

Coburn Amendment____: To allow veterans' access to non-VA health care providers

S. 1982 provides little relief to veterans suffering due to mismanagement at VA, and the VA's failure in utilizing effectively its Fee-Based care or the Patient Centered Community Care program which affords a limited number of veterans the ability to seek care at non-VA providers. This amendment improves VA's public-private partnerships and will provide substantial relief to veterans suffering long and unacceptable appointment wait times, and receiving delays in treatment for their service-connected disabilities.

According to the VA's Office of Rural Health, in FY13, 6.1 million, or 28% of veterans live in rural areas.¹ 3.1 million of those veterans, or 36% of VA beneficiaries, are enrolled in the VA system.²

31% of Iraq and Afghanistan veterans, many who have recently returned to civilian life, or are preparing to transition from the military to transition life, live in rural areas.³

According to a survey done by the American Health Information Management Association, they found that the average distance traveled by surveyed veterans was 54 miles.⁴ According to the survey, 1-in-4 veterans reported that their decision to seek care at VA was directly impacted by their travel considerations.⁵ Also, the survey found that travel

¹ Department of Veterans Affairs, Office of Rural Health

http://www.ruralhealth.va.gov/docs/factsheets/ORH_FactSheet_General_April2013.pdf

² Department of Veterans Affairs, Office of Rural Health

http://www.ruralhealth.va.gov/docs/factsheets/ORH_FactSheet_General_April2013.pdf

³ Department of Veterans Affairs, Office of Rural Health <http://www.ruralhealth.va.gov/about/index.asp>

⁴ Benjamin L. Schooley, Thomas A. Horan, Pamela W. Lee, and Priscilla A. West, "Rural Veteran Access to Healthcare Services: Investigating the Role of Information and Communication Technologies in Overcoming Spatial Barriers", American Health Information Management Association, Spring 2010.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2889372/>

⁵ Benjamin L. Schooley, Thomas A. Horan, Pamela W. Lee, and Priscilla A. West, "Rural Veteran Access to Healthcare Services: Investigating the Role of Information and Communication Technologies in Overcoming Spatial Barriers", American Health Information Management Association, Spring 2010.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2889372/>

considerations impacted them higher when deciding on seeking care at a VA facility, than a Non-VA facility.⁶

Specifically, this amendment creates a program which affords veterans the ability to receive treatment at the private health care providers of their choice.

In addition to proving our veterans with timely care and allowing veterans to choose their own doctors—closest to their homes—affording veterans a choice may provide economic benefits to veterans’ local economy, and the ability for veterans to access local services would do more to connect veterans to their communities.

AVOIDABLE VETERAN DEATHS AT VA RELATED TO APPOINTMENT WAIT TIMES

Lapses in care have resulted in patient deaths at VA medical centers—CNN investigated veterans’ complaints of misdiagnosis and improper care for gastrointestinal conditions and linked the 2-year consultation delays to the deaths of three cancer patients.⁷ Also:

- According to CNN, at least 19 veterans died because of delays in diagnosis and treatment at VA hospitals. Delays were in simple medical screenings like colonoscopies or endoscopies.⁸
- Also, according to CNN, these veterans were part of 82 vets who have died or are dying or have suffered serious injuries as a result of delayed diagnosis or treatment for colonoscopies or endoscopies.⁹

⁶ Benjamin L. Schooley, Thomas A. Horan, Pamela W. Lee, and Priscilla A. West, “Rural Veteran Access to Healthcare Services: Investigating the Role of Information and Communication Technologies in Overcoming Spatial Barriers”, American Health Information Management Association, Spring 2010.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2889372/>

⁷ Scott Bronstein, Nelli Black, and Drew Griffin, “Veterans dying because of health care delays,” CNN, January 30, 2014.
<http://www.cnn.com/2014/01/30/health/veterans-dying-health-care-delays/>

⁸ Scott Bronstein, Nelli Black, and Drew Griffin, “Veterans dying because of health care delays,” CNN, January 30, 2014.
<http://www.cnn.com/2014/01/30/health/veterans-dying-health-care-delays/>

⁹ Scott Bronstein, Nelli Black, and Drew Griffin, “Veterans dying because of health care delays,” CNN, January 30, 2014.
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- The VA hospital in Augusta, Georgia, recently apologized for the death of three veterans at their facility, which occurred because of delays in medical care. CNN explained their “investigation revealed that military veterans are dying needlessly because of long waits and delayed care at U.S. veterans hospitals” and found that “numerous VA hospitals actively engage in cover-ups of their extensive patient wait times, including the falsifying of records. Additionally, the administrators of these hospitals are regularly rewarded with bonuses, rather than facing consequences for patient neglect.”¹⁰
- In 2011 and 2012, 5,100 Augusta and Dublin, GA, VA beneficiaries who were in need of gastrointestinal procedures went without consultations.¹¹ Furthermore, VA HQ in Atlanta revealed a delay in 2,860 screenings, 1,300 surveillance and 340 diagnostic endoscopies.¹² According to an internal VA memo, reported on by The Augusta Chronicle, the Augusta VA sought assistance from “non-VA care partner facilities” in September 2012 for help in reducing consult delays—by January 2014, the VA was able to resolve all delayed consultations through utilizing options which existed within the Augusta community.¹³
- *The Daily Caller* obtained audio of an internal VA meeting which confirmed that Los Angeles VA officials deliberately canceled backlogged patient exam requests.¹⁴ The audio from a November 2008 meeting shows how VA officials decided that backlogged patient exams over a year old “should be canceled”¹⁵ and that the “Backlog should start

