, according to a paper on VA mental health providers, increased risk of veteran suicide. Providers suffering from burnout may make more medical errors, which, in turn, leads to lower patient satisfaction scores, worse healthcare outcomes, and higher healthcare costs. It also makes employees feel less satisfied in their jobs. One study of job satisfaction among VHA mental health staff said that staff turnover involves "staggering" costs. (A recent literature review found that the COVID-19 pandemic has greatly exacerbated burnout.)

According to another paper, the challenges of caring for complex patients are magnified when clinicians and other workers must cope with administrative policy changes which deprive them of necessary resources. A recent study of behavioral health providers found that VA providers are at higher risk of burnout because "the VHA has a unique patient population and bureaucratic demands." Studies on VHA physicians have highlighted similar problems, particularly for primary care providers, as well as those working in rural areas.

A 2021 study found that the increased burden of coordinating care with non-VA providers has also "resulted in higher rates of burnout among VHA primary care providers." A 2022 study of seriously ill kidney patients using both VA and private sector care emphasizes the stress staff experience because of "limited control and understanding of the referral process after submitting the consultation" and the uncertainty about what happened to a veteran in the private sector. Clinicians are, in other words, distressed by the "bureaucratizing of their clinical role." Staff were also concerned that using private sector providers, "led to duplication of services and increased the work of VHA clinicians while limiting the quality and timeliness of the care they were able to provide."

ANALYSIS OF VHA SURVEY RESPONSES AND COMMENTS

ALL THE PROBLEMS DESCRIBED ABOVE are highlighted in the survey responses and comments discussed in the following sections. Our data also confirm what VA Secretary McDonough has consistently highlighted—the "dedication and excellence of VA employees." These are, McDonough said, "highly-skilled professionals, many veterans themselves—veterans serving veterans who deserve our profound respect and support." Sadly, the results of our survey do not paint a picture of a workforce feeling adequately respected or supported.

SERVICE CUTBACKS

Nearly 70 percent of survey respondents reported a reduction in programs, units, clinics, beds, or other facility services in their facilities, which spanned the country. One respondent said their facility closed four inpatient units. "Over half of our hospital beds are closed due to staffing," explained an employee from Texas. "They even shut down our oncology ward and are doing chemo on acute care wards. Surgeries have been postponed because of lack of beds due to staffing."

Ninety-five percent of respondents said staffing shortages caused care delays that were subsequently used to justify sending more veterans to the private sector. One respondent said their facility had only three full-time cardiologists, even as it was expected to serve a large population in Nevada. Another said their emergency department is chronically understaffed, leading to the diversion of ambulances to private hospitals.

Almost 60 percent said that veterans were sent to VCCP providers even if they stated a preference for VHA care. "I was ashamed to have to offer veterans community care when our next opening was just over the line by one day," vented one respondent from

"I was ashamed to have to offer veterans community care when our next opening was just over the line by one day," vented one respondent from Kansas.

Kansas. “The community care appointment was two months out, got canceled, then the veterans had to wait another 30-plus days to return to our clinics. This is a disgrace on the national level.”

Forty percent said veterans were sent to outside clinicians even if they specifically stated they were willing to wait for a VHA provider. “Over and over, we are told by our veterans that they prefer to have their care at the VA and are not interested in privatization,” said one respondent. “It is the VA’s job to care for veterans. It is wrong on every level to attempt to outsource this.”

Q2: Has your VA facility lost resources (money, staff, beds, buildings, budgets, etc.) in the last four years?

YES	77.12%
NO	22.88%

Ironically, when veterans are sent to the private sector, they often face longer wait-times than at the VA, as dozens of interviews, plus numerous OIG reports and academic studies document. One 2021 publication found that California veterans seeking care for sleep apnea in the private sector faced far greater delays than in VHA facilities. The study also found that communication in the private sector was “incomplete,” while continuity of care was “disrupted.” The VA’s electronic medical record, on the other hand, facilitates communication between sleep apnea clinicians and primary care providers. When a health system lacks care coordination, the study noted, the burden of this work falls on the patient.

MENTAL HEALTH STAFFING SHORTAGES

As has been widely documented, the VHA’s patient population suffers from a high prevalence of mental health conditions. Thirteen to 20 percent of Iraq and Afghanistan veterans, and 30 percent of Vietnam veterans, experience PTSD post–deployment. More than 30 percent of women serving in the U.S. military say they have experienced military sexual trauma. VA’s 2022 National Veteran Suicide Prevention Annual Report found that, in every year from 2001 through 2020, age-and-sex-adjusted suicide rates of veterans exceeded those of non-veteran U.S. adults. In 2020, the veteran suicide rate was 57.3 percent higher than that of non-veteran adults. Timely access to—and coordination of—mental health care is therefore critical, especially as the U.S. military remains in more than 80 conflict zones across the world.

VHA mental health staffing shortages significantly impact veterans’ ability to get needed care and to prevent veteran suicide. Problems with care coordination are particularly important for those struggling with the kinds of conditions common among veterans. Despite White House and Congressional assurances that suicide prevention is a national priority, neither lawmakers nor the last three VA Secretaries have adequately addressed the fact that VHA mental health services are short-staffed throughout the country.

According to a 2022 OIG report, 73 out of 139 VHA medical centers had “severe” shortages of psychologists. Seventy-one centers identified “severe” shortages of psychiatrists. Before the pandemic, in New Mexico’s VA system, chronic mental health shortages led to four-month wait-times for new patients. Facing similar issues in

Rhode Island, mental health counselors were ordered to double their number of weekly visits to meet demand. "They kept pushing the numbers, the numbers, the numbers," said Ted Blickwedel, a Marine Corps veteran and former VA counselor who was caught up in the order. "We had counselors taking leave, burning out, or obtaining their own therapists."

As of the first quarter of FY 2020, 58 percent of facilities failed to meet VHA Directive 1161—which requires facility outpatient mental health staffing ratios to be a minimum 7.72 full-time outpatient clinical mental health professionals per 1,000 mental health patients, a ratio that, when attained, has been shown to prevent suicide.

To address veteran suicide, the VA has employed Suicide Prevention Coordinators (SPCs) who identify high-risk veterans and ensure that care and monitoring for these veterans is intensified. A recent study that examined six years of VA services explained that each additional SPC contact with a VA patient identified as high risk for suicide was associated with a four to five percent lower odds of suicide attempt, suicidal behavior, or reactivation of high-risk status over the next year. Adequate staffing also enhances quality of care, access, and satisfaction, as measured by Strategic Analytics for Improvement and Learning (SAIL) metrics.

While adequate staffing reliably predicts better mental health treatment, pressing therapists to deal with too many patients, without sufficient time to treat them, could have the opposite effect. Our survey mirrored the conclusion of two other recent studies. One study of VA mental health staff concluded that, "too high of productivity is associated with chaotic work environments and provider burnout." The other was a 2021 report from the Government Accountability Office (GAO). It revealed that excessive patient loads had led to staff burnout and high turnover.

Provider dissatisfaction is unlikely to help VHA recruit new staff from a broader mental health workforce that suffers from long-standing shortages that the pandemic has exacerbated. As one documented, 77 percent of U.S. counties faced a severe shortage of practicing psychiatrists, psychologists, or social workers. More than 50 percent lack a single psychiatrist. Another report explained that only 55 percent of American psychiatrists will accept patients who pay via private insurance or Medicare. Only 43 percent will accept Medicaid payment rates. Psychiatrists, a VISN chief of staff told VHPI, who can now name their own salaries and working conditions may thus balk at working for the VA, which does not offer market rate salaries.

The agency today reports a shortage of more than 1,500 psychologists and other mental health positions. If the VA's mental health provider shortages are not effectively addressed, they will get even worse. That's because the PACT Act is beginning to increase the number of veterans requiring VA suicide prevention services. The new 9-8-8 lifeline number is similarly predicted to increase Veterans Crisis Line call volume by 50 percent, resulting in a spike of referrals to local suicide prevention coordinators who will have difficulty managing the increased load.

This was emphasized in the comments of survey respondents. As one stated, "We know that veterans with a high risk for suicide do better if they are followed by the VA. But it takes a lot of effort to do that. If we were fully staffed, no one would complain, but staffing is so low that it is really hard to follow people and assess for suicidality." Another said there wasn't enough staff to "comply with the 'close observation' policy for mental

"We know that veterans with a high risk for suicide do better if they are followed by the VA. But it takes a lot of effort to do that. If we were fully staffed, no one would complain, but staffing is so low that it is really hard to follow people and assess for suicidality."

health patients. “Patients are not getting the attention they need,” a respondent in Nevada worried. “We do not have enough staff to safely monitor them. There is a high-risk for suicide on the mental health unit due to lack of staff.”

One survey respondent reported that only eight out of 28 positions in their mental health clinic were filled. A respondent from Arkansas said a staff of 12 full-time outpatient psychiatrists has dwindled to one. “The patients are miserable,” the respondent explained. “It’s not like demand has gone down for psych as the number of psychiatrists dwindled.”

“We are losing psychologists to non-VA positions at an alarming rate,” a respondent in Houston warned.

MANAGING AND MONITORING PRIVATE SECTOR CARE

Since 2015, VHA staffing shortages have worsened due to the fact that VHA clinicians and support staff spend their days trying to monitor private providers rather than delivering direct care to veterans.

The experience of Chris Horton, a long-time mental health professional at a Western VA Medical Center, illustrates the problems that occur when VA staff no longer deliver care, but supervise it. (VHPI is using a pseudonym to allow Horton to speak freely.)

Horton no longer provides direct care to veterans but instead serves as what is known in VHA jargon as a “Delegation of Authority,” or DoA, for mental health. A DoA reviews requests for an initial episode of care from a private provider as well as requests for further therapy sessions. Over three years in this role, Horton has become increasingly worried about the fact that DoA’s do not receive adequate information about the treatments that veterans receive in the VCCP or about the quality of care its providers deliver.

Horton contrasted the quality of mental health care veterans receive in the private sector with that delivered in the VA. “In the VA, we have had some of the best evidence-based practice training programs that exist. First you go through training in a particular psychotherapy, say Cognitive Processing Therapy for PTSD. Then, after your initial training you have six months of consultation where an expert listens to your cases and gives you feedback. You don’t get certified unless you demonstrate mastery. Then we have ongoing support to continue to implement those evidence-based practices with fidelity.” None of that happens in the private sector.

Like Ward-Smith in Las Vegas, Horton is concerned about the larger impact of diverting more clinical and support staff to monitoring and supervisory roles. Horton now spends about 24 hours a week on reviewing and approving requests for private care. Other mental health professionals at the same facility collectively put in another 15 hours weekly serving as gatekeepers to insurance companies. Horton said that because the pay is better, a number of the Medical Support Assistants (MSAs) have also shifted to scheduling private care appointments or undertaking other clerical duties: “Some people now work full-time scheduling appointments for veterans with private sector providers and receiving and uploading medical documents.”

“Some people now work full-time scheduling appointments for veterans with private sector providers and receiving and uploading medical documents.”

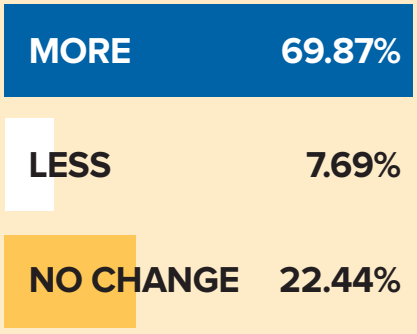
Despite their best efforts to coordinate and monitor VCCP care, it can seem like a Sisyphean task. "We are sent faxes that are uploaded onto the computerized medical record," Horton explained. "Most are handwritten, and largely illegible. If you can read them, they contain such minimal information that it's very difficult to make a clinical decision. Generally, we're left with the uncertainty of, 'What decision do I make here? The word angst comes to mind," Horton said, describing the job. "This is very upsetting work."

Nothing frustrates Horton more than the ineffectiveness of the third-party administrator (TPA) who is mandated to facilitate the provision of outside care. Horton reports that the TPA sends veterans to providers who lack basic training on everything from mental health care to drug counseling: "We find out patients have been receiving inappropriate treatment because a year later they come back to us, their insomnia is worse, and they tell us about their unsuitable treatment." Horton continued:

> *In the end, the TPA decides what to do. We might say we don't approve of something. But they can overrule us. They can approve more duration of treatment than we've approved. The TPA can connect a veteran to a provider who doesn't have the expertise we specified. Even when we express numerous concerns about a particular provider, the TPA can decide to keep the provider in the network. That has all happened. If they curtail that provider and send the patient back to the VA, they lose money. It's shocking. I don't think Congress even knows what questions they should be asking about this program. They just don't know what's really going on here.*

The frustration felt by Horton is a result of the demands VA has placed on its staff following passage of the MISSION Act. In a Congressional 2019 report, the VA laid out the painstaking processes it had developed to "ensure consistency and standardization of care across all its facilities and even with non-VA providers."

Q39: Compared to four years ago, how much of your time is spent scheduling exams outside of the VA?



While leaders and legislators imposed a weighty array of private sector duties on VHA staff—from monitoring, coordinating, and following up on care—they failed to provide the funds needed to increase staffing so VCCP care could be monitored without compromising the VHA's direct care mission. (VA, perhaps inadvertently, incentivizes this shift by offering some staff higher pay or, in the case of registered nurses, more predictable schedules if they work in the Office of Community Care.) When a nurse or physician or psychologist works—either part or full-time—in the Office of Community Care, there are positions that are not always backfilled.

Instead, remaining staff must take on the daunting task of overseeing care delivered by outside providers even though they have no authority to require that those "VCCP partners" collaborate or cooperate with VA. The

stress and strain of this work is expressed in sharp relief in survey responses and accompanying comments. Over 80 percent of staffers reported that administrative duties, like paperwork and private care monitoring, have increased over the past four years.

“I spend significant time doing clerical work, including scheduling my own patients and referring them to non-VA care,” said one clinician in Baltimore. Another had to remedy billing issues for patients after private clinicians wrote them prescriptions outside of the VA. “How can the VA manage a private doctors office??” this VHA staffer in Florida asked. “THEY CAN’T!!”

Almost 30 percent of respondents said their responsibilities had been partially shifted from providing direct care, or the support of direct care, to monitoring or coordinating the VCCP. Some estimated they were spending more than 40 hours a week remedying issues associated with the private sector. One respondent admitted that they’ve had to fill out administrative paperwork while performing exams on patients. “This does affect patient care and creates a safety issue,” this respondent acknowledged.

“I haven’t had the time or the inclination to calculate the time lost,” wrote another Oregon clinician. “It’d be too depressing.” The impacts of these trends are profound. Moving just two psychologists in a large medical center from providing therapy to monitoring care could, for instance, reduce the ability of that single center to provide individual or group therapy to between 60 and 90 patients a week.

Even Secretary McDonough, a long-time champion of the VA’s community care program, acknowledged in a September report, that “veteran feedback makes clear that some veterans seeking care in the community are driving further or waiting longer for that care than they would if VA provided that care; on top of these delays, veterans are also experiencing fragmentation of care, duplicative testing and unnecessary billing from community providers.”

