DEATH, DELAY & DISMAY AT THE VA

FRIENDLY FIRE

> **To care for him who shall have borne the battle and for his widow, and his orphan.**
>
> *- Abraham Lincoln*

The Department of Veterans Affairs Motto

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INTRODUCTION

Dear Taxpayers,

Too many men and women who bravely fought for our freedom are losing their lives, not at the hands of terrorists or enemy combatants, but from friendly fire in the form of medical malpractice and neglect by the Department of Veterans Affairs (VA).

Split-second medical decisions in a war zone or in an emergency room can mean the difference between life and death. Yet at the VA, the urgency of the battlefield is lost in the lethargy of the bureaucracy. Veterans wait months just to see a doctor and the Department has systemically covered up delays and deaths they have caused. For decades, the Department has struggled to deliver timely care to veterans.

The reason veterans care has suffered for so long is Congress has failed to hold the VA accountable. Despite years of warnings from government investigators about efforts to cook the books, it took the unnecessary deaths of veterans denied care from Atlanta to Phoenix to prompt Congress to finally take action. On June 11, 2014, the Senate recently approved a bipartisan bill to allow veterans who cannot receive a timely doctor's appointment to go to another doctor outside of the VA.[1046]

But the problems at the VA are far deeper than just scheduling. After all, just getting to see a doctor does not guarantee appropriate treatment. Veterans in Boston receive top-notch care, while those treated in Phoenix suffer from subpar treatment. Over the past decade, more than 1,000 veterans may have died as a result of VA malfeasance,[1] and the VA has paid out nearly $1 billion to veterans and their families for its medical malpractice.[2]

The waiting list cover-ups and uneven care are reflective of a much larger culture within the VA, where administrators manipulate both data and employees to give an appearance that all is well.

Good employees inside the VA who try to bring attention to problems or errors are punished, bullied, put on "bad boy" lists, and transferred to other locations. These whistleblowers, who come forward to expose the problems, demonstrate many employees within the VA are dedicated to serving veterans and willing to put their livelihood at risk to ensure our nation's heroes are getting the care they were promised. Without their courage, more veterans may have died unnecessarily and Washington would have continued to ignore the systemic problems within the VA.

As a Marine, Oliver Mitchell lived by the motto "No Marine left behind." As a VA employee, Mitchell was ordered to leave behind thousands of former service members by purging their requests for medical appointments. Mitchell refused and suffered years of retaliation before he left the agency.[3] Meanwhile, employees who bend the rules or even break the law are rewarded with financial bonuses or put on paid leave from work.

This has created an environment where veterans are not always the priority. For example, the Department suffers from a shortage of health care providers; yet, the VA pays nurses to perform union duties and allows doctors to leave work early rather than care for patients. It also tolerates employees skipping work for long periods of unapproved absences, while veterans cannot get phone calls answered or returned.

This is not the type of service veterans should receive, and it certainly does not reflect the commitment made by our nation to the defenders of our freedoms.

As is typical with any bureaucracy, the excuse for not being able to meet goals is a lack of resources. But, this is not the case at the VA, where spending has increased rapidly in recent years. After splurging on junkets, generous salaries, bonuses, and office renovations for its employees, the VA ends nearly every year with tens of billions in unspent funds. This includes at least a half-a-billion dollars specifically intended to provide health care. Billions more are lost to poor planning.

Poor management is costing the Department billions of dollars more and compromising veterans' access to medical care. Most the VA's construction projects, for example, are over budget and behind schedule. And even when state of the art facilities are constructed—such as the new VA hospital in North Las Vegas, which has been called the "Crown Jewel of the VA Healthcare System"—the Department is unable to hire enough doctors.[4] The VA then must spend millions of dollars to send veterans to clinics in other cities and states, which is both costly and inconvenient. This, of course, is the problem when patients are trapped within a closed system. VA hospitals do serve an important and unique role. Many of the 9.1 million veterans enrolled in the VA Health Care System[5] like the doctors and appreciate the service provided by the VA. They also like having a health care system specifically designed to meet the unique and specific needs of retired members of the armed forces. But too many veterans who rely upon the VA are stuck in a bureaucratic maze that is inconvenient, unaccountable, inefficient, and limits choices with varying outcomes.

Ironically, the veterans who fought for freedom are given the least amount of freedom over their own health care decisions. There is a simple solution: Make every hospital, a VA hospital and allow veterans to choose where and when they receive treatment.

"We've seen battle. We've seen combat," says Vietnam veteran J.R. Howell, asking "why do we have to … fight when we come back home just to get proper medical care?"[6]

Veterans who have survived war should no longer have to battle with bureaucracy to access the best possible health care. The foundation of having other people serve depends on how well we take care of those that have.

This report, "FRIENDLY FIRE: Death, Delay and Dismay at the VA," outlines what still ails the VA and prescribes to hold the Department accountable to ensure our commitment to every one of our veterans is upheld.

Sincerely,

Tom Coburn

U.S. Senator

VETERANS ARE SUFFERING AND DYING UNDER THE VA'S WATCH

For many people serving in the military, the thought of returning home from a long overseas deployment is the most welcome of news. Trading away the comforts of home for service to country, deployments bring long hours, stressful working conditions, and often debilitating injuries. After months, and sometimes years, of being away from family and friends, service men and women should have the peace of mind to know they are returning to a nation ready to support them.

Unfortunately, for too many veterans it is the trip that begins the longest period of suffering. This is at the hand of the federal department created to serve them. After being gone for some of their most productive work years, some veterans look to the Department of Veterans Affairs (VA) for basic needs like health care, housing, and education assistance. In the area of health care in particular, the VA has failed those it should have served.

This section of the report identifies ways in which veterans who enroll in the VA Health Care System are negatively impacted by the Department's levels of care. From long waiting lists to back-logged benefit claims, those veterans who seek care from the VA have not been served well.

Veteran Eligibility for Enrollment in the VA Health Care System

The number of U.S. veterans who actually utilize VA's medical services is an important factor to consider when analyzing the Department's health care system. Out of the current veteran population of more than 21.6 million, more than 9.1 million veterans are enrolled in the VA system.[7] Additionally, not every enrollee necessarily receives medical care. "Some veterans may opt not to seek care during the year, while others may receive care outside the VA system, paying for care using private health insurance, Medicare, Medicaid, TRICARE, or other means."[8] As such, the number of patients at the VA is less than the number of enrollees.