¹⁰ Scott Bronstein, Nelli Black, and Drew Griffin, “Veterans dying because of health care delays,” CNN, January 30, 2014. <http://www.cnn.com/2014/01/30/health/veterans-dying-health-care-delays/>

¹¹ Wesley Brown “Gastrointestinal consultation backlog reported at second east Georgia VA hospital” Stars & Stripes/The Augusta Chronicle. January 29, 2014. <http://www.stripes.com/news/us/gastrointestinal-consultation-backlog-reported-at-second-east-georgia-va-hospital-1.264549>

¹² Wesley Brown “Gastrointestinal consultation backlog reported at second east Georgia VA hospital” Stars & Stripes/The Augusta Chronicle. January 29, 2014.

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<http://www.stripes.com/news/us/gastrointestinal-consultation-backlog-reported-at-second-east-georgia-va-hospital-1.264549>

¹⁴ Patrick Howley, “Department of Veterans Affairs employees destroyed veterans’ medical records to cancel backlogged exam requests” The Daily Caller, February 24, 2014. <http://dailycaller.com/2014/02/24/va-employees-destroyed-veterans-medical-records-to-cancel-backlogged-exam-requests-audio/#ixzz2uLQ2d9OT>

¹⁵ Patrick Howley, “Department of Veterans Affairs employees destroyed veterans’ medical records to cancel backlogged exam requests” The Daily Caller, February 24, 2014. <http://dailycaller.com/2014/02/24/va-employees-destroyed-veterans-medical-records-to-cancel-backlogged-exam-requests-audio/#ixzz2uLQ2d9OT>

at April 2007.”¹⁶ Audio shows VA officials determined that it was OK to cancel backlogged appointments because, “a lot of those patients either had their studies somewhere else, had their surgery...died, don’t live in the state...it’s ridiculous.”¹⁷ According to Marine veteran and former VA employee Oliver Mitchell, when Mr. Mitchell tried to sound the alarm on the VA’s deliberate attempt to fraudulently reduce the backlog, Mr. Mitchell was transferred out of his department and eventually lost his job.¹⁸ Mr. Mitchell also claims he contacted Congress about the issue in January 2011—suddenly, he was fired by the VA two months later.¹⁹

- Veteran Barry Coates was having excruciating pain and rectal bleeding in 2011. For a year the Army veteran went to several VA clinics and hospitals in South Carolina and was diagnosed by the VA with hemorrhoids. Aside from simple pain medication, he was told he might need a colonoscopy. Mr. Coates waited months, even begging for an appointment to have his colonoscopy, but he only found himself on a growing list of veterans also waiting for appointments and procedures. Many months later, Mr. Coates was finally told he could have a colonoscopy. However, at that point, VA delays led to drastic consequences for Mr. Coates, who is now undergoing chemotherapy in an effort to save his life.²⁰
- In January 2011, registered nurses at a Manhattan Veterans Affairs hospital failed to notice a patient had become disconnected from a cardiac monitor until after his heart had stopped and he could not be revived.²¹ An October 2011 VA OIG investigated the death of the

¹⁶ Patrick Howley, “Department of Veterans Affairs employees destroyed veterans’ medical records to cancel backlogged exam requests” The Daily Caller, February 24, 2014. <http://dailycaller.com/2014/02/24/va-employees-destroyed-veterans-medical-records-to-cancel-backlogged-exam-requests-audio/#ixzz2uLQ2d9OT>

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²⁰ Scott Bronstein, Nelli Black, and Drew Griffin, “Veterans dying because of health care delays,” CNN, January 30, 2014. <http://www.cnn.com/2014/01/30/health/veterans-dying-health-care-delays/>

²¹ Charles Ornstein and Tracy Weber, “Patient Died at New York VA Hospital After Alarm was Ignored,” ProPublica, May 15, 2012; <http://www.propublica.org/article/patient-died-at-new-york-va-hospital-after-alarm-was-ignored>.

patient, who was in his 80s, at the Manhattan campus of the VA's New York Harbor Healthcare System. The man had undergone several heart procedures and on his fifth day at the hospital, monitor records show that an alarm indicated a problem with the device or the patient, but there is no evidence nurses were aware of the alarm until the man was discovered unresponsive an hour and a half later. He was declared dead shortly afterward, according to the OIG report.²²