In February 2021, national VA leadership launched a new VCCP monitoring effort, known as the Referral Coordination Initiative (RCI). According to internal agency documents, the RCI introduced a “revised process to streamline the scheduling of referral appointments” by shifting even more clinical and administrative staff to newly created Referral Coordination Teams (RCT).

Barb Galle, a registered nurse and President of AFGE local 3669, in Minneapolis, said this initiative is "duplicating the work of the Office of Community Care and creating extra workload for staff in the Office of Community Care." In her facility, four nurses have been shifted from direct care to this RCI work.

Elsewhere, as staff are diverted to monitoring and coordinating private care, 55 percent of respondents said that private healthcare records are not often provided. Seventy-four percent said private sector providers rarely report their outcome measures. Almost 60 percent said specific VA treatment recommendations were not followed "We have to constantly request the records," one respondent in Las Vegas wrote, echoing many others "Sometimes we never get them."

Another explained: "we do get records, sometimes, but they don't always come in a timely manner which can make it difficult if a non-VA provider is recommending medication changes." A third recalled being shocked after a private mental health counselor failed to document a veterans' self-harm assessment, or a subsequent suicide attempt.

"When my veterans receive community care, it is up to me to try to chase them down for status changes or outcomes."

"When my veterans receive community care, it is up to me to try to chase them down for status changes or outcomes. More often than not, they are unwilling to give me more than basic information stating that they are too busy with other patients," one VHA employee in Massachusetts wrote. "The care in the community program has failed miserably," another in Delaware responded. "Veterans have waited almost a year for basic services such as a colonoscopy. And follow-up is non-existent."

Over 70 percent identified instances where care delivered outside the VHA could have been provided in-house. In other cases, thanks to scant communication, private providers have duplicated work that's already occurred inside VA. One respondent recalled a private neurologist "ordering all sorts of tests that had already been done at the VA, when the referral was specifically for an [electromyography]. Utter waste of money." The concerns and complaints of survey respondents are echoed in a 2022 study published in *JAMA*. Lead author Ann O'Hare, a nephrologist at the Seattle VA Healthcare, and her colleagues analyzed the electronic health records of veterans with advanced kidney disease. The authors found that outsourcing VA care to the private sector created three interrelated problems.

First, outsourced care requires "extensive care coordination by VA staff members and clinicians to facilitate care outside the VA and the tendency of veterans and their non-VA clinicians to rely on the VA to fill gaps in this care. Second, it creates a lot of "hidden work of veterans" around referrals and communication between VA and private networks. Finally, outsourcing puts significant "strain" on VA providers as "cross-system care has stretched the traditional roles of VA staff and clinicians and interfered with VA care processes."

HUMAN RESOURCES MISMANAGEMENT

Pulmonologist Jason Kelley has been a clinician and chief of service at VHA medical centers in Kentucky and then Vermont for 24 years. In his experience, local hiring has long been hampered by staffing issues within HR offices themselves, lengthy and cumbersome decision-making and the VHA's inability to offer recruits market rate salaries.

Nonetheless, Kelley was always able to overcome these bureaucratic obstacles to get talented, new people on the VHA payroll. In recent years, however, the HR Modernization project unveiled under President Trump has

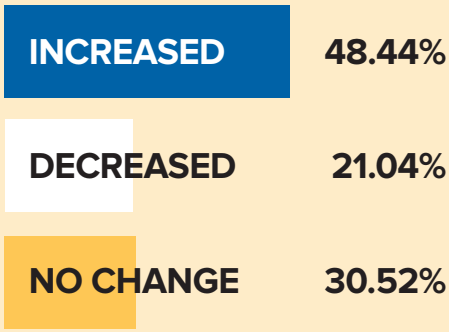
made things far more difficult. “There is now only one HR person in our facility, and they are very hard to reach,” he said. “You have to make an appointment weeks in advance to see them to sort out a problem that may be urgent.”

Kelley cites as an example, the difficulty of recruiting and onboarding internists, who function as what are known as Medical Officers of the Day (MOD). “An MOD is a physician, often an emergency room physician, who is on staff but takes on the administrative duty, on a rotating basis, of overseeing the flow of patients at any time during the day or night or on the weekend.” To fill such positions, he says, “We select candidates, do the initial paperwork, and get letters of recommendation. Then we may have to wait for maybe six months for HR to do its part.” Kelley said local HR officials sometimes fail to complete even simple tasks like making changes in a doctor’s official status—if, for instance, a physician moves from the emergency room to an outpatient clinic—or processing merit pay.

Almost 50 percent of respondents said that the HR modernization project had increased the time it takes to hire a new employee while over 30 percent said the initiative had secured no improvements in the hiring process.

In our survey, frontline staff reported similar problems. Almost 50 percent of respondents said that the HR modernization project had increased the time it takes to hire a new employee while over 30 percent said the initiative had secured no improvements in the hiring process. Nearly 80 percent said that there were vacant positions in their facility for which no recruitment was taking place, while 93 percent said they had lost candidates to competing offers because of delays in the HR hiring process.

Q22: Has the Human Resources Modernization process at your facility increased or decreased the time it takes to hire a new employee?



Eighty-one percent of respondents believe that the VA’s failure to offer competitive salaries has discouraged interested candidates from working at the VHA. This, coupled with the fact that VA patients are more complex and the workload often higher, can also discourage potential job applicants. “It feels like people are quitting at a faster rate than we can hire,” observed a VA staffer in Orlando, Florida. “This is often because they can get higher salaries elsewhere for work with less complex patients.”

One respondent in New Mexico cited the case of a co-worker who wanted to remain at the VHA but shift to a different job. However, the nurse became so demoralized by delayed HR processes that she simply quit. “She had been with the VA for 16 years and left due to no help from HR in getting a different job,” the respondent explained. “She was experiencing burnout and they didn’t help. A big loss to the VA.”

THE BURNOUT PROBLEM

While our survey didn't ask specifically about burnout, hundreds of respondents described its classic components, like emotional exhaustion and a reduced sense of positive meaning in their work. Components of burnout showed up in other survey questions. Twenty-six percent of respondents, for instance, said they were dissatisfied with their jobs. Nearly 20 percent said they were very dissatisfied. A staggering 66 percent said they were considering leaving in the next few years.

A majority of respondents said their desire to leave the VHA was fueled by short-staffing, excessive workloads, and myriad new responsibilities created through outsourcing laws. One respondent bemoaned "how exhausted and overworked our front-line staff is due to changes brought forth by the MISSION Act." All these issues, they stated, were taking away from the VHA's overall mission, which is what they'd signed up for.

One respondent noted that 12 dedicated employees from the department's lauded HUD-VASH housing program had left over the last year. "Unless things undergo some drastic changes, retirement is looking like a pretty smart option," another in Georgia commented.

"I believe, as a combat veteran, that change starts with staying in the fight."

Overall, the message was clear: Both VA and Congressional leadership have made the mission of caring for veterans far more difficult. "The only reason I've stayed is for my veterans," wrote a Texas staffer. Another explained, "I believe, as a combat veteran, that change starts with staying in the fight." Many pointed to the same solution. "I do not want to leave because this is the most stable job I ever had," a staffer in Phoenix said. "I just want the VA to hire more staff."

These sentiments are echoed by VA patients. In a survey conducted by the Veterans of Foreign Wars, 92 percent of veterans opposed VA privatization. "When asked how they would improve their health care system, veterans overwhelmingly reported that they believe VA must fix current deficiencies; that VA is already improving; or that there is nothing to improve in VA when compared to private sector health care."

AIR AND ITS AFTERMATH

While community labor protests and other national and local political pressure succeeded in shutting down the AIR Commission in 2022, survey respondents nonetheless expressed lingering anxiety over their facilities being targeted for closure.

Sixty-seven percent of survey respondents from within VHA said facility shut-down threats had led them to consider leaving the VA. One typical respondent called McDonough's recommendations "ridiculous," adding "we are a very rural state, and we need [these hospitals]."

By releasing a targeted facility list, the VA Secretary made hiring more difficult at those locations and others. "Why would anyone want to come work at the Manhattan VA," one former VA VISN director commented," if people think it will be closed in a few years?"

Survey respondents confirmed that the Biden Administration is proceeding, in piecemeal fashion, to dismantle VHA infrastructure, without the benefit of any AIR Commission input, good or bad.

For example, in Beckley, West Virginia, AFGE Local 2198 President Melissa Miklos recently learned that VA headquarters decided to cut funding for already approved and scheduled construction projects at her facility. Among those affected is a previously planned expansion of the local "Whole Health"' program, which includes chiropractic services and other alternatives to the use of opioids for the treatment of chronic pain. Also impacted is a local Community Living Center, and housing for adult daycare and home-based primary care.

Q29: Have the recent VA's recommendations about facility/ programs/service closures led to you considering leaving the VA?

YES	73.44%
NO	26.56%

Beckley has also been denied additional funding for the expansion of women's health services so that a separate clinic, located away from male veterans, could be created. This top-down decision was made despite a projected seven percent increase in the local population of female veterans. Meanwhile, because of MISSION Act-mandated out-sourcing, 65 percent of the VHA patients already served by Local 2198 members are now getting outside appointments, whether they want them or not.

"Nurses have become overworked, underpaid, and less appreciated. Nurses are leaving the profession. Nurses are leaving the profession due to burnout and harsh working conditions. If these circumstances are not addressed, unfortunately, the nursing shortage will worsen and have a major impact on patient health outcomes."

—The Nurses Organization of Veterans Affairs

As a result, local management now insists there is no way to justify the addition of "another square foot to the Beckley VA." Union officials and staff fear that the entire facility will still be shut down, as Secretary McDonough recommended, based on faulty market data.

Miklos is now concerned over how the VA will handle an influx of PACT Act patients, most of whom will need to see pulmonologists. Her facility is understaffed, while it can take more than six months to see a private sector pulmonary specialist. "We have one pulmonologist on staff, and he will be unable to handle the new patient load," she estimated.

VBA HISTORY

UNDERSTAFFING AND UNDERFUNDING STRIKES AGAIN

While most Americans think that every veteran is eligible for VA care and benefits, simply having served in the military does not guarantee automatic eligibility to either. Veterans are not automatically enrolled in the VA's slate of care and benefits, and must instead navigate a dizzying process filled with arcane forms and evaluations.

While VBA's dedicated staff, more than 50 percent of whom are veterans, rarely get much attention, their work impacts whether and how much a veteran is compensated for a service-related condition. They determine who is entitled to receive healthcare, home loans, pensions, and G.I. Bill benefits. Although a small minority of VA employees work at VBA (about six percent), a majority of VA's annual budget (55 percent) is spent on non-medical benefit payments to veterans and dependents.

VBA employees are often the first point of contact for veterans who are required to complete the complex paperwork that must be submitted to substantiate claims. Some active-duty service members who become wounded, injured, or ill while serving will also be evaluated by VHA staff within the Integrated Disability Examination System (IDES), who proactively work to build up the requisite information for a subsequent disability determination. The agency also runs a highly effective program providing benefits delivery at discharge. Both of these programs may save these new veterans from requiring other disability exams, and in turn speed up the claim process for veterans.

VBA staff often have conversations in which the veterans explain their healthcare and other problems. Because veterans usually have far more than one service-connected condition, (for example, PTSD, diabetes, hypertension, a traumatic brain injury, and chronic pain), they may have to undergo multiple disability exams, including "compensation and pension" (C&P) exams related to these problems.

Many of the claims that veterans submit are requests for an increased rating for a particular condition that VA has already determined to be service-connected. The veterans file these claims (for example diabetes, or musculoskeletal problems) because their condition has worsened over time. When veterans disagree with

VA claim determinations, they can seek a review of them at a VBA regional office, or a new decision entirely through the Board of Veterans' Appeals, located in Washington, D.C. As AFGE and advocates for veterans have noted with growing concern, veterans law judges serving on the board are no longer expected to have at least seven years of experience with veteran-specific claim issues. In the union's view, this personnel policy change is "negatively impacting the Board's overall quality and productivity, while destroying employee morale."

Congress has consistently balked at paying the full, long-term costs of war. Instead, legislators have tried to keep VA benefit costs under control by maintaining a byzantine claims processing system, which angers and frustrates many veterans and imposes unnecessary administrative burdens on VHA and VBA staff. Navigating this maze is extremely arduous and often results in inexplicable denials or long delays in accessing care, after getting a disability rating for service- connected injuries or illnesses.

In times of conflict, and immediately afterwards—as a new generation of veterans is born—the VBA has repeatedly struggled to handle the flood of claims applications. Each conflict also produces a new set of unrecognized conditions from which some veterans suffer. Because Congress invariably takes too long to create new presumptions about the service-connectedness of those medical or psychological problems, VBA staff are forced to play the role of gatekeeper, sometimes denying claims and then dealing with the personal backlash from veterans and their families.

This was most recently witnessed with the fight to pass the PACT Act, which belatedly recognized toxic exposure issues that veterans have been urgently sounding the alarm on for decades. From 1991 to 2020—according to Congressional hearings and independent reviews of VBA rating decisions for Gulf War illness and post-9/11 related toxic exposures—VA improperly denied 80 to 90 percent of the Veterans' disability claims. After years of advocacy Congress passed, and President Biden signed the PACT Act in August 2022. Since then, veterans have filed nearly 300,000 PACT Act-related claims. The new claims are due to the ongoing wars and increasingly toxic battlefields.

A 2021 report from Brown University's Cost of War Project provides a much-needed reality check on the full tab for the "Global War on Terror." This open-ended $8 trillion military campaign exposed hundreds of thousands of men and women to repeated deployments, which, in turn, created the most disabled generation of veterans in American history. Healthcare spending alone on post-9/11 vets, is now projected to reach $2.5 trillion by 2050, making it the most expensive (and underappreciated) budget item in the War on Terror.

PUNITIVE MANAGEMENT PRACTICES

Rather than correcting the VBA's historic management problems, the Trump Administration made them worse, by scapegoating VHA and VBA employees for real and imagined failings of the agency. This took the form of the White House-backed VA Accountability and Whistleblower Protection Act of 2017.

Then-President Trump applauded this law because, "the VA will now have the tools it needs to hold bad employees accountable and protect whistleblowers from the threat of retaliation." This legislation unfairly weakened due process for VA employees and curtailed their appeal rights, effectively superseding worker protections secured through statutory provisions and collective-bargaining agreements.

Within months of the Act's passage, thousands of employees—many from within VBA—were fired, demoted, or suspended, often with little or no cause. Most of the workers impacted were in bargaining unit jobs, not mid-or higher-level management positions. And as AFGE Local 2157 Vice President-VBA David Bump pointed

out, at the height of this purge, in Portland and other locations, the job holders being targeted were sometimes disabled veterans themselves, working in housekeeping or claims processing.