Even still, the VA operates the largest integrated health care system in the country.[9] With over 288,000 employees, the Department provided medical care to over 6.4 million patients in 2013 – 680,000 of which were eligible non-veterans.[10] The VA health care system is unique and different from other publicly-funded health care programs in the sense that "the federal government owns the medical facilities and employs the health care providers."[11]

However, not all eligible veterans enroll in VA's health care system. In fact, as of 2013, less than half of veterans used medical services provided by the Veterans Health Administration (VHA).[12] But, the number of veterans opting to enroll in VA health care is rapidly increasing. While the total veteran population has decreased by 17 percent from 2001 to 2014, the number of veterans enrolling in VA health care has increased by 78 percent in the same time period.[13] The number of non-veteran patients has also increased in recent years.[14]

Who is Eligible for VA Health Benefits?

To enroll in the VA health care system, veterans first must meet eligibility requirements. Generally, for the purposes of VA health care benefits, a veteran who is defined as a "person who served in the active military service and who was discharged or released under conditions other than dishonorable" may qualify for medical benefits.[15] Additionally, a select group of non-veterans may be eligible for VA health benefits. While family members of veterans are not generally eligible, certain dependents, caregivers, and survivors of certain veterans may qualify for the Civilian Health and Medical Program of the Department of Veterans Affairs.[16] Under this program, the VA reimburses qualifying non-veterans for specified medical expenses.[17]

However, not every veteran is entitled to VA health care. Whether a veteran is eligible depends on his or her "veteran status" resulting from military service. Factors considered to determine an eligible veteran status include: (1) active duty service in the military, naval, or air service; (2) satisfying a minimum period of duty, and (3) release under conditions other than dishonorable.[18]

In order to be eligible, a minimum duty requirement must be met. Veterans who enlisted after September 7, 1980 or entered active duty after October 16, 1981, must have served 24 continuous months (or the full period for which they were called to active duty) in order to qualify.[19] However, exceptions to the minimum duty requirement are made for some veterans, including those discharged for service-connected disabilities, returning combat veterans, and certain members of the Reserve and National Guard.[20]

Returning combat veterans who "served in a theater of combat operations after November 11, 1998, and were discharged on or after January 28, 2003" enjoy a special period of enrollment eligibility.[21] These veterans can "enroll in VA health care for five years from the date of their most recent discharge without having to demonstrate a service-connected disability or satisfy an income requirement."[22] Under this enhanced "Combat Veteran" authority, the VA will provide cost-free health care services and nursing home care for conditions related to military service.[23] Combat veterans continue to be covered by the VA even after the five-year eligibility period ends.[24]

Enrollment Process and Priority Groups

Veterans who meet eligibility requirements are then subject to VA's enrollment process. VA's enrollment system categorizes veterans into eight "Priority Groups," based on factors such as service-connected disabilities, income, former prisoners-of-war, Purple Heart recipients, and pension benefits – just to name a few.[25] Because the number of veterans who receive health care benefits depends on annual congressional appropriations, and "funds are limited," Priority Groups allow certain groups of veterans to enroll before others.[26] Priority Groups are ranked from one to eight, with Priority Group 1 being the highest priority for enrollment.[27]

For example, Priority Group 1 includes "veterans with service-connected disabilities rated 50% or more" and "veterans assigned a total disability rating for compensation based on un-employability."[28] In contrast, Priority Group 8 includes "veterans with gross household incomes above the VA national income threshold and the geographically-adjusted income threshold for their resident location."[29]

If veterans fall into more than one Priority Group, VA will place them into the highest available group.[30] Once veterans are enrolled, they do not have to reapply annually.[31] VA generally

> **Thousands of veterans have been subjected to Veterans Administration services that were inappropriate and insufficient or provided too late or not at all.**

re-evaluates the financial information of veterans who were originally enrolled based on their income (Priority Group 5).[32]

In 2013, the Congressional Budget Office (CBO) determined that ending enrollment for veterans placed in Priority Groups 7 and 8 could help reduce the federal deficit.[33] Priority Groups 7 and 8, which "gained access to the VA system only in the mid-1990's," are reserved for veterans with higher incomes who do not have service-related medical needs.[34]

By 2003, the "VA could no longer adequately serve all enrollees, prompting the Department to cut off new enrollment of veterans in priority group 8."[35] But as wait lists to see doctors became longer and larger across the country,

"VA eased that restriction in 2009 to allow some additional enrollment of priority group 8 veterans."[36] However, in 2012, "nearly 90 percent of enrollees in priority groups 7 and 8 had other health care coverage, most notably Medicare and private health insurance," indicating that this expansion may have been unnecessary.[37] Despite the fact that most of these veterans had alternative health care access, "about 2.3 million veterans who were enrolled in VA's health care system had been assigned to priority groups 7 and 8."[38]

Veterans Died Because of Long Waiting Lists and Insufficient, Inappropriate Care

PERHAPS NO ISSUE has affected more veterans than the long wait times to receive medical care at VA facilities. As in a court of law, medical care delayed is no better than medical care denied – and the results of both are often the same.

After waiting months to see a VA doctor, a Navy veteran died of Stage 4 bladder cancer. Rushed by his family to a Phoenix, Arizona VA emergency room in September 2013, he was sent home, even though his medical chart said his situation was "urgent."[39] According to reports, the VA never called to schedule a follow-up appointment, so the veteran and his daughter-in-law called "numerous times" to get the urgent appointment for him. She says she called "day after day" for months, but the response was never helpful. "Well, you know, we have other patients that are critical as well," she was told. "It's a seven-month waiting list. And you're gonna have to have patience." After enduring months of agonizing pain and suffering, he died on November 30, 2013. She said the VA finally returned the calls to schedule an appointment on December 6 – one week after her father-in-law had died.[40]

This is not an isolated event. Thousands of veterans have been subjected to VA services that were inappropriate and insufficient, or provided too late or not at all. Nearly 1,000 veterans' deaths have been linked to this kind of substandard care,[41] with thousands of others impacted in similar ways at VA facilities around the country. Many cases involved patients suffering serious maladies, from hearing loss to mental illness to cancer.

At least 82 vets have died or suffered serious injuries as a result of delayed diagnosis or treatment for colonoscopies or

endoscopies at VA facilities.[42] After investigating these deaths, CNN could not determine whether any VA employee has been fired or even reprimanded for these failures.[43] In fact, "some of the people responsible may have even received bonuses in recent years for their work, despite the delays in care or treatment for the veterans."[44]

On May 30, 2014, former VA Secretary Eric Shinseki said that he would fire the top administrators of the VA Medical Center in Phoenix, Arizona, following allegations of inappropriate scheduling practices. He resigned later that day, however, and it has not been confirmed if any Phoenix employees were fired since his exit.[45]

Following Shinseki's resignation, current Acting Secretary Sloan D. Gibson made similar vows to fire top VA administrators after reports confirmed at least 18 Arizona veterans died while awaiting doctor appointments in Phoenix.[46] In a public statement in Phoenix on June 5, 2014, Gibson said, "we initiated the process to remove senior leaders."[47] On the same day, Congresswoman Kristen Sinema asked Gibson in a private meeting whether top VA Phoenix officials would be fired.[48] Gibson responded that he needed Congress to give him that power. According to Congresswoman Sinema, who "wrote down his exact words," Gibson stated, "if I get the authority, I'll use it."[49]