- In 2012, Eddie Creed, who served in the Army in the 1950s went on to play piano for Seattle's Chamber Jazz Quartet in civilian life. On April 19, 2012, Eddie died at the Veterans Affairs hospital on Beacon Hill—his death certificate said throat cancer had killed him.²³ According to A KUOW (a Puget Sound, Western Washington, and Southern British Columbia radio station) investigation, on Creed's second night at the VA, Eddie was hooked up to an Infusomat device—which was under a Class I recall—when it malfunctioned and drained all of its morphine into Eddie while he was asleep. Around 11 p.m. that night, a nurse discovered that during the malfunction Creed had received about 10 times the dose he was prescribed, and Eddie was pronounced dead shortly thereafter.²⁴

VETS WAIT MORE THAN TWO WEEKS FOR MENTAL HEALTH THERAPY

The VA failed to meet its 14-day goal in 34 percent of new mental health appointments in treatment categories including psychiatry, psychology, post-traumatic stress disorder and substance abuse in 2013.²⁵

In nearly half of 47,700 first-time psychiatric therapy appointments in 2013, veterans waited longer than two weeks.²⁶

²² Charles Ornstein and Tracy Weber, "Patient Died at New York VA Hospital After Alarm was Ignored," ProPublica, May 15, 2012; <http://www.propublica.org/article/patient-died-at-new-york-va-hospital-after-alarm-was-ignored>.

²³ John Ryan, "How a Recalled Medical Device Killed a Vet at Seattle's VA Hospital," KUOW, December 5, 2013; <http://kuow.org/post/how-recalled-medical-device-killed-vet-seattles-va-hospital>.

²⁴ John Ryan, "How a Recalled Medical Device Killed a Vet at Seattle's VA Hospital," KUOW, December 5, 2013; <http://kuow.org/post/how-recalled-medical-device-killed-vet-seattles-va-hospital>.

²⁵ Gregg Zoroya and Meghan Hoyer, "Many veterans still wait weeks for mental health care, USA Today, November 4, 2013; <http://www.usatoday.com/story/news/nation/2013/11/04/veterans-mental-health-treatment/3169763/>.

The average time it took to start any type of behavioral health therapy was 15 days.

In Houston, Texas, veterans needing new appointments waited an average of 28 days to receive services.²⁷

Approximately 22 veterans commit suicide every day.²⁸

ANNUAL REPORT SHOWS VA NOT MEETING TARGETS FOR PRIMARY AND SPECIALTY CARE FOR 3 OUT OF 4 VETERANS

Based on GAO recommendations to improve reliability of reported wait times for new medical appointments, in 2013 the VA changed the way it tracks and calculates its performance.

Using the new tracking method in 2013, the VA reported only 41 percent of veterans were scheduled for new a primary care appointment and only 40 percent of veterans were scheduled for new specialty care appointments within the 14 day standard.²⁹

In contrast, in 2012 the VA reported that 90 percent of new primary care appointments and 95 percent of new specialty care appointments had met the 14 day standard.³⁰

Utilizes Existing Health Care Infrastructure to Reinforce Veteran Health Care

²⁶ Gregg Zoroya and Meghan Hoyer, “Many veterans still wait weeks for mental health care, USA Today, November 4, 2013; <http://www.usatoday.com/story/news/nation/2013/11/04/veterans-mental-health-treatment/3169763/> .

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²⁸ Gregg Zoroya and Meghan Hoyer, “Many veterans still wait weeks for mental health care, USA Today, November 4, 2013; <http://www.usatoday.com/story/news/nation/2013/11/04/veterans-mental-health-treatment/3169763/> .

²⁹ http://www.va.gov/budget/docs/report/2013-VAPAR_Part_II.pdf

³⁰ <http://www.va.gov/budget/report/>

This amendment creates a new program to improve access to health care for our veterans, surviving spouses, spouses of veterans, and their children. The program will provide immediate relief to veterans by affording them the ability to seek care nearer to their homes—and with providers they trust. It will also benefit veterans who live near an existing VA facility who will receive greater access to care by the reduction of veterans being treated at VA facilities, and provide relief to VA staff struggling to provide timely care to our veterans.

This program will also lead to more cost effective care for our veterans, as providers would be reimbursed according to pro-rated Medicare rates for the equivalent procedures or diagnosis. To ensure veterans are being provided with a high standard of care, the VA Secretary will have the authority to restrict certain providers from caring for our veterans—if our veterans found a provider’s care to be substandard.

Furthermore, as the VA is the third largest owner of federal government real property, behind the Department of Defense³¹, this program would reduce costs to the government by preventing the expansion of inefficient and expensive VA leasing of real property.

³¹ Department of Veterans Affairs, “The VA Construction Review Council Activity Report” November 2012..
<https://www.vendorportal.ecms.va.gov/>