One casualty of the Accountability Act was Kenneth Rosa. During his military career, Rosa served as a Fire Control Technician. This work involved maintaining weapons systems, which brought him close to enemy fire. The VA has since rated him as 90 percent disabled. He struggles with depression and has a Traumatic Brain Injury that affects his memory.

Once he returned home, Rosa secured a job with the VA's Solid Start program, in which VBA connects with all newly-separated service members three times during their first year after leaving the military. That's because studies have identified that outreach to veterans during the year following their separation from the military as crucial in preventing things like suicide, homelessness, and social isolation.

Over two sprawling floors at a call center in Phoenix, Arizona, Rosa and several hundred other claims representatives (formally known as Legal Administrative Specialists) fielded phone inquiries from veterans and their family members. Rosa took pride in this work, but he experienced a great deal of stress when VBA initiated new productivity metrics that increased his workload and decreased his ability to help vulnerable veterans. VBA employees today have just eight minutes 30 seconds per call on a rolling average. "It's now more important to get them off the phone in the right time period than it is to assist them with the actual issue they're calling about." Rosa explained.

"It's now more important to get them off the phone in the right time period than it is to assist them with the actual issue they're calling about." Rosa explained.

Facing chronic understaffing, VBA re-instituted so-called "talk time" rules that mandate calls lasting only a few minutes. "Sometimes you get a call that's simple and you can get off the phone right away," Rosa acknowledged. But many of the calls he dealt with involved multiple injuries that require significant documentation. These sorts of calls could easily stretch on for 45 minutes. One of Rosa's colleagues described the tension of the job simply: "quality and talk time run interference with one another."

Despite Rosa's good work, VBA managers deemed that he was taking too much time. He admitted that sometimes his calls would run long. Due to the memory problems produced by his brain injury, he'd forget that he made a point and accidentally repeat it. Before too long, he was put on a Performance Improvement Plan (PIP). For years, PIPs offered an opportunity for struggling employees to improve. The Trump administration largely ended the practice of offering PIPs, effectively curtailing any opportunity for a second chance. Some survey respondents claimed PIPs, when offered today, are used chiefly as a pretext for termination.

When Rosa received his PIP, he was struggling with family and mental health issues. The PIP pushed Rosa into a breakdown. "I just couldn't handle it anymore. When the rules are made to force you to choose whether you help the veteran completely or hang up in the middle of the call, it's not really fair." Rosa said his bosses pushed him to make seven-minute talk times. Rosa responded angrily, "Listen, I can't fucking do this in that time."

In the end, Rosa left his job, and his life fell apart. He was homeless when we spoke to him, while all his belongings sat in a storage unit. "I'm just wandering at night trying to find places to hide so the police don't stop me."

This sort of work-related stress is increasingly common at the VBA. An Army combat veteran who served as a veterans-service representative at an office in the VA's Pacific Coast district said the VBA's punishing new work standards jeopardized her job and created a toxic work environment that triggered her post-traumatic-stress disorder. "I had to start going back to counseling, and I know others have gone to counseling too," the employee said. "I came to this job because I wanted to serve veterans. It's where I felt safe after getting out of the military. But now no one is supporting us to do well at our jobs—no one has our backs anymore. It's hard to function under these conditions."

Patrick Henry, a Gulf War veteran who has been processing veterans' claims at a VA facility in Florida since 2009, was fired under the Accountability Act for failing to meet new work standards. Henry said that management is now asking claims processors for double the amount of work in the same period. He often missed his lunch break to keep up and had difficulty managing the increased workload.

"Veterans have a different skill set than someone [who has] gone to college for four or five years," Henry said. "It takes me a bit longer than the average guy, but I take pride in my work. Each veteran to me is not a number; these are real people, and we are here to serve them."

PRIVATIZING COMP & PEN EXAMS

Shortly before leaving office, President Trump increased the outsourcing of another critical VBA function: conducting compensation and pension (C&P) exams. In the past, these medical and psychological evaluations, which provide crucial evidence for determining a disability rating, were largely done by VHA staff with deep knowledge of veterans' health problems. Not only did this process ensure accuracy, but it also reduced fragmentation. A veteran undergoing evaluation could be seen by multiple clinics in a day, an efficiency that prioritized their time and health.

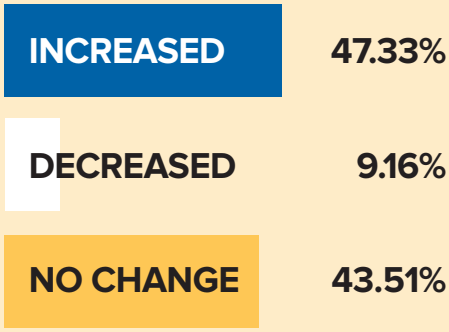
One of the earliest players in outsourcing this work was Anthony Principi, who served as VA Secretary for President George W. Bush. After he left his government job, Principi faced scrutiny when his business, QTC Services, secured millions in C&P contracts from Bush's VA. (QTC was once owned by Lockheed Martin - the massive military contractor.)

Today, many poorly trained contractors with limited experience conduct the vast majority of these exams. According to a 2021 GAO report, 90 percent of C&P exams are performed by private contractors, who performed about 1.1 million of the 1.4 million exams completed in FY 2020. Initially, private contractors were not permitted to complete exams on complex cases like Gulf War Illness, Military Sexual Trauma, PTSD, and Traumatic Brain Injury (TBI).

That's no longer the case. The report states that VBA's quality review office "does not assess the potential challenges of completing exams for certain complex claims." This failure of oversight helps explain another finding: that "exam reports for complex claims were returned to examiners for correction or clarification at about twice the rate that exam reports were returned overall." It is thus not surprising that one VBA employee told us that urgent issues around private C&P exams have further jammed the phone lines. He noted that VBA employees must also navigate an entirely separate exam request process than what they use for exam requests that go to VHA facilities.

In a 2022 OIG report, investigators also found serious issues with the accuracy of outside exams. Using sample data, the VA watchdog estimated that errors were not corrected for about 35 percent of potentially insufficient exams before claims processors decided a claim, resulting in a significant number of veterans who have been improperly denied benefits.

Q38: How difficult is it to rate veterans who have received private Compensaton and Pension Exams?



David Lash, a former Navy Independent Duty Corpsman and current VHA physician assistant, said he and his colleagues "often had to redo and resubmit the disability recommendations done by nearly all of the contractors performing Comp and Pen exams." Private contractors, Lash said, seldom understood either what they were supposed to be evaluating or the demands of a military lifestyle. They also often failed to fill out the required forms correctly. This, Lash noted, "resulted in delays in getting the veterans rated, as well as them having to come into our comp and pen department for additional appointments."

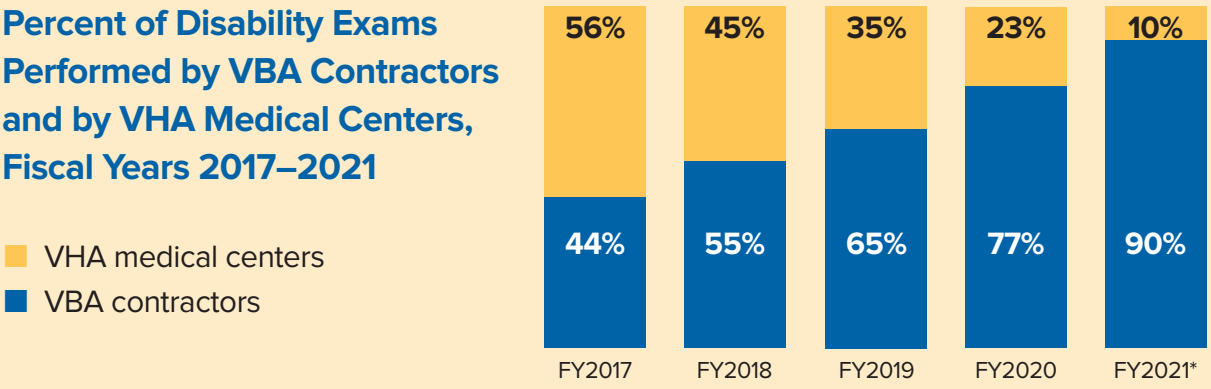
Many private C&P companies have poor track records. A 2018 report from the Government Accountability Office (GAO) found that the major C&P contractors routinely subjected veterans to long wait times and made significant errors in exam reports. The GAO also found that the VA was unable to oversee how efficient, effective, and costly these private contractors were in performing their work. A year later, the GAO said the VA was still unable to effectively gauge these metrics.

This follow-up report further found that the department "has not been able to implement an automated invoicing system that it plans to use to validate the accuracy of contractors' invoices," which meant that officials "still cannot ensure that it is paying contractors the correct amounts based on the terms of the contracts." In short, the VA is perhaps paying far too much for these exams. (Of the four major C&P policy recommendations first issued by the GAO in 2018, two of them—which demand better training and accountability for private sector providers—have still not been addressed.)

One of the companies the GAO previously criticized is Veterans Evaluation Services (VES). In 2015, the Tampa Bay Times reported that the company sent dozens of veterans to a Tampa doctor who was under federal investigation for dangerous prescription practices. The company has also been the subject of many troubling allegations on the employer review website Glassdoor. VBA employees contended that VES prioritized the quantity of evaluations—rather than the quality—that were performed. Margaret Rajnic**,** a nurse who worked briefly for VES in early 2018, told VHPI that the organization is poorly run and that many of its reviewers had no familiarity with basic medical terms or procedures. Rajnic said she was fired after raising questions over the company's business practices.

"Their operational efficiency is poor, they are bad at providing necessary medical records and it's failing veterans," she said. "It's a money-making machine, and the VA is not evaluating the true outcomes of their spent money."

Percent of Disability Exams Performed by VBA Contractors and by VHA Medical Centers, Fiscal Years 2017–2021



Source: www.gao.gov/products/gao-21-444t

*As of March 10, 2021

Other contractors have faced similar allegations. A former Marine with hearing loss was recently sent to VetFed Resources after requesting an increase in his 10 percent disability rating. This veteran, who didn't have a car, said that VetFed required him to drive at least an hour, then threatened to cut off his benefits altogether if he didn't show up. (VetFed, like VES, has similarly been the target of complaints that it improperly denied medical benefits to vets.)

There's also QTC, which as far back as 2008 was flagged by the VA's Office of Inspector General for over-billing. (A more recent inquiry found no irregularities.) Amid QTC's many mixed reviews on Glassdoor, one anonymous user claims that "people do not know where to report ethics issues and when they do report them then there is retaliation."

ANALYSIS OF VBA SURVEY RESPONSES AND COMMENTS

IN OUR SURVEY RESULTS, VBA staff described a perfect storm of mounting claims, staffing shortages, and management's introduction of punishing productivity standards. Nearly 80 percent of VBA survey respondents said their departments desperately needed new staff. Nearly 60 percent said the agency isn't actively recruiting to fill important roles. The agency is today struggling with nearly 3,000 open positions.

"We are on a ridiculous assembly line production schedule," one survey respondent explained. "Management needs to realize we are building a custom product; no two claims are the same."

Another respondent said that staffing issues were so severe that VBA employees focused only on Special Adaptive Housing (SAH) were being pushed to answer calls focused on benefits they know nothing about. "SAH veterans get angry because they are waiting so long for grant approvals while we answer calls, just to transfer to someone who can answer their questions because we sure can't!"

Over 50 percent of VBA respondents said that there were vacant positions for which no recruitment was taking place; 53 percent said they had lost staff because of salary ceilings and 80 percent said they had lost staff to the private sector because of signing bonuses and financial incentives.

Almost 80 percent of VBA staff said they face workplace quotas and productivity measures. One respondent commented that, "Since October of 2020, we have been asked to reach unattainable production goals. We are now a production 'sweatshop.' I used to be able to give Veterans time to return my calls so that I can assist them with adding dependents to their award or answering questions that are difficult to understand with the paperwork we mail, however, I am no longer able to get that type of customer service because I am required to complete a vast number of cases per day."

"We are on a ridiculous assembly line production schedule," one survey respondent explained. "Management needs to realize we are building a custom product; no two claims are the same."

Another added: “I am okay with quotas and productivity requirements. However, they should be fair, reasonable, and achievable. As a new VA employee, I am observing and experiencing staff thrown into a job with poor training and lack of guidance and support. We should want staff to be successful.”

Eighty-two percent of respondents echoed the concerns, held by Rosa, that metrics and other time restraints impact their ability to deliver timely, accurate, and full VA benefits. “We have to do a kazillion things in 45 minutes,” one respondent vented. “There is a checklist of things, always getting longer, we have to remember, and actions are always changing. It’s just not worth having a stroke and ending up in a nursing home over a job.”

Roughly 60 percent of VBA respondents said they are considering leaving their VBA jobs within the next five years.” I will die at my desk continuing to help veterans, but I don’t have that much longer until it happens,” one responded, while another said, “I am actively looking for jobs elsewhere before I end up with a mental breakdown or physical/mental exhaustion. I love customer service. I really enjoy helping people, but I am so exhausted. I am burned out.”

Another employee echoed these concerns: “In order to make production I have to take a ‘point-accrued action’ every 35 minutes. How can I review a claim, fix the prior work, and do the next action in 35 minutes? Answer: I can’t!!! Either I make production, or my quality suffers!! I am retiring as soon as possible!”

In their comments, respondents also said that their inability to adequately serve veterans because of short staffing, and unrealistic productivity measures, has also generated complaints from veterans. This in turn, hurts the agency’s reputation with them and the public. Survey respondents frequently discussed the anguish of dealing with former service members who can’t get what they need. “I am tired of stressing 24/7,” one respondent said. Another added: “I want to do a complete job every time I touch a claim, so that I am best serving the veterans. But that means I will usually not make production goals.”

“I want to do a complete job every time I touch a claim, so that I am best serving the veterans. But that means I will usually not make production goals.”

All of this is exacerbated by the privatization of compensation and pension exam work. Of the VBA respondents who said veterans had spoken to them about their comp and pen exams, nearly 63 percent said they’d had negative experiences with the contractors involved. Forty-seven percent of VBA respondents confirmed it is more difficult to rate veterans fairly and properly, based on faulty outside medical assessments.

One of the veterans victimized by this overall process—and deeply angry about it—is Sarah Terry. She joined the Army when she was 19. A year later, she was deployed to Iraq, where she drove a semi-truck loaded with a 14-foot rocket launcher. On a typical day, Terry would drive to a specified location, enter numbers into a computer, and fire rounds. Once Terry returned to her compound, she and her team would watch videos of the strikes that had been fired and assess the damage. Often, she would get a very vivid picture of whether the enemy target was hit, how much harm was done, and what collateral damage occurred.

“Although I never actually stood in front of anyone and shot them, day after day I watched these recordings,” she explained. “During the 35 days I was there, there were a total of 718 fire missions.” During these fire missions she watched bodies, including civilians, be incinerated.

“I once watched an enemy target be hit by a rocket that was a dud and did not explode,” Terry explained. “The person wasn’t incinerated. But this huge rocket tore into him, and we watched his head and arms and legs ripped off his body.”