More than 20 veterans are dead or dying of cancer "because they had to wait too long for diagnosis or treatment" at just one VA facility in South Carolina.[50]

The deaths of three veterans at a VA facility in Georgia were caused by delays in care.[51] In total, 5,100 veterans in need of gastrointestinal procedures went without consultations

between 2011 and 2012 in Georgia.[52] These included a delay in 2,860 screenings, 1,300 surveillance and 340 diagnostic endoscopies.[53] (As of January 2014, the facility had no pending GI consults).[54]

If the problems – or "adverse events" – arising from delays are serious enough, the VA is required to disclose that fact to a patient's family. "In the Florida region, five veterans are dead, and 14 vets or their families were sent the disclosures, notified that they suffered 'adverse events' because of delayed or denied care or diagnosis."[55]

"In the Rocky Mountain region, two veterans died, and four families were sent the disclosures or notified."[56]

"In the Texas region, seven vets or their families were sent disclosures about adverse events and serious injuries suffered because of delayed care."[57]

"Institutional disclosures," in which "patients or their representatives were notified that the veterans were harmed during their care," occurred at two separate VA centers in

explained AHCA Secretary Liz Dudek. "Without an ability to review the processes in place regarding risk management and quality assurance, we cannot ensure that our veterans who have so bravely fought to defend and protect our nation are receiving that quality care."[63]

After the AHCA inspectors were turned away from a VA hospital for a third time, Florida Governor Rick Scott stated, "the safety of our veterans is of paramount importance and they deserve answers. My office stands ready to dialogue with the VA about their lack of transparency, and with every VA hospital that turns away state inspectors, my concerns are more heightened, not diminished."[64]

For some veterans who died waiting for care, the VA did not disclose anything, and instead tried to bury the information. "At least 40 U.S. veterans died waiting for appointments at the Phoenix Veterans Affairs Health Care system, many of whom were placed on a secret waiting list," according to a CNN investigative report.[65] When the veterans

> **"That means the patients did not receive the tests or treatment that had been ordered, but rather the orders for the follow-up procedures were simply deleted from the agency's records."**

Florida.[58] The facilities were the James A. Haley Veterans' Hospital in Tampa and the C.W. "Bill" Young VA Medical Center in Bay Pines.[59] The VA did "not provide any specifics about the level of harm" to the veterans.[60]

The VA has rebuffed congressional calls to disclose information about deaths and injuries, and the Department has even turned away state medical inspectors.

When inspectors from Florida's Agency for Health Care Administration (AHCA) attempted to conduct onsite oversight of the sites, they were turned away from the two VA facilities in April.[61] Florida has now sued the VA demanding access to these sites.[62]

The inspectors were attempting to "assess implementation of Quality Assurance and Performance Improvement activities required as part of the internal investigations conducted by representatives of the Department of Veteran Affairs,"

on the secret list died, they were simply removed with no record that they ever waited for care, according to a retired doctor who worked with the VA system in Phoenix for 24 years.[66]

Since the disclosure of these deaths, the VA has confirmed that at least 18 veterans in Phoenix died while waiting to be treated by the medical center.[67] On June 11, 2014, the FBI launched a criminal investigation into VA scheduling practices to determine whether hospital officials "knowingly lied about wait times for veterans in order to receive performance bonuses."[68]

An independent review and a criminal investigation exposed a series of suspicious deaths and high mortality rates at the VA Medical Center in Lexington, Kentucky. "Insufficient nurse staffing levels, a lack of communication and planning, and significant gaps in key leadership roles may

have contributed to a higher-than-expected mortality rate among patients treated in the intensive care unit," according to an independent review.[69] This analysis found a "25 percent death rate for patients transferred into the local VA hospital's intensive care unit from other wards," which "compares with a national peer group mean of 17 percent."[70]

Two out of three intensive care unit staffers at the hospital conceded they "would not feel safe being treated as a patient" at the facility, and "high percentages of staffers in other departments gave the same response."[71]

A nurse at the Lexington medical center was charged with killing a World War II veteran and eventually admitted fault with very little consequence. The veteran, who served in Europe, was killed by a morphine overdose at a VA Hospital in Lexington, Kentucky in September 2006. The nurse who administered the lethal dose was charged with murder. Some of the veteran's family members said the nurse "harassed them for two years to try to get them to admit guilt" in the death.[72] The veteran's stepdaughter said, "the FBI was here a couple of times. They interrogated me and tried to make me say I did it and not to ruin the VA hospital's reputation."[73] The court found the "additional doses of morphine provided by" the nurse "were a contributory cause of" the veteran's death and she eventually pled guilty to involuntary manslaughter.[74] At least two other veterans cared for by the same nurse "died under suspicious circumstances" after being given morphine,

according to a special agent with the VA Inspector General (IG).[75] The nurse was sentenced to "time served of eight days." [76] Eight days represent significantly less time than most veterans spend waiting to receive care at a VA center.

The VA IG recently investigated circumstances surrounding the unexpected death of a patient in the Substance Abuse Residential Rehabilitation Treatment Program (SARRTP) at the Miami VA Medical Center. The investigation found that the Miami facility did not provide an adequately safe environment for patients, and "methods used for monitoring SARRTP patients for illicit drug use could be strengthened."[77]

The patient who died was an Afghanistan combat veteran. He had been diagnosed with polysubstance dependence, PTSD, sleep apnea, mood disorder, and traumatic brain injury.[78] During the course of his VA treatment, he repeatedly tested positive for illicit substances.[79] Despite numerous restrictions of his "pass" privileges to leave the SARRTP unit, the veteran died of "acute cocaine and heroin toxicity" the day after he left the facility on a two-hour pass.[80]

The IG found a various flaws in several management practices at the Miami SARRTP that enabled the patient's fatal overdose. The report noted insufficient patient monitoring and supervision, including defective surveillance cameras and lax contraband searches when patients returned from pass outings.[81] The IG also discovered staff members were not

At least three veterans who sought care at a Kentucky VA medical center died under suspicious circumstances when a nurse at the center was arrested for the murder of a patient.[101]

always physically present at the SARRTP unit as required, and patients who leave the facility enjoy easy access to illicit substances due to the facility's location in a high-drug area.[82]

More than half of the 2.6 million veterans who fought in Iraq and Afghanistan say they struggle with health problems stemming from their service and are dissatisfied with the government services provided to them, according to a recent survey.[83]

"The unexpected deaths that the OIG continues to report on at VA facilities could be avoided if VA would focus first on its core mission to deliver quality health care. Its efforts would also be aided by discussion of the best organizational structure to consistently provide quality care," concluded the IG.[84]

