

VA Scandal Widens

On Memorial Day, which honors those who died in service to the country, the Department of Veterans Affairs (VA) Office of Inspector General (OIG) is investigating medical facilities in at least 26 cities (1). The scandal started in Phoenix where Sam Foote, a retired VA physician, alleged that up to 40 patients in Arizona died awaiting care in a network where some veterans could not get appointments for more than a year. Foote claimed that Phoenix VA officials were misrepresenting wait times to collect bonus checks while maintaining "secret lists" of patients. These accusations resulted in the suspension of Sharon Helman, the Phoenix VA hospital director, along with her associate director and another unnamed senior administrator. Dennis Wagner in an article in the Arizona Republic listed many of the accusations made against various VA hospitals outside of Phoenix (1). These include:

- Chicago: Germaine Clarno, president of a federal employee union, said secret lists and falsified wait times had been an "everyday practice" at the Hines VA Hospital, and complaints of data fraud were ignored. Helman was previously at the Hines VA director prior to coming to Phoenix. Clarno also said the inspector general conducted an inquiry, but targeted tangential issues. "The problem is the government covers up for the government — the OIG is a bed partner of VA administration." The OIG had investigated the Phoenix VA in late 2013 but Robert Petzel, then undersecretary for Veterans Healthcare Administration, said the OIG found no evidence to support Foote's claims (2). Petzel later resigned and the White House has nominated Jeffrey Murawsky who previously served as director of VA Veterans Integrated Service Network (VISN) 12 which oversees the Hines VA and who directly supervised Helman (3).
- Walla Walla, WA: VA auditors who visited the Walla Walls VA, where Helman previously served as director prior to coming to Hines VA, identified improper and inconsistent patient-scheduling practices, according to the Walla Walla Union-Bulletin. A psychiatric nurse, who won a whistle-blower settlement after being terminated, told NBC News that intimidation and retaliation were commonplace at the medical center.
- San Antonio, Texas: Dr. Joseph Spann, who retired in January after 17 years with the VA, told federal investigators that physicians were regularly asked to alter the "request date" for medical procedures to hide backlogs for tests. Spann attributed the practice to pressure to meet performance measures that reward administrators bonuses. When told local VA officials had conducted a review and denied the allegation, Spann said, "Central Texas (VA) investigating itself is just worthless." Raymond Chung who was the previous Chief of Staff at the Phoenix VA came to Phoenix from San Antonio.
- Cheyenne, WY: Congressional investigators uncovered an e-mail written by a nurse to other VA employees describing techniques for "gaming the system" by falsifying appointment records to meet goals set by bosses. The nurse was suspended after the e-mail was made public. The director of the Cheyenne VA is Cynthia McCormack who previously was chief of nursing at the Phoenix VA.

- Fort Collins, CO: OIG investigators in December found that medical clinic staffers were trained to make it appear veterans were getting appointments within 14 days, per department guidelines, even though waits were longer. McCormack supervises the Fort Collins clinic.
- Albuquerque: U.S. Sen. Tom Udall, D-N.M., called for an investigation after allegations that wait-time records were falsified Phoenix. Phoenix and Albuquerque are both supervised by Susan Bowers, the VISN 18 director.

As the above illustrates, the connections between these administrators is striking. Beginning several years ago, according to internal VA records, VA central office in Washington realized medical centers around the country were finding ways to manipulate the numbers. The VA had for several years been the subject of congressional inquiry and criticism not just due to long waits for care, but because of mismanagement but no action was taken.

Although Congress, VA central office in Washington and the local VISNs are all charged with overseeing the VA hospitals, the task of supervising this large, complex bureaucracy is daunting and appears to have been inadequate. A system needs to be put in place where healthcare providers who care for veterans and veteran patients who use the facility have a role in the oversight of their local VA hospital. Creation of a hospital board of directors consisting predominately of healthcare providers from the facility and veterans might be able to provide the supervision that this ever widening scandal suggests is needed.

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References

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3. O'Dell R, Nowicki D, The Arizona Republic. May 16, 2014. Available at: <http://www.usatoday.com/story/news/nation/2014/05/16/top-va-health-official-resigns-under-fire/9182311/> (accessed 5/26/14).

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