This work created in Terry a deep moral injury, alongside insomnia and nightmares. Terry thought these problems were symptoms of PTSD, but the Army insisted she was depressed. Before long, she was medically discharged.

When Terry subsequently filed claims with the VBA, there were agency disagreements over how to categorize her issues, as well as the level of her disability rating and her compensation. Terry found the whole claim filing process so upsetting that she settled for a compensation rating far lower than the one she believes she deserves. Terry’s experience with the VBA was so bad that she has since been reluctant to get treatment for her lingering mental health problems within VHA. “I just don’t want to have anything to do with any government department with the letter V attached to it,” she said angrily.

AN ALTERNATIVE AGENDA FOR THE VA

JUST AS VETERANS ONCE SERVED THE NATION IN UNIFORM, VA employees provide vital services to those now eligible for health care and other benefits. VHA employees—a third of whom are veterans themselves—deliver superior care. Their pioneering research has benefited the entire country and the world. They play a central role in training and mentoring America's next generations of providers, in medicine, nursing, and other healthcare professions (They also provide critical assistance during local and national emergencies, from the Pulse nightclub shooting in Florida to the COVID-19 pandemic nationwide.)

VBA employees determine whether a veteran receives VHA healthcare services, as well as the affordable higher education or occupational training necessary for a smooth transition to civilian life. They also assure, where possible, that veterans receive timely compensation for injuries or illnesses acquired or exacerbated by military service.

In light of the VA's many essential missions, we offer the following survey-based recommendations for an "Alternative Agenda for the VA." If implemented, even partially, these much-needed changes would provide stronger support for nineteen million U.S. military veterans and the federal employees who have volunteered to serve them.

☑ VA FUNDING AND BUDGETING

The VBA and VHA must be adequately funded so they can hire and train the workforce needed to process claims and provide in-house health care for veterans of all backgrounds and eras, including the post-9/11 generation, who while relatively young, are among the most disabled in the nation's history. VHA and VBA must have enough staff to meet current and projected demand that is delivered in-house.

The VHA must also have enough staff to fulfill its teaching, research, and Fourth Mission responsibilities to the nation and to accommodate increased demand should there be a new conflict or public health emergency.

The recommendations contained in "The Independent Budget," released annually by the Disabled American Veterans, Paralyzed Veterans of America and Veterans of Foreign Wars provide important recommendations. In their FY 2024 budget, these major veterans service organizations are recommending an increase in funding to support a greater emphasis on VHA hiring and retention, infrastructure improvements, and construction of new and expanded VHA facilities.

Other budgetary issues that must be confronted include how the VHA allocates funding to its different facilities. Budgetary allocations to the VHA must capture the current and future demand of veterans for in-house care and services as well its ability to fulfill its other missions.

☑ ELIMINATING HIRING OBSTACLES

In recent months, the VA has taken some encouraging steps to recruit and retain mental health providers, registered nurses, claims processors, and other key staff. Due to local AFGE initiatives, some VHA caregivers have even secured well-deserved raises.

Nevertheless, swift hiring for the agency's thousands of unfilled positions will require system-wide changes. First, leaders must jettison Trump's failed Human Resource Management project. HR activities should be brought back to the local level. Decentralization, rather than top-down control and direction, is the key to enabling skilled and experienced VA personnel managers to better respond to healthcare labor market conditions, now and in the future. Shortages of HR staff should also be promptly addressed.

In the short term, leaders should prioritize work that brings all facilities in line with VHA Directive 1161, which mandates a minimum outpatient staffing of 7.72 outpatient clinical mental health FTEs per 1,000 mental health patients. VHA must also quickly hire more suicide prevention coordinators and other behavioral health staff. It should also hire adequately to comply with its own staffing methodologies for other clinical areas.

☑ COMPETITIVE SALARIES AND BENEFITS

Secretary McDonough has described VHA outsourcing as a form of "healthy competition" between his agency and the private sector. As such, the Secretary must help his own team be more competitive by offering market-rate salaries and, where needed, signing bonuses.

VA employees will be more likely to stay in their jobs if the VA can reliably match market salaries for all employees. Ongoing local market surveys would reveal important wage data and help craft better pay policies. The VA could also offer more benefits, like paid family leave, and targeted retention bonuses, where needed. These improvements would help retain valued, long-term caregivers who are now being recruited by private hospital chains and medical practices seeking to expand their market share in the burgeoning veterans' healthcare field.

The Biden Administration could further help VA shore up its talent pool by increasing the number of students inside the Uniformed Services University, and designating some to serve in the VA, in addition to their current assignments in the military and the U.S. Public Health Service. This federally funded program heavily subsidizes

the professional training of physicians, nurses, and biomedical scientists. In exchange for this assistance, they commit to periods of post-graduate service in the military or U.S. public health service but not the VA.

☑ VCCP CONTRACTOR OVERSIGHT

Secretary McDonough believes that outsourcing also grants VHA significant leverage over the operations of private hospitals and doctors in the VCCP. The Centers for Medicare and Medicaid Services (CMS) have long tried to encourage best practices through their carrots—like federal reimbursements—and sticks—like withholding that funding from providers who fail to meet minimum standards. Unfortunately, these efforts have often fallen short.

The VHA's annual spending on outside care is only a fraction of CMS or the Children's Health Insurance Program (CHIP). While this limits McDonough's leverage, there's still room for him to be far more aggressive with the 1.2 million private care providers inside the VCCP. He must crack down on fraudulent billing and other common bad practices, some of which were recently exposed by *The New York Times*. (One of the major contributors to dubious cost inflation within Medicare Advantage plans, according to the *Times*, is the United Healthcare Group, which also owns Optum, one of the two third party administrators of the Veterans Community Care Program and frequent subject of over-billing investigations by the VA's OIG.)

As the Centers for Medicare & Medicaid Services clearly states, "defrauding the Federal Government and its programs is illegal. Committing Medicare fraud exposes individuals or entities to potential criminal, civil, and administrative liability, and may lead to imprisonment, fines, and penalties." In its report of fraudulent billing in the VCCP, the VA OIG only recommended that VCCP providers receive more training in how to accurately bill the VA. Training for VCCP providers is not a sufficient remedy to this problem. No VCCP provider should be allowed to participate in the network if they have fraudulently billed the government for services that were not provided or for which they already received payment.

☑ VCCP CARE COORDINATION AND QUALITY

The VHA must use all tools at its disposal to ensure that if veterans are offered community care, it is equivalent in quality to what VA would provide. This requires promulgation of strict wait-time and quality standards to ensure that veterans are seen quickly, and by clinicians who deliver high-quality, evidence-based treatments. (See "Patient Referral Reform" below.)

There should also be rules—and related penalties—to ensure coordination of care veterans receive in the private sector. Every contractor in the VCCP network should be required to share relevant medical records in a discreet, readable, and timely fashion—or they should be excluded from the program. At minimum, no VCCP provider should be paid until they submit the kind of timely, appropriate, and thorough documentation necessary for the VA to assure continuity and coordination of care.

None of these objectives can be achieved through half-measures and voluntary compliance. A wide range of outside providers have been recruited to the VCCP regardless of their qualifications or willingness to participate in sufficient training around veterans' care. One 2018 RAND assessment of New York's private care clinicians found only passing interest in learning about military culture and the wounds of war among those interested in caring for veterans.

Supporters of VHA privatization insist that making even minimal demands will drive too many providers away and limit outside options. These privatization advocates would do well to heed the advice of RAND researcher Carrie M. Farmer, who has testified that "it is critical that discussions about veterans' access to care always consider care quality....An appointment available tomorrow that provides poor care could be worse than waiting for good care."

Staffing shortages are currently exacerbated by shifting employees from direct care or administrative support roles to overseeing or assisting the private sector. Those vacated positions must always be backfilled.

VHA patients will also derive great benefit from the Military Construction, Veterans Affairs and Related Agencies Appropriations Act of 2022. This law requires that information about the relative quality of in-house and out-sourced care be made available so eligible veterans can use these data to make better informed patient choices.

☑ THE VA EMPLOYEE FAIRNESS ACT

Last year, AFGE and other labor unions representing VA employees secured House passage of the "VA Employee Fairness Act" (H.R. 1948 as amended). This legislation would enhance the agency's ability to attract and retain healthcare professionals, in large part by expanding bargaining rights for all Title 38 employees appointed under 38 U.S.C. 7401(1).

For too long, Title 38 employees—a population that includes physicians, dentists, podiatrists, chiropractors, optometrists, registered nurses, physician assistants, and expanded-function dental auxiliaries—have been denied a full seat at the table. The VA's policy on collective bargaining rights today deprives these clinical staff of the ability to grieve workplace matters such as assignments, overtime pay calculations, and alternative work schedules—issues that are routinely resolved through grievances by other VA employees and healthcare employees at military hospitals and other federal health care systems. These restrictions hurt morale, patient safety, and labor relations.

☑ VHA PATIENT REFERRAL REFORM

Secretary McDonough considers himself a data-driven leader. He has looked at the numbers and noted, accurately, that the only way to stem the exodus of patients from the VHA is to change the access standards hastily promulgated by his Republican predecessor, Robert Wilkie, as part of President Trump's overt pro-privatization agenda. McDonough should follow his own "hunch" about what needs to be done to reverse course, take the VA in a different direction, and save it for current and future generations of veterans.

McDonough could start by expediting a relatively minor rule-making change that would, according to his own estimate, save the VHA $1 billion per year in unnecessary outsourcing costs. In 2019, Secretary Wilkie issued misguided rules that telehealth appointments would be considered as access to care if delivered by a private sector provider, but they would not be counted as such if equivalent in-house VHA telehealth services were readily available to the same patient. This has resulted in unnecessary outsourcing of care.

The now more than $33 billion a year drain on VHA resources can only be stemmed by much broader administrative action, aimed at repealing patient referral guidelines inherited from the Trump Administration. Even within the statutory constraints of the MISSION Act, McDonough can promulgate new regulations that

prioritize medical necessity, quality, and timeliness of care over all else, as the VHA often did in the past when individual patients were only sent outside the system under limited circumstances if appropriate care was unavailable inside it. The for-profit healthcare industry, which is feasting on VHA privatization, will not applaud this move. But veterans, their families, and VHA caregivers would long remember Denis McDonough as the VA leader who rescued them from a costly, wasteful, and failed experiment with private provisioning.

☑ GIVE VBA STAFF ADEQUATE RESOURCES, TIME, AND TRAINING

For years, VBA leadership has imposed unrealistic productivity standards and talk-time metrics for staff speaking with veterans hoping to get into the front door of the VA. This is a shortsighted fix to an issue of understaffing. In some cases, these rules have led to severe mental health problems and other major stressors among staff. VBA must be properly budgeted, while claims processors should receive the training they need to succeed in their jobs and effectively serve veterans and be graded under holistic standards that properly account for the many complex cases and people they speak with every day.

☑ IMPROVE COMP AND PENS EXAMS

The near-total privatization of C&P exams should be reversed.

There should be a clear separation between VHA employees who serve veterans in providing health care services and those who serve veterans in providing disability evaluations. Comp and Pen exams should be done by a separate cadre of VHA staff, whose full-time workload is devoted entirely to performing C&P exams and who are responsible for meeting VBA's demand for exams. Additionally, this should include full staffing of the IDES program, whose full-time work is conducting exams on military personnel who are nearing discharge from their military service and will expand VA's internal capacity to administer disability exams.

The VA should follow the diligent recommendations of the GAO and comply with two outstanding recommendations made following an assessment of agency Comp and Pen policies. Specifically, VA must create stringent training requirements for all C&P examiners and then ensure it has tools to assure that examiners and their companies are held accountable for following these rules. Training requirements should assure that examiners follow VA's rigorous guidelines for exams (like those relating to PTSD developed by the VA's National Centers for PTSD) and should be culturally competent, trained and supervised so the quality and thoroughness of their exams can be adequately monitored.

Further, the VA should offer tele-exams for C&P evaluations whenever possible. The use of tele-exams for conditions that do not require physical examination is beneficial to both the veteran and the examiner. The veteran saves travel time, waiting-room time, travel expense, the need for childcare, and taking extra sick leave. Many veterans prefer the familiarity of their own home or have major mobility challenges.

Tele-exams also benefit employees, who save travel time and are afforded increased safety given the occasionally unsafe nature of the evaluation process (in particular for mental health evaluations.) The utilization of tele-exams also systematically eliminates the geographic constraints for examiners. This allows the VA to use its workforce more efficiently. Plus, in the age of COVID-19, having fewer people enter a hospital setting and unnecessarily expose themselves to a highly contagious virus is better for both veterans and VA staff.

Telehealth appointments result in fewer missed appointments for the VA than in person appointments. As a result of the VA both having fewer missed appointments and a reduced chance for delays in the start times for appointments, Comp and Pen exams can be completed more expeditiously.

VA should be encouraged to expand the use of existing VA, military, and other records to decide service connection claims and increased disability ratings in circumstances when those records are sufficient to decide the outcome of a claim without the need for a C&P exam. This would continue VA's current policy of "Acceptable Clinical Evidence" (ACE). This would shorten the time needed to process new and increased rating claims, expedite provision of veteran's benefits, and significantly open up the availability of the number of C&P examiners that should reduce the backlog and inventory of pending claims. In turn, the ACE policy would expedite access to VHA care for veterans in need.

☑ MORE CLAIMS TRANSPARENCY

VBA should provide Congress, VSOs, and the public frequent (at least quarterly) updates on the number of PACT Act claims filed.

The reports on PACT Act claims should be sorted by new claims filed, pending, denied, and granted each month so there can be a proper trend analysis of incoming, completed, and pending claims. The reports should list each of the new presumed conditions and their grant/denial rate. VA should also inform Congress regarding the reasons for VA's denials so that advocates can better understand how to assist veterans and avoid a repeat of the improper denials. The VBA reports would serve to illustrate where PACT Act claims stand and improve policies to properly resource VBA and re-train (as needed) VBA staff as hundreds of thousands of new claims flood into VBA as the wars and deployments continue.

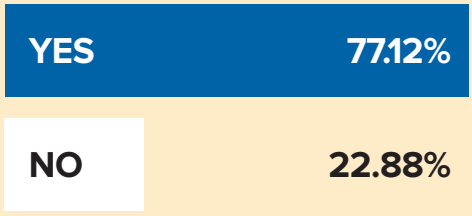
☑ PASS THE EVEST ACT

Finally, Congress must enact the Ensuring Veterans' Smooth Transition (EVEST) Act, which authorizes automatic enrollment of new veterans by VA. Veterans who don't want to enroll for VA care may easily opt out. If enacted, it would send a strong signal that VA is ready, willing, and able to help veterans quickly get the quality VA care they need for their military-related medical conditions. Under this bill, VA is actively encouraging new veterans to get that care sooner, when that care is more effective and less expensive.