Lack of Mental Health Services Left Veterans Without Proper Care

WITH 22 VETERANS committing suicide on a daily basis, it is vital that immediate mental health appointments are available to those seeking help.[85] Yet, 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.[86] In nearly half of 47,700 first-time psychiatric therapy appointments in 2013, veterans waited longer than two weeks.[87] The average time it took to start any type of behavioral health therapy was 15 days.[88]

These numbers were provided by the VA, and possibly make the wait times look shorter than they actually are. According to GAO, the VHA "does not have a reliable and accurate method of determining whether they are providing patients timely access to mental health care services." As a result, "performance measures used to report patient's access to mental health care do not depict the true picture of a patient's waiting time to see a mental health provider."[89]

Dr. Margaret Moxness, a former physician at the Huntington VA Medical Center in Charleston, West Virginia, said that when she reported patients who needed immediate mental health treatment, supervisors instructed her to delay care anyway.[90] She saw at least two patients commit suicide while waiting for treatment between psychological appointments.[91]

As a psychiatrist, Dr. Moxness believes that VA administrators failed to pay attention to the real pain and suffering veterans were experiencing, and they had little empathy for their patients' struggles.[92] Adequate mental health treatment requires more than one visit every ten months – which is how long most patients at the Huntington Medical Center had to wait.[93] When Moxness reached out to her supervisors to tell them certain veterans needed more than this kind of "partial" treatment, her bosses stopped talking to her.[94]

At the Manchester, New Hampshire VA facility, clever tactics were used to cover up the true extent of the backlog for mental health care. According to a former official who worked at the facility, "Performance measures include a requirement that a veteran treated by the mental health service is to be scheduled for a mental health appointment within 14 days of his or her 'desired date' for service." [95] He pointed out a number of issues that "made it impossible to offer veterans the frequency of psychotherapy appointments to meet their clinical needs. While a veteran and his or her clinician might agree that the veteran should return next week to continue his progress, the availability of appointments were simply not there. Nevertheless our service 'met' this measure by simply eliminating the opportunity for the veteran to give us a desired appointment date. Instead, the veteran was told when the next appointment with his provider was available and that appointment (often weeks, even months away) was entered as his 'desired' date, thus 'meeting' the measure."[96]

He added, "Veterans who are unable to be scheduled for their actual desired date should be placed on an Electronic Wait List (EWL) developed for this purpose and meant to track the demand versus the availability of services. But facility leadership 'unofficially ordered' that the EWL was not to be used under any circumstances."[97]

Elsewhere, the response to the demand for mental health services by the Atlanta VA medical center (VAMC) was "fragmented, ineffective, and resulted in poor care, and may have contributed to the death of some of the veterans among the 4,000 to 5,000 patients referred for non-VA care," according to the VA IG.[98]

"Serious patient neglect" resulting from care being delayed for years at the VA health care system in Brockton, Massachusetts, has been alleged by a whistleblower to the U.S. Office of Special Counsel.[99] According to the Office, "the whistleblower first reported that a resident admitted for a service connected major depressive disorder went more than five years without appropriate psychiatric consultation, treatment, or medication. The whistleblower next disclosed that an individual diagnosed with a service connected schizo-affective disorder and drug-induced Parkinsonism went more than 11 years without appropriate psychiatric treatment and specific lab monitoring required by VA regulations and policies for individuals taking anti-psychotic and psychotropic medications."[100] These horror stories are enough to make anyone sick.

> **" She saw at least two patients commit suicide while waiting for treatment between psychological appointments. "**

Difficulties in Scheduling Appointments and Filing Claims Caused Unnecessary Delays

EVEN WHEN THE VA is able to give veterans the medical care they deserve, often times it is too late. Veterans have voiced ardent frustration over how difficult it is just to schedule an appointment or speak to a representative at the Department's health care system.

Complaints of appointment cancellations, unanswered calls, and month-long waits make up a VA system that veterans describe as an "impenetrable and unresponsive bureaucracy."[102] Many patients are lucky enough to turn to alternate health care coverage when the VA is unresponsive, but some veterans rely on the VA as their only option for medical care.[103] Sadly, many veterans "grudgingly accepted future appointments because they felt they had no other choice."[104]

Veterans "experienced excessive wait times" at the North Texas Veterans Health Care System.[105] At least five patients referred for vascular access had to wait three months or more for a procedure, with one dialysis patient waiting for "more than 4 months for permanent vascular access."[106] Ambulatory monitoring for a cardiac patient was delayed three months, while more than 200 others scheduled for ambulatory cardiac monitoring waited an average of 68 days.[107] The clinicians "did not review referral requests, consultation reports were not linked to requests in the EHR as required, and appointment dates requested by patients for vascular and cardiac procedures were incorrectly recorded by scheduling staff."[108]

Claude V. D'Unger, a 68-year-old Army veteran from Texas, said he stopped seeking care through the VA after he was unable to timely schedule a CT scan of his lungs.[109] "After calling for an appointment and being told that he would have to wait at least two months . . . he contacted a private doctor who performed the scan the next day."[110] D'Unger also had problems getting in touch with people at VA clinics regarding his medical claims – someone rarely answered the phones when he called.[111] "The claims side has a 1-800 number we refer to as dial-a-prayer," he said. [112]"Nobody answers, nobody listens."[113]

Army and Marine Corps veteran Justin Grimes returned from Iraq in 2006 and has struggled with nightmares and insomnia ever since.[114] He spent two years trying to make an appointment with a psychologist or sleep specialist at the VA online, only to come up fruitless.[115] He cannot manage to take off work to physically go to a VA hospital to inquire about appointments.[116] His father eventually paid for him to see a private psychologist, but he could not afford long-term treatment.[117]

Inspector General Confirms "Systemic" Inappropriate Scheduling Practices Throughout the Department

In response to the allegations of patient deaths due to delays and tweaked wait times at the VA Phoenix Health Care System, the IG initiated a comprehensive investigation of the medical facility, including an "in-depth examination of many sources of information necessitating access to records and personnel, both within and external to VA."[118]

The IG did substantiate "serious conditions at the [facility] negatively impacted access to health care."[119] The IG identified 1,700 veterans who were waiting for primary care appointments at one of the Phoenix clinics, but for some reason the veterans were not placed on the electronic waiting list.[120] These patients – all of whom should have been on the electronic wait list – were discovered through other means, including the new enrollee appointment request tracking reports, screenshot paper printouts of veterans who called the Phoenix help line, and lists showing patients referred from other clinics.[121]

Additionally, the IG compared data reported to the VA central office with wait the times for new patient primary care appointments completed at Phoenix. This study of 226 patients found that veterans waited an average of 115 days for primary care appointments, and about 84 percent waited more than 14 days.[122] This finding was inconsistent with national data reported by Phoenix, which showed the same patients waited an average of only 24 days for primary care appointments, and 43 percent waited more than 14 days.[123]

During the investigation, the IG also received allegations of sexual harassment, bullying by managers, and inappropriate hiring decisions.[124] They are in the process of assessing these complaints to determine whether other leadership deficiencies are present at Phoenix.[125]

The IG noted that its review of the VHA is ongoing and not confined to Phoenix. The IG is currently investigating at least 42 other VA medical facilities, confirming that "inappropriate scheduling practices are systemic throughout the VHA" and finding "multiple types of schemes used to reduce wait timing data."[126] Furthermore, this is not a recent problem. In 2008, among another dozen reports since 2005, the IG "reported that the problems and the causes associated with scheduling, wait times, and wait lists, are systemic throughout VHA."[127]

While the IG substantiated that multiple scheduling

practices are not in compliance with VHA policy at the Phoenix Health Care Center, they have not yet reported whether scheduling problems resulted in delays that caused patient deaths.[128] The VA, however, has confirmed that at least 18 veterans in Phoenix died while waiting to be treated by the medical center.[129] The IG's determination on patient deaths will require extensive analysis of medical records, death certificates, and autopsy results.[130] The final IG report is expected in August.

VA Confirms "Systemic Lack of Integrity" Across the Department's Health Care System

On June 9, 2014, the VA released a final audit assessing the integrity of scheduling and access management practices at VHA facilities nationwide.[131] These findings followed the release of a preliminary audit and the resignation of former VA Secretary Eric Shinseki, who stepped down amidst mounting allegations that veterans may have died as a result of botched wait time records.[132] The initial stages of the audit found "a systemic lack of integrity" throughout the VHA health care system.[133] The final audit confirmed inappropriate scheduling practices across the Department finding that "57,000 veterans have been waiting more than 90 days for an appointment."[134]

The VA audit examined 731 VA medical center sites and interviewed over 3,772 scheduling employees.[135] The VA considered initial findings to be "a strong basis for immediate action."[136] The final audit was consistent with this concern, and its findings included:[137]

- *Scheduling processes at the VA were "overly complicated" and resulted in "high potential to create confusion among employees";*

- *The 14-day wait-time target for appointments was "simply not attainable" – there were not enough providers to accommodate a growing demand of requests for appointments*
    o *Imposing this expectation on employees represented "an organizational leadership failure";*

- *13 percent of scheduling staff interviewed said they at one point received instructions from supervisors to enter in the "Desired Date" field for appointments a date that was different from the date the patient requested*
    o *At least one instance of this practice was identified in 76 percent of VA facilities (in certain instances, this may have been justified – the survey did not look into which were justified and which were not);*

- *Eight percent of scheduling staff indicated they did not use the Electronic Wait List (EWL) or VistA package as required to schedule appointments – they instead used alternate lists*
    o *At least one instance was identified in 70 percent of VA facilities; and*

- *Schedulers reported feeling under pressure to "utilize inappropriate practices in order to make waiting times . . . appear more favorable"*
    o *These practices were "sufficiently pervasive" and require VA to re-examine its entire performance management (i.e. bonus) system.*

Additionally, the audit found the greatest barrier to veterans receiving timely medical care at the VHA was a "lack of provider spots" to schedule appointments, as well as the impracticality of the 14-day wait-time goal.[138] VA had ample opportunity to improve these scheduling deficiencies, but often chose not to do so.[139]

The VA states that based on the results of the audit, "[s]enior leaders will be held accountable to implement policy, process, and performance management recommendations."[140] The VA also vows to "critically review" its performance management to determine why and how "front-line, middle, and senior managers felt compelled to manipulate VA's scheduling processes."[141]

"This behavior runs counter to VA's core values; the overarching environment and culture which allowed this state of practice to take root must be confronted head-on if VA is to evolve to be more capable of adjusting systems, leadership, and resources to meet the needs of Veterans and families. It must also be confronted in order to regain the trust of the Veterans that VA serves."[142]

"During the investigation, the IG also received allegations of sexual harassment, bullying by managers, and inappropriate hiring decisions.

Returning veterans in America's major population centers wait up to twice as long:

559 DAYS in White River Junction, Vt.

517 DAYS in Boston

642 DAYS in New York

517 DAYS in Philadelphia

618 DAYS in Oakland, Calif.

681 DAYS in Reno, Nev.

542 DAYS in Chicago

625 DAYS in Pittsburgh

612 DAYS in Indianapolis

619 DAYS in Los Angeles

496 DAYS in Little Rock, Ark.

584 DAYS in Phoenix

528 DAYS in Waco, Texas

490 DAYS in New Orleans

545 DAYS in Honolulu

586 DAYS in Houston

This map illustrates the average number of days veterans in America's largest population centers waited in 2013 to have their disability benefit claims processed.[146]

2009

Computerization effort launched

2013

$537 million spent; only **3%** of claims computerized

The computerization effort was launched in hopes of speeding up the claims process. This was the progress after four years.