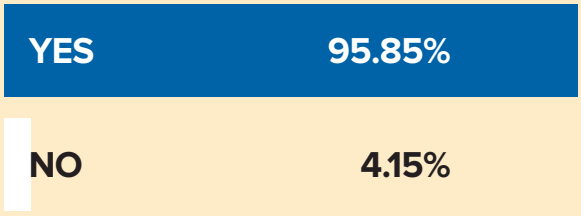
APPENDIX A: VHA GRAPHS

Q1: What is your job category?

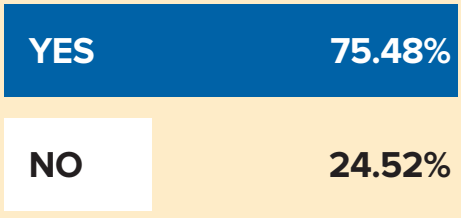
Q2: Has your VA facility lost resources (money, staff, beds, buildings, budgets, etc.) in the last four years?



Q3: Does your facility need more frontline clinical staff?



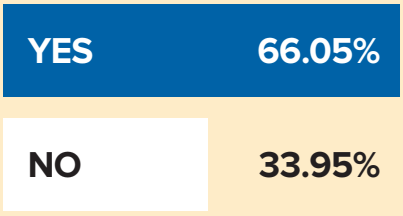
Q4: Does your facility need more administrarive/support staff?



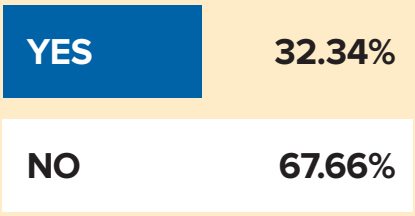
Q5: Are staffing shortages leading to more veterans being sent outside the VA to non-VA care?

Q6: How satisfied are you with your job?

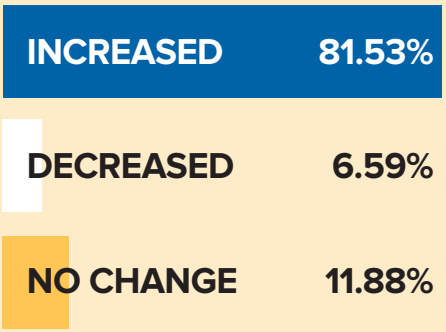
Q7: Are you considering leaving your VA job in the next few years?



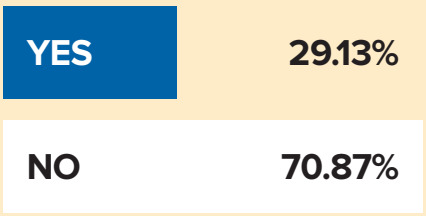
Q8: Have the recent VA's recommendations about facility/ programs/service closures led to you considering leaving the VA?



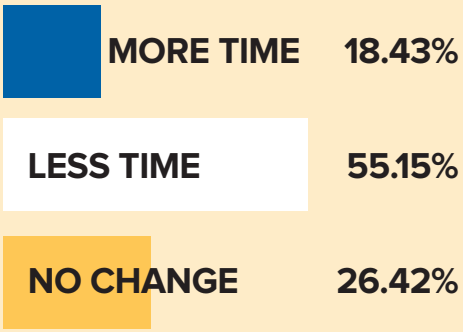
Q9: In the past four years, has the administrative work (paperwork, monitoring and authorizing referrals) involved in patient scheduling increased, decreased, or sayed the same?



Q10: Has any part of your time been shifted to coordinating or monitoring non-VA care?

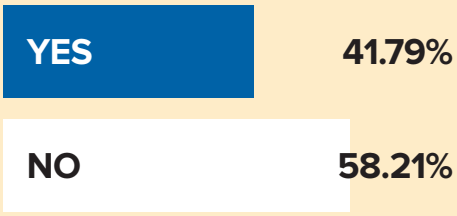


Q11: Compared to four years ago, how much time today do you have to deliver direct patient care and support services?

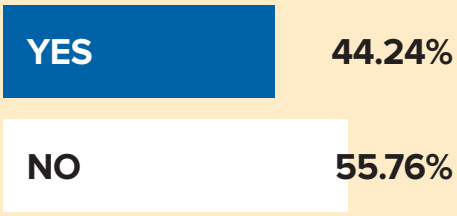


Q12: Are veterans referred for non-VA care if they state that is their preference, even if they otherwise fail to meet MISSION Act referral criteria such as drive time or wait time?

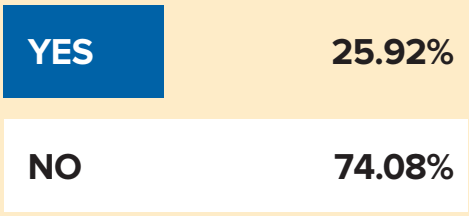
Q13: Are veterans referred to non-VA care, even if they state they are willing to wait and get care at the VA?



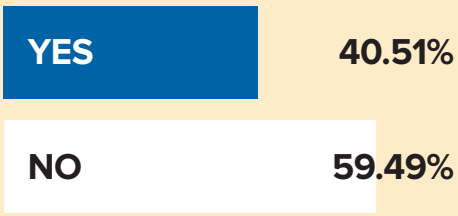
Q14: Are non-VA providers' health care records that describe patients' treatment and progress usually provided back to your VA?



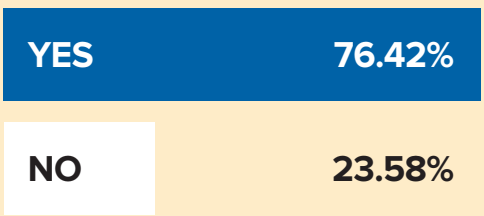
Q15: Are non-VA outcome measurements usually provided to your VA?



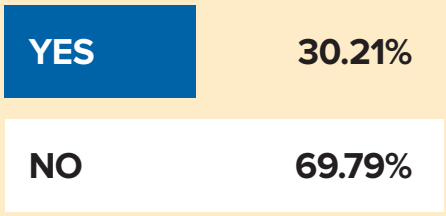
Q16: If you make a specific treatment recommendaton regading a patient in non-VA care, is it generally adhered to by the non-VA provider?



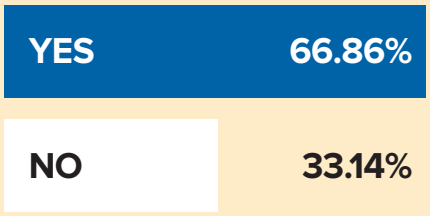
Q17: Have you seen an increase of non-VA care that could be done in VA?



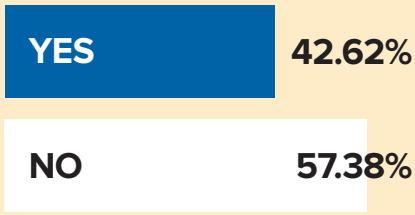
Q18: Are you aware of treatments being provided to vetrans in the non-VA sector that are not generally accepted standard practice?



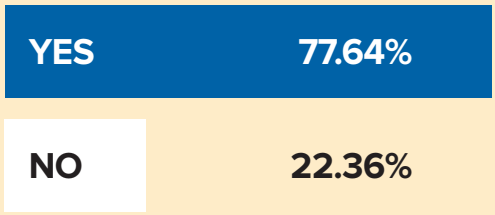
Q19: Over the last four years, have there been closures of programs, units, clinics, beds, or other services in your facility?



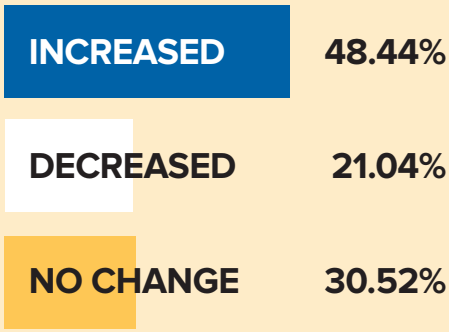
Q20: Have sernior officials discussed closing clinics, programs, units, or beds, or cutting staff in your facility?



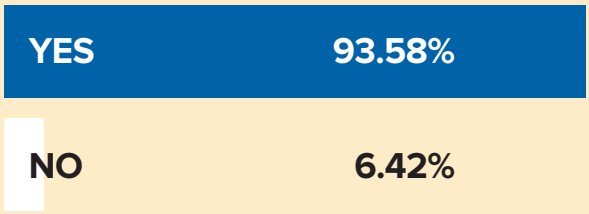
Q21: Ae there vacant positions at your site for which no recruitment is taking place?



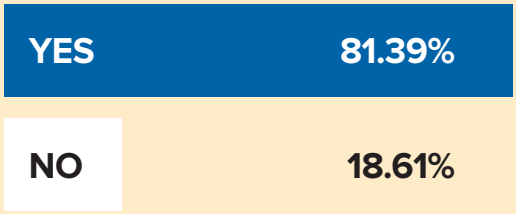
Q22: Has the Human Resources Modernization process at your facility increased or decreased the time it takes to hire a new employee?



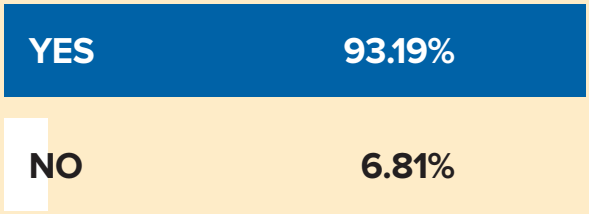
Q23: Have you experienced instances where interested candidates were lost to competing offers because of delays in the HR hiring process?



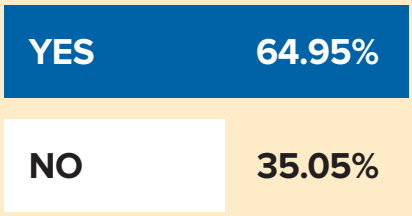
Q24: Are you aware of instances in which your facility lost interested candidates because of VA salary ceilings?



Q25: Have employees left VA for the private sector due to signing bonuses or other financial incentives?

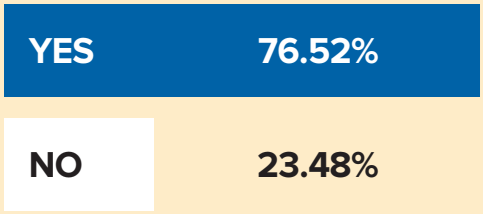


Q26: Have positions been eliminated from the organizational chart because they were not filled within six or more months.

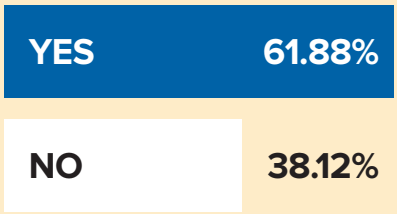


APPENDIX B: VBA GRAPHS

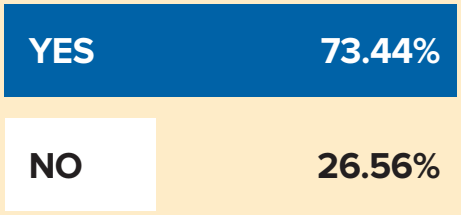
Q27: Does your facility need more administrative/support staff?



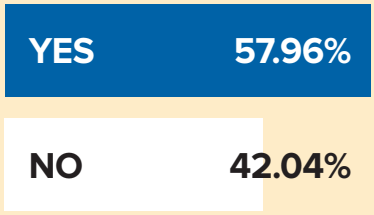
Q28: Are you considering leaving your VA job in the next few years?



Q29: Have the recent VA's recommendations about facility/ programs/service closures led to you considering leaving the VA?

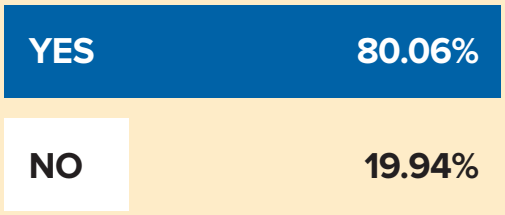


Q30: Are there vacant positions at your site for which no recruitment is taking place?

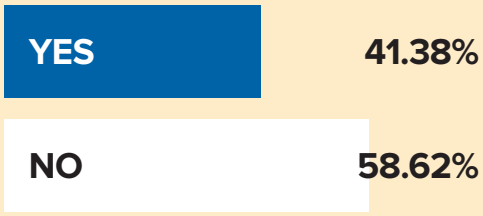


Q31: Are you aware of instances in which your facility lost interested candidates because of VA salary ceilings?

Q32: Have employees left VA for the private sector due to signing bonuses orother financial incentives?

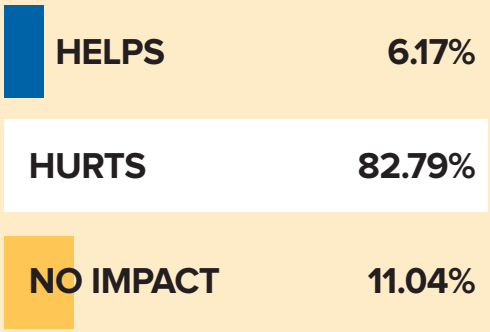


Q33: Have positions been eliminated from the organizational chart because they were not filled within six or more months?



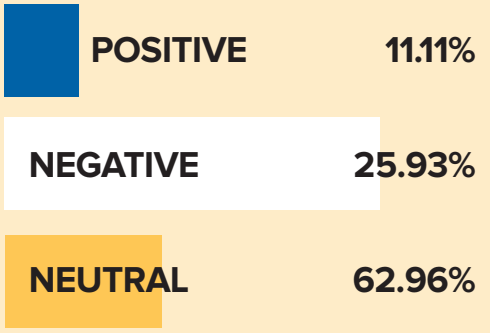
Q34: Do you face work quotas and productivity requirements?

Q35: If you answered "yes" to the above question ("quotas or requirements"), how do they impact your ability to provide veterans and dependents with timely, accurate, and full VA benefits?

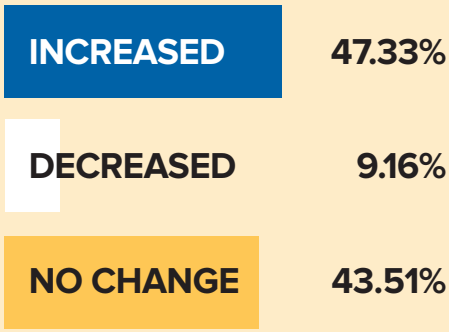


Q36: Do VBA veteran claimants comment to you about their Compensatonand Pension (C&P) Exams performed by the private sector?

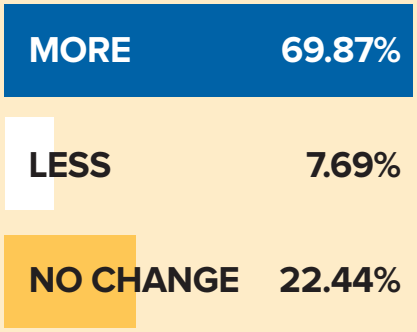
Q37: If you answered "yes" to the above question, how do they feel about these exams?