Number of veterans

1M

800K

600K

400K

200K

2013 Afghanistan withdrawal begins

2012 Obama re-elected

2011 U.S. out of Iraq, still in Afghanistan

Barack Obama takes office 2009

Troop surge in Iraq 2007

2001 George W. Bush takes office; 9/11 attacks

2006 Sectarian violence engulfs Iraq

2003 U.S. invades Iraq

80   160   240   320   400

Average number of days waited
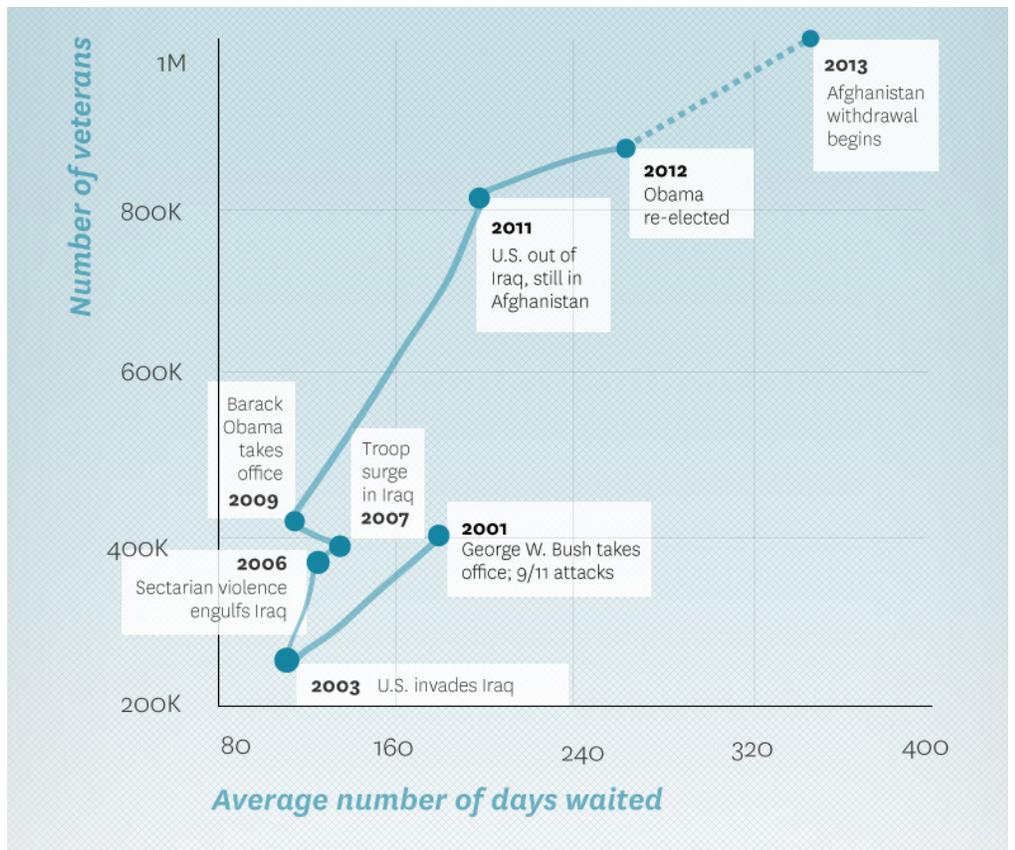
This chart helps illustrate the various problems associated with the VA care that veterans experienced. | All graphics from Center for Investigative Reporting

Disability Benefit Claims Often Take More Than A Year to Process

As of March 2014, more than 638,000 veterans were awaiting decisions on disability claims filed with the VA.[143] Over 360,000 of these—nearly three out of five—have been sitting for more the 125 days.[144] The VA defines a disability case as "backlogged" if it has been pending for more than 125 days.[145]

Veterans in Nevada experience the longest wait to have disability benefits claims addressed, as of December 2013. It took about 434 days to complete a disability request at the veterans facility in Reno,[148] and 4,000 Nevada veterans more than 125 days for completion of their claims.[149]

Veterans in Baltimore, Winston-Salem, Los Angeles, Cleveland, Chicago, Houston, Pittsburgh, and St. Louis have waited more than a year to have disability claims addressed.[150]

It takes 389 days for the Winston-Salem VA Regional Office in North Carolina to complete a veteran's compensation claim.[151] In 2012, the office had so many claims that they were warned the claims could be lost or damaged, and "the excess weight of the stored files has the potential to compromise the structural integrity" of the floor of the building in which the files are stacked.[152] Investigators "observed approximately 37,000 claims folders being stored on tops of file cabinets" and were told by staff that "inadequate claims folder storage impeded their ability to timely associate mail with folders and resulted in lost or misfiled folders."[153]

Baltimore, Maryland, faced a backlog of nearly 9,800 claims, of which almost 70 percent had been waiting more than 125 days.[154]

The backlog dramatically increased with the list of diseases and medical conditions the VA said could potentially be linked to Agent Orange,[155] and it peaked with 611,000 veterans waiting longer than 125 days in March 2013.[156] The number waiting that length of time today is about 400,000.[157]

Compensation and Pension Rating Bundle Totals (Represents the 8 End Product Claim Codes + Agent Orange Claims VA Uses to Define the 125 Day and 98% Accuracy Targets) As of March 17, 2014		# Pending	# Pending Over 125	Percentage Pending > 125 days
		638,295	360,629	56.5%
Original Entitlement	**Total**	**207,105**	**117,081**	**56.5%**
Initial entitlement for service-connected disability (=>8)	EP 010	45,588	25,171	55.2%
Initial entitlement for service-connected disability (<=7)	EP 110	148,250	89,409	60.3%
Initial entitlement - Veteran's Pension	EP 180	5,645	974	17.3%
Initial claims from surviving spouses, children or parents	EP 140	7,622	1,527	20.0%
Supplemental Entitlement	**Total**	**431,190**	**243,548**	**56.5%**
Increased entitlement and/or reconsideration for Pension	EP 120	8,303	1,195	14.4%
Increased evaluation and/or additional claimed conditions	EP 020	386,781	228,515	59.1%
Future examination for disabilities	EP 310	29,898	12,373	41.4%
Increased entitlement due to hospitalization or surgery	EP 320	2,064	609	29.5%
Reopened or new Agent Orange claims prior to 8/30/10	EP 681	4,111	841	20.5%
Nehmer review cases based upon new Agent Orange presumptives	EP 687	0	0	0.0%
Reopened or new Agent Orange claims After 9/01/10	EP 405	23	10	43.5%
Agent Orange claims where an interim decision was provided	EP 409	10	5	50.0%

Nearly three out of five veterans' disability claims are backlogged, meaning no action has been taken to address the filed claims in more than 125 days.[147]

Not A New Problem: Long Waiting Lists at the VA Are Historic

SINCE THE VA WAS established, veterans have had to wait to receive medical care. However, the severity of the wait time problem at the Department has ebbed and flowed. Often, publicity on management problems and wait time abuses has led to reform efforts by Congress.

In 1932, a delegation of lawmakers from Maryland appeared before the VA to advocate for a new hospital. According to reports from that time, the new hospital was needed because "at Fort McHenry, there were over 400 men's names on the waiting list for hospitalization, 180 of whom are classed as emergency care."[159]

In 1946, six months into the job as the head of the VA, General Omar Bradley declared how great a challenge he had in front of him and the Department. "It become apparent almost immediately after I took office that the increased demand for services could only be satisfied if certain operational procedures were changed," said the General.[160] "When the potential load of veterans' hospitals had been no more than 4,000,000, it was impossible to secure the number of doctors needed to operate efficiently."[161]

With the potential of 20 million veterans enrolling at the VA, "the program had to be changed so that full use of civilian doctors" could be leveraged.[162] With only 2,136 doctors, the waiting lists had to be triaged. According to Bradley, the VA focused on treating service connected injuries first, as "[o]ur hospitals are not yet able to care for all veterans who need medical attention at the moment they request hospitalization. We are, however, taking care of most service-connected cases without delay." [163]

In 1953, after four days seeking care from the VA, George Newton was found dead in his room.[164] He had been telephoning a VA office in West Virginia to request hospital treatment. A letter was found in Newton's belongings from the VA. It stated,

"all of the beds are presently occupied," and "[w]e were unable to learn just how soon a bed would be available for you, but we were told that you are about eighth on the waiting list." [165]

In 1955, Harvey V. Higley, the Administrator of Veterans Affairs, raised concerns about the "16,000 veterans [that] are on a waiting list for beds in mental hospitals."[166] At the time, Higley described these waiting lists as "one of the great problems facing his agency."[167] Higley soon confirmed that the VA needed more doctors, not more real estate. "The peculiar part of it is, building new hospitals isn't going to solve our problem."[168]

In 1963, there were 19,400 veterans waiting for treatment, and more than half of veterans on the waiting list (11,400) required mental health treatment. The VA gives "first priority to veterans whose illness or disability was brought on by military service."[169]

In 1971, the wait lists included around 6,300 veterans, "even though [the Department [was] rejecting 4 of every 10 applicants."[170] At the time, Administrator Donald Johnson noted that it was the largest waiting list the VA health care system had experienced in some time, but "only a fourth as long as in the peak year" of 1958 – a time when at least 25,000 veterans were on the waiting list.[171]

In 2003, there were an estimated 110,000 veterans "waiting for initial appointments at the VA." In 2002, an American Legion study found that the average wait for an appointment was seven months. One of the survey responses came from Robert Thomas, who served in Vietnam and Korea – "The thanks I received is to...be told that it will be another year before I can see my first VA doctor."[172]

VA CULTURE IS PLAGUED BY MISMANAGEMENT, NEGLIGENCE, AND A LACK OF ACCOUNTABILITY

Within every organization, there is a culture that determines whether it will succeed or fail. The culture of the Department of Veterans Affairs has developed into one that favors bureaucracy over service and mismanagement over accountability. Rather than putting the needs of veterans first, agency administrators used gimmicks to create the appearance of success in the midst of tragic failure.

While often touted as a model for health care, problems within the Department were masked by bogus statistics and shoddy practices over many years. While the first part of this report detailed how veterans suffered, this section seeks to explain the kinds of practices within the VA that led to such bad treatment.

No Accurate Numbers to Measure Delays in Urgent Health Care

THE VA RECENTLY ACKNOWLEDGED that 120,000 veterans were forced to wait months to receive care.[173] Prior to this, the Department was unable to produce any reliable figures to know just how many veterans were being denied care on a regular basis and for what amount of time.

Va officials have engaged in a series of schemes, from deleting appointment requests to keeping secret lists to cover up how bad the delays truly are. The FBI is currently investigating whether this was done to pad performance bonuses.

A recent review by the GAO concluded, "it is unclear how long veterans are waiting to receive care in VA's medical facilities because the reported data are unreliable."[174] The inaccuracy is the result of incorrect record keeping and intentional revisions to inflate numbers in an effort to make things appear better than they are.[175]

Many VA medical centers have fudged numbers,

backdated delayed appointments, destroyed evidence, and even kept secret lists to cover up the impact of the backlog on veterans' medical requests.

These issues were brought to the VA's attention for years by the VA IG and the GAO. At least 21 IG and GAO reports were issued between 2000 and 2014 highlighting internal scheduling issues.[176] As early as 2000, the GAO reported that the VA lacked data on patient wait times and that many veterans did not have access to timely care.[177] In 2005, the IG reported that schedulers did not receive adequate training and medical centers did not always utilize effective electronic wait list procedures.[178] Fast-forward to 2011, when the IG dubbed electronic waiting lists to be "inherently problematic," as they impaired veterans' access to timely and quality mental health care.[179] These reports were consistent, always public, and continue to reveal years of deficiencies, mismanagement, and cover-ups throughout the VA Health Care System.

The VA canceled over 1.5 million medical orders for veterans "without any guarantee the patients received the treatment or tests they needed."[180] "You don't know whether people received the care or if they received it in a timely manner. There's no audit trail. There's no way to know whether they were appropriately closed," said GAO's health care director Debra Draper.[181] GAO's review found numerous cases of consults being closed without clinical reviews or services being provided.

Some VA staff confessed to GAO "they change medical appointment desired dates so that the dates align with the VA's related wait time performance goals"[182] of 14 days.[183] In 2007, VA offices were "instructed to mass purge" outstanding requests for some medical services backlogged for more than six months that "were no longer needed."[184] However, whistleblowers at one of the major VA hospitals said that some of the services were "definitely" still needed.[185]

Thousands of medical test orders were "purged en masse" to erase a "decade-long backlog," according to documents obtained by the *Washington Examiner*.[186] About 40,000 appointments were 'administratively closed' in Los Angeles, and another 13,000 were cancelled in Dallas in 2012. "That means the patients did not receive the tests or treatment that had been ordered, but rather the orders for the follow-up procedures were simply deleted from the agency's records."[187]

Mrs. Jerletta Halford-Pandos is a 100% disabled veteran from Kellyville, Oklahoma. Mrs. Halford-Pandos, who served her country from 1980-2002, had both of her knees replaced by VA—twice each. On her second knee surgery on her left knee, the VA placed a 5-inch rod in her femur, which extended her leg one inch.[188]

The VA failed to notify Mrs. Pandos that the rod would extend her leg —until six months into her physical therapy. "It would have been nice if they (VA) would have told me," she said.[189]

She now has to have her shoes altered, costing her at least $50 per shoe.

Mrs. Pandos also suffers from knots and bunions on her feet. Pandos had been waiting for 18 months for follow-up knee surgery,[190] and now the VA has declined another knee surgery.[191] But, despite her constant pain, Mrs. Pandos is "not upset with the VA." However, she is "frustrated with how long everything takes. Right now we have a lot of kids coming now from Iraq and Afghanistan that need immediate care. They shouldn't have to 'take a number' and wait months" to see a doctor.[192]

In 2007, military veteran Christopher Ellison visited a Philadelphia VA facility for a routine tooth extraction. Suffering a stroke on his way home, because doctors performed the procedure despite Ellison's dangerously low blood-pressure, he is now permanently paralyzed.[193] Thaddeus Raysor, an Army veteran, reported to a VA hospital yearly for chest x-rays. For three years, VA staff failed to diagnose a growing lesion in his lung – which ultimately killed him.[194] At a South Carolina hospital, one veteran had to wait nine months for a colonoscopy, and by the time he had the surgery, he was diagnosed with Stage 3 cancer.[195] The VA admitted this was "a significant delay," and had the procedure been performed earlier, his cancer may not have been so progressive.[196] In Ohio, Air Force veteran Charles Pennington bled to death following a liver biopsy, because hospital staff did not check in on him after his procedure.[197] These cases, among others, are a testament that negligence and a buildup of backlogs and delays at VA medical centers are increasingly fatal for our nation's war veterans.