Q38: How difficult is it to rate veterans who have received private Compensaton and Pension Exams?



Q39: Compared to four years ago, how much of your time is spent scheduling exams outside of the VA?



VETERAN STORIES

Justin Straughan 32- year- old, U.S. Air Force 2009–2013, Kissimmee, Florida

In 2008, the opportunity to become the first in my family to attend college was swiftly taken away, thanks to severe educational budget cuts in my home state of Florida.

I had made a promise to myself that I would find a way to pay for school without taking out loans. So, I began to research the military, and the G.I. Bill. I enlisted in the U.S. Air Force in 2009. I served for four years, as a Ground Radar maintainer in a combat communications unit. After I was injured in service, I was reassigned to the Honor Guard, where I concluded my service. My injuries, which focused in and around my knees, occurred from cartilage damage due to my own flat feet and the intense, high-impact lifestyle of a combat unit. My medical condition became so severe that the Air Force coded me 'non-deployable,' meaning I was unable to re-enlist.

Soon after my separation—following a nightmarish time navigating the VA claims process—I made it into the Veterans Health Administration. Orthopedic teams at the VA's New York Harbor and Daytona Beach systems were able to diagnose issues that other doctors had missed, including some musculoskeletal damage. They've been able to recommend lifestyle changes necessary to prolong the use I have in affected areas, while my physical therapists have worked diligently through these injuries. In short, VA practitioners have been exemplary in their willingness to take the time to do little things that have made a large impact in my life.

When VA sends me to for-profit providers, I often feel like just another number in a healthcare system that is all about numbers and processing as many patients as possible in order to make as much money as fast as possible. I recently visited a private provider chiropractor who refused to see me if I didn't submit to a full back X-ray—which is not recommended or required for treatment.

The VA isn't perfect, but when the system has resources and the people have time, it works flawlessly in coordinating and delivering fantastic care. For me, 13 years later, the bottom line is that I am finally nearing my goal of a productive civilian career. That's because I've been fortunate enough to be treated by VA clinicians who've truly cared and inspired me to go into medicine myself. I just got into medical school.

Denny Riley 68- year- old, Air Force Veteran, 1963–1967, Canandaigua, New York

I signed up for the Air Force when I was 18. In 1966, I worked for a year on a base in Thailand in the target room of a fighter wing that was bombing Laos and North Vietnam. Then, in 1967, I went back to Thailand and worked in another target room, this time for a B-52 that was carpet-bombing South Vietnam. Although I never served in Vietnam, I was given a Vietnam service medal and am considered a Vietnam veteran.

I have been using the VA since I was 27 years old. That's because, in Thailand, I developed a serious and pretty rare digestive problem called achalasia. They don't know what caused it, but whatever it was killed the peristalsis that pushes food and liquid through your esophagus and into your stomach when you swallow. I had to have very extensive surgery at the VA hospital in Palo Alto. I was there for an entire month. For more than 50

years, I have had to chew meals until it's like baby food to get it down. I also have to sleep sitting up. To this day, the VA has cared for this chronic and incurable problem.

Apart from my serious digestive problems, I didn't go to the VA much until about 25 years after I got out. By that time, the VA had changed, and I got more services than I ever imagined existed. For example, I suddenly started having night sweats and would wake up soaked. I told my primary care doctor. They gave me all kinds of tests. They found, among other things, that I have three aneurysms, two in my lower aorta and one in my neck. All of this is being monitored closely.

After living in the Bay Area for 42 years, my wife and I moved to Canandaigua, New York, in 2022. When I went in to my primary care physician at the VA outpatient clinic, in Martinez, California, and I told her I was moving, she immediately turned to her computer and sent all my files to another VA office. A few weeks later, someone from the VA called to ensure my smooth transfer to another VA facility, one almost 3,000 miles away. She told me someone from that clinic would get ahold of me when I arrived at my new home. And sure enough, almost as soon as we got to Canandaigua, I got a call and they set up an appointment with a new primary care physician.

The VA in Canandaigua is huge and beautiful. It's like an Ivy league campus. In the past year, I've gone to a dental hygienist every three months for a teeth cleaning. It's amazing! I mean, how many people in America get their teeth cleaned quarterly without even asking for it? Because I've had detached retinas in both eyes, I get my eyes checked routinely and get free eyeglasses.

I've also been given hearing aids from the VA and been treated for tinnitus. During one appointment for hearing aids, someone asked if I had balance problems. When I said yes, it was noted in the chart. When I was recently having a hearing test, the audiologist noticed I had balance problems and I suggested I make a physical therapy appointment to work on balance. Which I did. That would never happen outside the VA because people are working for entirely different and disconnected business entities.

This is cool, but so is the fact that you can bundle appointments on the same day, which is easy because everything is done in the same place. For example, the other day a clerk called me up to schedule an MRI to check on my aneurysms. While talking about my appointment for the MRI, she looked at the schedule and noticed that I was having an upcoming dental appointment. She suggested I could do both on the very same day. That's what the VA does so well.

Sally Covington Widow of US Army Veteran Tom Moore, Richmond, California

I want to share my story about the amazing VA care my partner, Tom Moore, received at the end of his life. The story is, in a sense, a tale of two healthcare systems—Kaiser Permanente, a private, profit-motivated system and the Veterans Health Administration (VHA) a mission-driven, public system.

Tom, who was 85 when he connected with the VA, had served in the Army during the Korean War, but never outside of the United States. Although being in the Army was, for him, a formative experience, being a veteran wasn't a major part of his identity.

He had never used the VA and was a life-long member of Kaiser in California. Toward the end of his life, Tom suffered from Alzheimer's disease and worsening chronic obstructive pulmonary disease (COPD). In dealing with both problems, I became increasingly concerned about the lack of quality care Tom was getting from Kaiser.

Let me give a couple of examples. As Tom's COPD was getting worse, Kaiser seemed inflexible and unable to troubleshoot. Tom was having a terrible time breathing at night. His doctor recommended that he sleep propped up at a 30-or-40-degree angle. We'd try to prop pillows under his head, but that just didn't work. I asked Kaiser for a hospital bed that would raise and lower and help Tom sleep. What was the answer? No, that couldn't be done unless Tom was on hospice. Kaiser didn't have much specialized geriatric support either, and certainly there was no respite or home care services for me.

I had never thought about going to the VA until a friend learned that Tom was a veteran and suggested that that might be an option. I called the VA. We provided the necessary papers, and he was enrolled. We went to a VA clinic in Martinez, California, and met with a primary care physician, as well as with a team that included a social worker. The team was very thorough and not only gave Tom a complete physical evaluation but asked what challenges we were having. After I talked to the social worker, much to my surprise, the VA suggested enrolling Tom in a daycare program for people with dementia in Berkeley with which the VA contracted. Tom went to the program three days a week from nine to four. It was completely paid for by the VA. This was the first glimpse I had that the VA was very different from a private sector healthcare provider.

The team also told us we could get Tom's medications from the VA with lower co-pays. The team asked about Tom's swallowing and if we would prefer liquid versions of the medications he was taking, if available. We said yes. Then, three to four days later, I found a box of medication at my door. I didn't have to activate any prescription to get it.

They also asked about what equipment Tom needed at home to keep him safe. Then they arrived at our apartment and installed a grab bar in the shower, gave us a shower bench, and a raised toilet seat for the bathroom, and a bedside commode. Everything was geared to help solve daily problems.

As I said, Kaiser said it could not provide Tom with a hospital bed, so I called the VA and, within a couple of days, it was set up in the bedroom and Tom was breathing a lot better.

We were also able to switch to getting care at the San Francisco VA Healthcare System at Fort Miley rather than Martinez, which was logistically a bit easier for us. That switch was totally seamless, and we got an initial appointment with geriatric primary care. There, we met with a geriatric fellow (a medical doctor doing a specialization in geriatric care) and then with a geriatric team of four wonderful women that included two physicians, a nurse, and a licensed medical social worker.

The geriatric fellow was fantastic. She called me when she had quiet moments to find out how things were going. I received no less than three calls from her unprompted just to check in. I was stunned. She was a physician, and I wasn't calling her she was calling me.

When Tom's breathing took a sudden, sharp turn for the worse, I took him to the ER at Kaiser. Kaiser discharged him in an unstable condition on Friday evening and I quickly realized the next morning that Tom needed an emergency admission to a home hospice program. He couldn't stand up on his own and I couldn't lift him. I was totally panicked. It was Saturday. Even though it was the weekend, because the VA team had been so responsive, I emailed the social worker hoping that she might get, and respond to, my message. She did, and then called the geriatric fellow. They both got on the phone with me to discuss the best way to get Tom quickly enrolled in home hospice, which happened the next day. I am forever grateful for their care, kindness, responsiveness to me and to Tom, who died ten days after his entry into hospice.

From start to finish, this experience with the VA was seamless and oriented to making things as easy as possible during a stressful time. While individual clinicians within Kaiser seemed excellent, caring, and kind, the system itself lacked the flexibility, integration, and problem-solving capacity that the VA demonstrated when we needed it most.

Sameul Jay Keyser 87-year-old, U.S. Air Force, 1962–1965 Boston, Massachusetts

July 7, 2014 was my 79th birthday. I spent the morning in an ambulance. As ominous as that might sound, it was a blessing. I was being transferred from a not-for-profit private rehabilitation hospital to the VA hospital in West Roxbury, Massachusetts where, over the course of the next year-and-a-half, as an inpatient and outpatient, I would receive the best possible care for my spinal cord injury.

Two months, two weeks and two days earlier, I had suffered a bad fall. In a nanosecond, I was transported from the bipedal world into the world of tetraplegia. My arms and legs were paralyzed. I had no control over my bowels. I was, for all intents and purposes, an infant. Before my accident, I was very active. I walked constantly. I also had an active life as a jazz trombonist. I played Dixieland music with the New Liberty Jazz Band. We played on a firetruck and did 4th of July parades. I also played in the Aardvark Jazz Ensemble, the oldest continuous jazz ensemble in the United States.

A masterful neurosurgeon at the Massachusetts General Hospital performed surgery to relieve the pressure on my spine. Nonetheless, my doctor at MGH told me I would never walk again.

After a month at MGH, I was transferred to a private rehabilitation hospital. It was one of the best in the country. Unfortunately, they had to discharge me because of a “length of stay” problem. My Medicare insurance was running out. The hospital planned to send me to an assisted living complex with little or no rehabilitation capability. Why? I couldn’t afford to pay $3,170.75 per day to stay.

The next facility would house me for three weeks. Then my insurance would again run out. After that, I was on my own. Fortunately, at the last minute a caseworker at the private-sector rehab realized that I had served in the US Air Force. It occurred to her—as it had not to me—that, because my injury was catastrophic, I might be eligible for admission to a health care system that would provide me with free medical care for the rest of my life.

When the ambulance drivers rolled my gurney inside the West Roxbury VA, it was close to noon on my birthday. The first person I spoke to was the admissions clerk. I sensed immediately that something was very different. It took me a month to get it. One day, I wheeled myself into an elevator. Hospital workers I didn’t know were already there. As I was about to exit at my floor, they said, “Thank you for your service.” Shortly after that, Eddie, a painter in the hospital, invited me to listen to the jazz he was playing while he worked in the corridor outside the gym. A week later, a CD player and a stack of jazz CDs showed up in my room next to my bed. Eddie had put them there.

When I left the VA for home, I still couldn’t walk on my own. The VA gave me a freedom bridge, a motorized device that helped me get in and out of bed from my wheelchair. They also gave me a motorized wheelchair that could stand me upright so I could do aerobic exercises in my wheelchair. Finally, they provided me devices for going to the bathroom as well as one that enabled me to slide from the toilet into the shower. Oh, they also gave me a hospital bed.

Thanks to all this, I was eventually able to stand and walk on my own. And I now walk 8/10th of a mile everyday with the help of a walker. I also can play music again. In 2022, I played with the Aardvark Jazz Ensemble. It was our 50th anniversary concert.

That I am able to walk now, live a relatively normal life, and play music is evidence that the staff at the West Roxbury VA are superb at what they do. This is true of my primary care provider, the nurses in my ward, and the extraordinary physical and occupational therapists who showed me how to use my body again. On top of this expertise, these staff bring something else. Helping me was their way of thanking the thousands of veterans who had sacrificed so much on behalf of our country. The VA hospital people have a unique perspective. They see what they do as a way of giving back. No wonder they are so good at it.

Bruce Carruthers 78-year-old, US Army, 1966–1968, Ashville, North Carolina

As a Vietnam veteran, I want to describe two recent incidents that illustrate the kind of timely and effective care I receive at the VA in Asheville, North Carolina.

On December 2, 2021, I saw my primary-care provider (PCP) with a complaint about back and hip pain. In a period of two hours, I saw my PCP for a half-hour visit, had blood drawn, and got X-rays on my back and hips. My blood work revealed an elevated finding on one test, and a follow-up appointment with a specialist was scheduled for December 16. My X-ray showed arthritis on the spine and hips. An MRI was scheduled for a couple weeks later, in January. (It could have been scheduled earlier, but timing was at my convenience.) My primary care nurse was in constant communication with me about these follow-up appointments and my medications.

Almost a year later, on the morning of Wednesday November 16, 2022, I woke up with intense stomach pain. At 2:30 a.m., I went to the local emergency room. A CT scan revealed that I had gall stones and needed surgery. After a rough weekend, I called the Asheville VA on Monday morning. That afternoon, a VA surgeon called me and scheduled an appointment for Tuesday morning. I completed pre-op that day, and Thursday morning, the 24th, I was on the operating table. The surgery was completed laparoscopically, and I was discharged that day. My recovery was quick and smooth. I needed pain medication for less than a week. I returned for a follow-up appointment on December 6, and was cleared to return to normal activity a week later.

I couldn't be any happier with the care I received from the VA. The personnel there responded immediately to my call, and everything was handled efficiently, promptly, and with real concern. This is the kind of care all Americans should receive. I went to the local emergency room because it was the middle of the night, and the VA is about a half-hour drive for us. Had I gone to the VA emergency room, I am certain the surgery would have been scheduled even sooner.

I have received care in the private sector, and I can tell you from my experience, plus the experiences of family members and friends, that it is nothing like VA care. The patient has to manage referrals, transfers of medical records, pre-authorization for procedures, staying within network, hassling with insurance companies over payment, and expensive prescriptions. I know from personal experience that securing an appointment with a specialist often takes weeks, if not months. The VA offers a holistic, integrated approach to healthcare that most Americans would envy if they knew its quality.

Sometimes I see posts on social media from veterans who claim they are unable to receive timely and effective medical and psychological care from VA facilities. These stories are solicited by organizations bent on

privatizing the VA, no matter the cost to veterans. Rather than attempting to privatize the VA healthcare system, Congress should view it as a model for healthcare for all Americans. Numerous studies clearly show that VA care is equal to—and often better than—private care. It's more cost effective, and offers an integrated, holistic approach as opposed to the costly, fragmented, and inefficient private sector, which leaves so many Americans poorly served—often not served at all.

Joseph Riotta father of US Air Force Veteran, Joseph Riotta, Jr. Amityville, Long Island, New York

I am an American by choice, having emigrated from Argentina in 1974. I settled on Long Island, married, and raised a family here, including my beloved son Joey, who proudly served four years in the U.S. Air Force.

Six years ago, Joey, while still in the service, was diagnosed with schizophrenia. Thanks to excellent VA care delivered at medical centers in Brooklyn, Manhattan, and Northport, my son has been largely able to live independently, in an environment where he and others are safe. It was thus with shock and dismay that I learned VA Secretary Denis McDonough wanted to shut down these facilities, as well as others in New York State and around the country.

In February of last year, my son had a serious schizophrenic episode. Instead of taking Joey to the VA hospital in Northport, an ambulance took him to one of the private sector hospitals—Northwell's Huntington Hospital—which would have replaced the local VA hospital under Secretary Denis McDonough's AIR commission recommendations that were announced in March of 2022.

For five days, Northwell staff refused to acknowledge the fact that I am Joey's legal guardian and would not allow me and my wife to visit him. When challenged about their actions, Northwell staff blithely advised us that, "that sort of thing doesn't apply here." Joey was not allowed to shower or change clothes for five days and was treated callously by staff. When my wife and I finally were allowed to visit after four long days, we were aghast at Joey's condition and protested loudly. To reward us for advocating for our son, staff banned us from visiting him. We finally rescued Joey, and he was well cared for by the VA. When we complained to Huntington, its medical director sent us a letter acknowledging that "Northwell could have done better."

To assure that Northwell does, indeed, do better in the future, I reached out to the New York State Office of Mental Health (OMH). The agency was, at first, unresponsive and then assured me that Northwell had indeed educated its staff about guardianship issues. How did the OMH know the training was effective, I asked? because, Huntington Hospital said they'd done a good job, was the response.

My experience with both private sector mental health care providers and state regulators is hardly unique. In New York state, the vast majority of counties suffer from severe shortages of mental health providers. It's almost impossible—and believe me I have tried—to get a patient like Joey into a program that delivers both care for severe mental illness and substance abuse. This is true even if you are, like my family, privileged enough to afford to pay for the cost of such a program.

That's why, as a parent of a mentally ill veteran, I urge Congress to stop privatizing the VA and sending veterans like my son to private sector providers. Instead of continuing these misguided policies, the VA should be expanded to help more veterans, as well as their families and the communities that the American healthcare system too often underserves.

Joseph Ferneau 86-year-old, US Navy, 1954–1958, Chillicothe, Ohio

Almost as soon as I returned home to Ohio after leaving the military, I began using VA healthcare services. Back then, I had to go to Cincinnati to get treated because Chillicothe was 100 percent a psychiatric facility. During the Vietnam War, they opened it up to anybody, and things changed a lot.

Over the past six decades, I have received care at the Chillicothe VA as well as at Wright Air Force Base, and the Cincinnati, Dayton, and Columbus VA Medical Centers. Chillicothe is not only the most convenient medical center, but the one I value the most. Our hospital was built in 1924, just after World War One. It has old bricks, but it's been completely renovated and remains a beautiful building. They've spent millions on it, and it has the latest equipment money can buy, and the best care for veterans. It serves not only people who live in Chillicothe, but 17 adjoining counties here in southern and southeastern Ohio. We have 22,000 outpatients in our hospital, which is very conveniently located right off a whole bunch of major highways.

Over the decades, the VA has dealt with my blood pressure problems, a stroke, and a hernia. I'm a physical wreck right now, but I've got the best care you can get from the Chillicothe VA. After working here a whole lot of time, VA nurses and doctors really understand veterans. We're not just a number, we're a name. They know us, they understand our problems, and they really care about veterans. We don't get the kind of care they give here anyplace else.

But now they're shutting down programs and services in Chillicothe. They shut 44 inpatient beds and the ICU. They shut down the emergency room and turned it into an urgent care center. And they are outsourcing us to private sector hospitals, both in the region and sending patients all over the state, even as far as Ann Arbor, Michigan.

In his AIR commission recommendations, VA Secretary Denis McDonough threatened to close our hospital entirely. It's terrible, what's going on. They want to send us to private sector hospitals or people nearby or make us drive hours to other hospitals or VA facilities. But a lot of us are old. Can you imagine what it's like if you're an 86-year-old veteran like myself and your wife is 84 and you have to drive two hours from a rural area like this and navigate through city traffic? It's too much. I've heard some veterans say a trip like that would kill them.

I've been sent to private sector hospitals and they just treat you like a number. I was outsourced to a local hospital, and they didn't even have a washcloth or towel in my bathroom. When I turned on the faucet of the sink, horrible stuff came spewing out. I complained to the nurse and she said, "Oh yes, I've reported it several times." That would never happen at the VA.

To save our hospital, I've been working with other veterans as well as the American Legion, the VFW, AMVETS, and the American Federation of Government Employees. I've met a number of times with both of my Senators and with Congressional representatives. I once talked with VA Secretary Denis McDonough. Everyone says they will never shut our hospital and yet, they keep cutting back services because they say we don't see enough patients.

Jeffrey Ferneau son of Joseph, 58-year-old, U.S Marine Corps, 1984–1988

I not only use the VA hospital in Chillicothe as a patient but, for the past ten years, I've worked there as a housekeeper on its acute care units. While my father is 60 percent service-connected, I am 70 percent service-connected. I use the VA for everything. Everything my father says about the VA is spot on. I don't want to go to

any other hospital but the VA. But they're sending people out. They shut down the acute care units I worked on for ten years. When I got pneumonia, in September of 2022, they sent me to a local hospital, and it took me two hours just to get a blanket. It was not a good experience. It's totally different than the VA.

We are not one of these city hospitals that's a concrete jungle. We are a country hospital, with a beautiful campus at the foot of the Appalachian mountains. We've got a Community Living Center (VA nursing home) with a 5- star rating. Why on earth do they want to shut us down?

We've lost many nurses. When the VA Secretary announced that the facility would be closed, people decided to leave. Now, they're in a hiring frenzy, but it's hard to hire because local hospitals are offering nurses hiring bonuses of maybe just $20,000.

They keep saying we're losing money. But we're not losing money. When someone points that out, they say, "Well we don't have enough nurses to staff acute care units." I keep thinking back to what Abraham Lincoln said about caring for veterans and their widows and orphans. He didn't say we should put a price tag on that or that we should outsource care for those veterans because it would save money.

Bryce Gustafson 44-year-old, US Army 1996–1999, Indianapolis, Indiana

I did my basic training in the U.S. Army in 1996 at Fort Sill, Oklahoma, and then went to Fort Stewart in Georgia. I also served four months in Kuwait in 1998. I left the Army in 1999 and now work for Citizens Action Coalition (CAC), as a consumer advocate and organizer around environmental and consumer issues. CAC is the largest and oldest consumer advocacy organization in Indiana.

Before I joined CAC, I started using the VA in Fort Wayne, Indiana. I went to the emergency room at a private sector hospital because I thought I was having a heart attack. I had no insurance at the time. The first person who entered my room was a woman with a clipboard who asked me how I was going to pay for the ER visit. Since I thought I was dying of a heart attack, I said something like, "I don't care how I'm going to pay since I'm probably dying." then, a doctor came in the room and spent a few minutes with me. He asked about my caffeine intake and told me I'd do well to lay off caffeine since I was having a panic attack. Then he left. For that, I got a bill for $1,000.

A few weeks later, I ran into a veteran friend who told me about the VA. He asked me if I was using the VA. I said I didn't even know I could use the VA. I knew nothing about my benefits when I left the Army.

I thought it would be really hard to get healthcare and benefits. I also thought you could only get benefits if you were a combat veteran and believed that I wasn't really a combat veteran, even though technically I was. When I went to sign up for the VA, I was surprised that it really wasn't that hard. I talked with somebody and they walked me through the process.

I've been pretty fortunate with my health, but about three or four years ago I was suffering from some depression and I went to the VA for that. I told my primary care doctor about it and got some pills. That opened the door to therapy, which I've done off and on now for two or three years.

Not only was the therapy helpful but being in a system that understands I am a veteran is helpful. The VA has a high level of experience dealing with the most difficult cohort of patients in the country. They have an institutional knowledge about veterans that you can't find anywhere else. An example is how they deal with

PTSD. I have a different form of PTSD than combat PTSD. I've also gotten chiropractic care from the VA, and during the pandemic, my Covid vaccines, which was all done very efficiently. I was really glad to see how seriously they took the pandemic.

I am very worried about efforts to privatize the VA. Anytime you inject profit into essential human services like healthcare, it does not go well for the patient.

In spite of its problems, I feel like I get treated like gold at the VA. I not only have confidence that people there know about veterans but that I'm not going to go bankrupt if I have some health issue. This has been very important to me because when I got out of the service and back to the real world in 1999, I was fairly disillusioned. You don't have that sense of comradery you have in the military. When I started working for CAC, I felt that comradery again and that's why I stuck around and have been doing it for 13 years now. Having VA healthcare has given me the freedom to take a job I love but which doesn't pay a whole lot of money. I have been able to continue my service to my country in a different way, by working to advocate around consumer and environmental issues. It's given me an invaluable sense of mission and purpose.

David Sparka 66-year-old, US Army, 1983–1987, US and Germany Chillicothe, Ohio

In March 2014, I arrived at the Chillicothe VA to be admitted into the domiciliary program. I was a homeless veteran, a result of circumstances that were out of my control. I was scared, apprehensive, and a multitude of other emotions were going through my mind. I didn't know what to expect. All I had were the clothes on my back.

I proceeded to the first floor, called the domiciliary, and had no idea what to expect let alone what was going to happen to my life. To be honest, I was in tears, depressed, my stomach was in knots, how could I have let my life become such a mess?

In a short time, I was being checked in and given the ground rules. I was assigned a room, given a bed, linen, and was assured by several staff members that everything was going to be fine, and they were there for me and get me the help and answers that I needed.

Before I knew it, I was overwhelmed with a vast amount of medical services that were essential to my health. You name it, I was offered it! Dental, optical, radiology, lab work, primary care, gastrointestinal, pharmacy, podiatry, dietary consultation.

Much to my surprise, the above-mentioned services were not the end. There was more, much, much more. I'm going to take the time to mention them due to their importance, not only to me but many other veterans: social workers, vocational rehabilitation services, homeless programs, mental health, chaplains and religious services, a service to get some much-needed clothing, treatment team, food service, gym with a pool, police, fire, and EMS, treatment team, transportation services. Wow! All of these wonderful services were in place and, mind you, all of it in is one place. These programs can help a veteran like me begin to put a life back together.

Since I entered the VA, nine years have passed. I am now gainfully employed, have my own place, have successfully rebuilt my life, and now have pretty much put together a fairly decent retirement plan. I'm now 65 years old, I will need to work until age 70 for a good financial retirement. I hope you can clearly see that this was possible only due to the fact the tools needed were there, all in one toolbox, to put my life back together.

Mark Foreman 75-year-old, US Navy 1966–1968, Milwaukee, Wisconsin

When I was 19, I volunteered to serve with the U.S. Navy. Before going to Vietnam, I was trained to be a Navy Corpsman, a medic essentially, and was attached to the Marines. I was only in Vietnam for five weeks before being seriously injured. I was with a company of 83 Marines when we were given orders to go to the top of a mountain, where we were completely surrounded by 1,500 North Vietnamese Regulars. It is impossible for me to describe what it was like to be the target of 1500 machine guns firing all at once. Eighty percent of us were either killed or wounded in the first ten minutes of battle.

During a lull in the firing, I was able to reach a horribly injured Marine whose brain was hanging over his face. I had to wrap my legs around his flailing arms to stop him from pulling off the battle dressings that I'd tied on his head.

When the firing quieted down again, I belly crawled over to a Marine whose left arm was blown off. That's when I was shot in the hip, which was essentially blown off. I was conscious, but in deep shock for the next five days.

Because we were in extremely dense jungle, it was impossible for medevac helicopters to land. So, I lay there with an open wound for the next five days before they could reach us. When they finally evacuated me, it took seven days for surgeons to stabilize me enough to be flown to a much larger Naval hospital, in Japan. There I had ten more major surgeries to debride the wound before being flown to Bethesda Naval Hospital, in Maryland. There I remained in a body cast for five months. My whole right hip joint was destroyed, and I had osteomyelitis—a life-threatening bone infection.

After spending five months in a body cast at Bethesda, I was then transferred to a VA hospital in Des Moines, Iowa, just 30 miles from my hometown. I quickly found out how terrible this VA hospital was back then. When I got out, I stopped going to the VA and didn't go back to a VA hospital for more than two decades.

I still got other help from other VA programs. I used VA funds to go to art school to learn to be a stone sculptor and also to get a master's degree in art education, so I could teach art in public schools, which I did for 20 years.

When I finally went back to the VA, in the mid-1990s, it was pretty clear when I walked through the door that things had radically changed for the better. The attitude towards patients was wonderful. The VA has since helped me with pain management and all the other conditions I've experienced as an aging veteran.

When I returned to the VA, I knew I had psychological problems because of what I went through and witnessed in Vietnam, but I didn't have a name for it. When we returned from Vietnam, no one had a name for what vets were going through. By the time I went to the VA, doctors had learned a lot about how to deal with PTSD. I got the benefit of that education.

I was angry and thought I had every right—even the responsibility—to be angry. got help from VA psychologists. I still think I have every right to be angry about what happened in Vietnam, but the VA helped me develop different behavioral options. My mind and my vision of the world had been stained for a lifetime by what I experienced in Vietnam, but I'm learning to focus my vision in a more positive ways and that feels a lot better. I love to see beauty and there is a lot of beauty in the world.

Crystal Bland 38-year-old, US Army 2001–2009, Dolton, Illinois

I deployed three times to Iraq. When I was transitioning out of the military—moving from Tricare to registering with the VA—there was a period where I didn't have insurance. When I didn't have insurance, trying to go to places like Planned Parenthood for women's health was really hard. Even when I went to a private doctor, it took forever, sometimes six to eight months, to get an appointment. There aren't that many doctors in the state of Illinois who do women's care, and even fewer who understand veterans' problems.

Veterans are a unique population. On top of our many physical problems, many of us have PTSD, or mental issues. I get great care at the Hines VA, in Chicago. They actually created a women's clinic to take care of women veterans, which means the world to me. For a while it was a little rough, because they had to get adjusted to the fact that all these women are now veterans after the wars in Iraq and Afghanistan. Since they got it established, it has been great.

I have my own personal primary care doctor, as well as a patient care team, which they call them a PACT (Patient Aligned Care Team). I see my primary care doctor. If I have to go to a specialty clinic, they refer me there. If there is something they can't take care of, they will refer me to Loyola, which is across the street. That works well as a last resort because they can transfer my records and make sure the doctors know who the patients are. My gynecologist works in both locations, VA and Loyola, so there's no discontinuity of care.

I have mental health issues because of my service and the VA understands this. They have special groups we are assigned to that identify special traumas. I also get treated for my knees, my back, joint mobility issues, and chronic pain. The VA offers alternative treatments and physical therapy as well. I have been able to get care quickly.

The VA has proved that socialized medicine works. If it doesn't work, it's only because it hasn't received funding. It's like the public schools. You take away money from the public schools and then they don't work as well. Now they're going to take money away from the VA and say it isn't working. It would work very well if given the resources it needs. What we should be doing is staffing up the VA and making more satellite locations, more CBOCs (Community Based Outpatient Clinics), so we don't have to drive as long.

Christopher Scott "Henri" Henrikson 38-year-old, U.S Army, 2002–2008, Portland, Oregon

When I served in the Army, my base was Fort Lewis in Takoma, Washington. I was deployed twice to Iraq. The Army left me with a collection of parting gifts. Some came from serving in combat, others from breathing in the toxins emitted 24/7 by burn pits, and others from bacteria I picked up when I was deployed. (Not to mention the crappy food they gave us, which I ate for years.)

As a result, I have Crohn's Disease, Crohn's related arthritis, PTSD, and also bronchiolitis. I can't take in enough air. I can't run. Even walking is sometimes difficult.

After I left the service, I moved to Oregon. When I was diagnosed with Crohn's, I was in college. After college, I worked at a local jail as a corrections technician. But I lost my job because I was sick with abdominal pain and diarrhea. At the time, I was going to a private specialist for what was diagnosed as Crohn's disease and it was just costing a fortune. So, I went to the VA. It was not hard to get in. I was assigned a primary care physician. At the VA, I also got a new gastroenterologist, who was exceptional. Even though these doctors have changed over the years, they have all been exceptional.

I was prescribed HUMIRA for my Crohn's, which is a very expensive medication. If I hadn't been going to the VA, I would never have been able to afford that medication. I also see a rheumatologist for fibromyalgia. The VA has helped a lot with my pain. I also see a psychiatrist at the VA every three months, and a psychologist at the Fairview clinic.

When I was living in the Dales, Oregon, I was seeing a non-VA psychologist who was very good. But what is so different about the VA from private doctors is the coordination of care. My VA psychologist can put in referrals and send messages to other providers in the VA system. VA providers are also willing to put in a lot of extra time and effort to make things work for the patient. My gastroenterologist, for example, works with a coordinating nurse. If I have a problem with medication or anything else, I have her extension and can all her anytime. In my experience, that doesn't happen outside the VA. Civilian doctors want you to make an appointment when in fact many of my problems—I'd say 40 to 50 percent of them—can be dealt with over the phone.

I have experienced this kind of care coordination even when I have gone to the emergency room, which has happened over the years. After a couple of days, I get a call from a nurse or doctor to find out how I am doing and to make sure I get the appropriate follow up care.

I have never gone to a private provider under the MISSION Act. If there is a delay at the VA, which there rarely is, I would prefer to wait for the VA. Not only is it one-stop shopping there, but I have the comfort of knowing that nothing is getting lost because the care is coordinated among the many different providers I see.

Keagan Miller 36-year-old, US Navy, 2009–2013 Portland, Oregon

I was born in Texas but moved around a lot when I was growing up. In order to put myself in a better professional position, and use G.I. bill benefits to go to school, I joined the Navy when I was 23 years old. I was stationed in Fort Gordon in Augusta, GA, where I worked at the National Security Agency (NSA) site there. I was in Navy intelligence and never deployed overseas.

After I got out of the Navy, I moved to the California Bay area. I lived in Concord. Using the G.I. Bill, I went to Diablo Valley college. I moved to Portland in 2016 and now work for Clackamas County for a Housing and Urban Development-funded housing program for homeless veterans.

Like a lot of veterans, I had been minimizing my own experiences in the military and really wasn't aware that I had PTSD. How could I have PTSD, I thought? I hadn't deployed. Other people had worse problems than I. Even though I needed serious help, I didn't think I did, until other veterans encouraged me to get help from the VA.

When I started to take my mental health issues seriously, in 2016, I went to the VA Portland Health Care System. People there are very accessible. I have seen a psychologist, which helped somewhat. But I still had episodes, and couldn't sleep. The VA started me on medication, and I started getting a lot more sleep. The VA also paid for couple's counseling for me and my wife. My wife was trying to get some ideas about how she could help me if I escalated. We didn't see the counselor for very long but, the therapist helped me understand where some of these core feelings were coming from.

I also have arthritis and had ACL surgery in the Navy, so I am service-connected for that. But I use the VA mostly for mental healthcare. I love the coordination of care I get at the VA. I can have problem in one area, they can talk to each other, which allows for more cohesive care. My psychologist and psychiatrist talk to each other.

They're not just in a silo doing their own thing, like in the private sector where you have to know who's "in network" and "out of network. " I don't have to worry about that.

I am very worried about people who are trying to privatize the VA. I haven't used private healthcare much, but my wife does and so do my friends. They sure don't get the kind of care I get at the VA. I really believe if you signed your name on the dotted line to serve your country, America should take care of you at the VA.

Clifford Ray "Sam" Matics 73-year-old, US Navy veteran, 1968–1972, Beckley, West Virginia

I served in the Navy in Puerto Rico and on a heavy cruiser, the USS Newport News, for my final tour. For my last deployment, we were off the coast of Vietnam, where we did shore bombardments. Then I returned to West Virginia, where I was born and raised.

I first went to the VA in 1994, out of necessity. I'd lost my insurance where I'd been at work in customer service. I wasn't really aware of the VA until I lost my insurance. I had a serious kidney stone attack, and I went to the VA in Beckley for that. I've been in the VA system ever since. hey've treated me for kidney stones several times. I've had three lithotripsies, treatments to break up kidney stones that are too large to pass. I have also been treated on occasion for urinary tract infections which is a cause of the kidney stones. I have a primary care doctor who works in a clinic at the VA. I've had this doctor for almost 25 years. I am also seeing a dermatologist for some skin cancer.

Although I would prefer to get all my care at the VA, where they really know me and I am treated well—special—because I am a veteran, I have had to go outside the VA because the urologist at Beckley VA retired three years ago and they never replaced that doctor. I also have to go to an outside dermatologist because the VA doctor can't perform the surgery I need. I am worried about my primary care doctor, whom I've seen for 25 years because he's retiring in March, and I don't know if they are going to replace him.

I was very upset when they announced they were going to close the Beckley VA. Their ER is open all the time. I can go over any time and their waits are probably a tenth of what they would be at an outside hospital. They have only two hospitals other than the VA in Beckley. These hospitals are already overextended and understaffed and if you add 5000-7000 veterans in Southern West Virginia to their current patients I don't think they could handle it. ER waits would be huge and wait-times with surgeries would be prolonged.

In the VA they know me, know my medical status and history. They bend over backwards to help you. If you go to an outside physician, you're just another patient. I don't think people understand the benefits of the VA.

Patrick Cano 47-year-old, US Marine Corps, 1995–2004, Park Forest, Illinois

I served in the Marines for eight years from 1995 to 2004, where I fought in Clinton's drug wars. I went to Panama and Ecuador in an effort to stem the flow of narcotics. Obviously, it didn't work.

I have three service-connected injuries. One of them is PTSD because of what I experienced in the Marines. I also have hearing loss and have had surgery on my right knee and had rotator cuff surgery on my right shoulder. The thing that means the most to me about the VA is its continuity of care. If I go in with a problem with my shoulder and they are fixing my shoulder and I am a little off in my head and the doctor notices I am a bit iffy, he can send me over to see a counselor. And when I'm talking to the counselor, he notices I've got a bad tooth and he can say go down and see the dentist.

I go to the dentist, and he gives me what I need. I walk out of the VA, and my shoulder is fixed, I got some counseling, my tooth dealt with and no bills, no worry, no hassle. The attitude at the VA is "what can I do to help you?" If I go to a doctor in the private sector with a bad shoulder, the doctor looks at the shoulder and doesn't notice other things.

At the VA they also understand how to handle me and manage my PTSD. When I go outside of the VA, that's not always the case. Once, when I was in a private hospital for surgery, I woke up from the anesthesia and was angry. I don't even remember what I was saying. My wife was with me. She's been with me for 27 years, even when I was in the Marines. Instead of understanding what was going on with me after the surgery, the nurses were hostile and disrespectful. In fact, they said they if I continued to behave the way I was behaving they were going to call the police. That would not be good. I am a federal employee and if I were to get arrested, I could lose my job.

I was lucky that time. The doctor who came in to see me was a Vietnam veteran. He said, 'Hold on guys, he's a veteran, he's served overseas, I know how to handle this." They sedated me, put me to sleep and I rested well.

If I was in the VA, I would never have had such a problem. At the VA when they see someone for a medical problem, and that patient has mental health issues, they roll you down to a counselor or a counselor comes and sees you. In the VA, I would never have had to worry about getting arrested and losing my job as a federal employee.

I prefer the VA, so I am willing to take the two-hour drive from the South suburbs to Jesse Brown VA hospital because I get better care there. In fact, I was just there getting my disability re-evaluated and increased to 60 percent. This is not charity, I earned it.

Kelly Parrott 40-year-old, US Army, 2009–2012, Tampa, Florida

I joined the Army late, when I was 27. I was raised by a single father who was disabled and, since high school, I've had a desire to serve. When I joined the Army, I had a husband and three kids. i wanted to become a medic but that was a very popular MOS (military occupation specialty) and so I went into aviation, working as a mechanic fixing electrical systems on Black Hawk helicopters.

I was based at Fort Stewart in Georgia and deployed to Afghanistan for six months in 2011. In Afghanistan, I was exposed to burn pits. Over the course of my service, I also developed PTSD. Why? Because I experienced the kind of toxic leadership that exists in the military.

In January 2012, I was raped by my Non-Commissioned Officer in Charge. I reported the rape. What happens when you report a rape is almost worse than the rape itself. You have to go to mental health, and they said I was no longer safe or fit to serve. They coded me with a personality disorder. I also experienced a lot of harassment after I made the report. They tried to get me to withdraw my report or say that what happened was consensual. Finally, I was given an honorable discharge. There was a command-directed court martial of the soldier who raped me. All that happened is they gave him a half-month's pay for two months.

When I left the Army, my husband and I moved to Tampa, where I got into a program to become a licensed nurse. I went to school, worked in a lab, and tried to keep my mind from thinking about what had happened to me. But I had a panic attack in class. Thankfully, my instructor had been active duty Air Force and I broke down and told her everything. She told me about the VA's Vet Center, and I started seeing a therapist there which was a lifesaver.

I have been going to the Tampa VA ever since. I'm today getting help with chronic pain due to a rare auto immune disease that affects my connective tissue. I had cervical cancer and continue to have PTSD exacerbated by my Military Sexual Trauma (MST).

What works so well at the VA is that it's one-stop-shopping. If I need a referral to see a specialist, my primary care provider is going to put that in. The VA is also starting to understand and support alternative therapies for pain management. They focus on holistic care, like changes in diet and exercise, meditation, and yoga. Every time I go to my psychiatrist, she gives me a new video about breathing exercises or meditation. I also go to the VA for aquatherapy. They have a heated pool and they do light exercises and check your range of motion.

There is also a holistic health group and an all-women's group. You get to know these other women veterans, which is amazing. As an MST survivor ,you know the numbers of people who have been assaulted are high. But when you actually sit down and talk with, and are supported by, other female veterans who have gone through the same things, it's amazing. I've had surgery at the VA and when you wake up from anesthesia, they are so gentle. They explain everything. If they know you're an MST survivor, they put a sign on your door, "please knock if you are male staff."

Plus, a majority of time the people who care for me at the VA are also veterans. When I see a nurse come up to me with a bunch of tattoos on his arms and I realize he was a former Marine, it's such a relief. Even if providers aren't veterans, they've worked with veterans for so long, they understand us.

Could the VA improve? Of course. But we shouldn't try to privatize it. I always tell my veteran friends, "the VA was built for us and we need to use it."

ABOUT THE AUTHORS

SUZANNE GORDON is an award-winning journalist and author. She has written for The New York Times, The Los Angeles Times, The Washington Post, The Atlantic, The Nation, The Washington Monthly, The American Prospect, The Boston Globe, The Globe and Mail, JAMA, The Annals of Internal Medicine, The British Medical Journal, and others. She was the co-editor of the Culture and Politics of Health Care Work series at Cornell University Press. Suzanne is the author,editor, or co-author of 21 books. Her books on veterans issues include Wounds of War: How the VA Delivers Health, Healing, and Hope to the Nation's Veterans and The Battle for Veterans' Healthcare: Dispatches from the Frontlines of Policy Making and Patient Care and Our Veterans: Winners, Losers, Friends, and Enemies on the New Terrain of Veterans Affairs. Her other books on health care include Life Support: Three Nurses on the Front Lines, Beyond the Checklist: What Else Healthcare Can Learn from Aviation Teamwork and Safety. She received the DAV's Special Recognition Award for her writing on veterans' healthcare.

RUSSELL B. LEMLE, PHD, is a Senior Policy Analyst for the Veterans Healthcare Policy Institute, the VA-Community Care Lead for the Association of VA Psychologist Leaders (AVAPL) and is Clinical Professor, University of California San Francisco (UCSF) Medical School, Department of Psychiatry. From 1981 to 2019, he worked at the San Francisco VA Healthcare System, the last 25 years as Chief Psychologist. He is a fellow of the American Psychological Association (APA). Dr. Lemle has been widely recognized for his contributions to veterans' healthcare policy and firearm suicide prevention, including the APA Presidential Citation (2005), APA Division 18 Harold Hildreth Award (2011), AVAPL Antonette Zeiss Distinguished Career Award (2013), AVAPL Patrick DeLeon Advocacy Award (2016), and the Special Recognition Award for Veterans Health Care Advocacy from the Disabled American Veterans (DAV, 2020). In 2017, the AVAPL Russell B. Lemle Leadership Award was established in his honor for those who promote leadership development to improve mental health care for veterans. He has testified to the House Committee on Veterans' Affairs and the Commission on Care, and published numerous scientific articles and news outlet commentaries on the deleterious impact of VA's rapid expansion of veterans' healthcare into the private sector.

JASPER CRAVEN has covered a plethora of policy issues on the local, state and federal levels for outlets including Politico Magazine, The American Prospect, The Nation, The New York Times, The Boston Globe, The Chicago Tribune, and Vermont Digger. He is presently focused on military and veterans' issues, where he has written about snake oil salesmen hocking dubious PTSD treatments, untoward corporate and ideological lobbying over veterans' policy, and corruption inside the Vermont National Guard. He's co-author of the 2022 book "Our Veterans: Winners, Losers, Friends and Enemies on the New Terrain of Veterans Affairs"

For more information about veterans healthcare, please contact VHPI at ExecDirector@veteranspolicy.org

Veterans
Healthcare
Policy
Institute

Strengthening Care for Veterans and the Nation