VA Management Knew About 'Scheduling Tricks' and Did Nothing

THE LEADERSHIP OF THE VA has known for at least six years that "scheduling tricks" were being used to hide the delays for veterans' health services, according to an internal memo.[198] Two dozen different tactics to cover up the real wait times for care were identified by the Department in 2008 and outlined in an internal VA memo dated April 26, 2010.[199] The VA IG has released reports and audits on the backlog since 2005.[200] The VA's Deputy Under Secretary for

Health Operations and Management wrote, "it has come to my attention that in order to improve scores on assorted access measures, certain facilities have adopted use of inappropriate scheduling practices sometimes referred to as 'gaming strategies.'"[201] These included telling patients to call back when an appointment was not available within 30 days, using a separate secret log book to avoid entering excessive wait times in the Electronic Wait List, canceling appointments and

then rescheduling within a 30 day time frame, overbooking patients, and entering the days available as the desired dates of patients.[202] The memo made clear that "this is not patient centered care" and "these practices will not be tolerated."[203] Yet, the practices continued and were tolerated for years despite continued warnings from whistleblowers, government investigators, and the media.

A scheduling clerk has disclosed to the U.S. Office of Special Counsel – the federal office created to hear whistleblower complaints – that "he was directed to alter appointments to reflect minimal patient wait times in violation of agency policy" in Austin and San Antonio, Texas.[204] The staffer said "he and other clerks achieved that by falsely logging patients' desired appointment dates to sync with appointment openings. That made it appear there was little to no wait time, and ideally less than the department's goal of 14 days."[205] In reality, the clerk said, "wait times for appointments could be as long as three months."[206] Recent VA audits have confirmed these lengthy delays.

The VA IG is investigating a secret list the Phoenix VA

List system in 2012, ten years after the system was deployed by the VA to do away with "'ad hoc' waiting lists."[212]

This was particularly a problem in Phoenix, where instead of admitting they had a problem, they tried to cover it up. Dr. Sam Foote, a whistleblower and doctor who worked at the Phoenix health system, said problems started to surface in 2010, when seven physicians left the VA and were never replaced.[213] With a shortage in staff and a growing backlog, it was then that Director Helman decided to "fudge" waiting list numbers to make it look like VA was meeting goals.[214] The wait list problem eventually spiraled out of control, with veterans dying in the process.[215]

Records released pursuant to a Freedom of Information Act (FOIA) request revealed even more unsettling information amidst allegations of fraud and abuse at the Phoenix VA Health Care System. Documents released to Open the Books, a non-partisan non-profit transparency organization, indicate that a majority of the workers employed by the Phoenix VA system were paid large salaries, though many of the high-paying jobs had nothing to do with health care.[216]

> "More than half of the VA's 50,000 schedulers do not even know how to accurately report the information needed to determine wait times, which includes logging the date a veteran wants to be seen, as well as the actual date of the appointment."

Health Care system maintained to hide the true number of sick veterans who were waiting for medical assistance, that includes at least 18 veterans who died while waiting to see a doctor – a number that the VA confirmed.[207] "The secret list was part of an elaborate scheme designed by Veterans Affairs managers in Phoenix who were trying to hide . . . [the fact that] sick veterans were forced to wait months to see a doctor," CNN reported.[208] The VA IG has confirmed that at least 1,700 patients were on secret lists.[209] The whistleblower doctor said the VA staff "would report to Washington, 'Oh yeah. We're makin' our appointments within -- within 10 days, within the 14-day frame,' when in reality it had been six, nine, in some cases 21 months."[210] If a veteran died while waiting to see a doctor, the VA "could just remove you from that list, and there's no record that you ever came to the VA and presented for care."[211] The Phoenix VA only installed an Electronic Wait

Over a three-year period, the Phoenix VA spent close to $70 million of taxpayer dollars to pay its employees.[217] Fifty-nine percent of the hospital's salaries were spent on administrative and operational positions, including interior designers, gardeners, and architects.[218] The hospital has only designated a single employee toward its "Quality Assurance" unit.[219] This is troublesome, considering the mounting quality care complaints against the medical center and the fact that VA often blames its shortcomings on insufficient medical staff. While they claimed a staff shortage, the doctors, nurses, and other medical staff at Phoenix were paid significantly more than their private sector counterparts.[220] Even as salaries for doctor executives at the VA reached $350,000 in 2013, the average Arizona doctor made just over half that amount.[221]

Many veterans also waited months to see a doctor at the Fort Collins VA clinic in Colorado, where clerks were

"instructed last year how to falsify appointment records so it appeared the small staff of doctors was seeing patients within the agency's goal of 14 days."[222] One whistleblower claimed "schedulers are directed to record the patient's desired appointment date as the actual appointment date, resulting in faulty wait time data."[223] If a clerk allowed a record to show a veteran waited longer than two weeks, the clerk would be "punished by being placed on a 'bad boy list.'"[224]

There was also a "bad boys list" for employees who accurately report patient wait times at the VA medical center in Cheyenne, Wyoming.[225] In a June 19, 2013 e-mail directing the staff on how to hide the true wait times of veterans, the Telehealth Coordinator told employees who had documented wait lists that they "can still fix this and get off the bad boys list, by cancelling the visit (by clinic) and then re-scheduling it with a desired date within the 14 day window."[226] He explained how every appointment should be recorded to appear to always meet the 14 day goal, even if it did not.[227] "Yes, it is gaming the system a bit," he wrote, "but you know the rules of the game you are playing, and when we exceed a 14 day measure, the front office gets very upset, which doesn't help us."[228] A CBS News investigation found "the VA's Office of the Medical Inspector had already investigated and substantiated claims of improper scheduling practices at the Cheyenne VAMC, sending a report to the Office of Special Counsel on December 23, 2013." Yet, no official action was taken to discipline the staffer or remedy the situation for five months, until the news media made an inquiry.[229]

While discipline was considered for a several-months wait, one man has waited nearly a decade to be get the care he needs. A Bronze Star Vietnam veteran in Florida has been waiting for a liver transplant for over ten years.[230] In 2003, Bill Feliciano received a letter from the VA informing him he was placed on a transplant waiting list.[231] As of May 2014, he is still waiting for a new liver, contracting Hepatitis C in the meantime.[232] The Department declined to comment on this case, but did state "the average wait for a liver is about three years."[233]

A former employee of the Los Angeles VA Center and

Marine veteran, Oliver Mitchell, said he "was instructed to help cancel backlogged veteran medical exam requests during a coordinated process that began at the facility in March 2009."[234] Mitchell said, "there was no selective review. There was a list that went back to the '90s and they just went through and canceled each one."[235]

The interim service chief at the Los Angeles VA hospital's radiology department told schedulers "she was under pressure from VA headquarters to reduce the backlog." She said "her job was on the line and that this would be the death of her if we didn't delete and/or cancel any of the pending backlog," according to Mitchell.[236]

An audio recording of an internal VA meeting obtained by the *Daily Caller* revealed that VA employees in Los Angeles were instructed to cancel all pending appointments over one year-old.[237] At the time of this meeting in November 2008, some patients were "waiting six to nine months for an exam," according to Mitchell. He noted, "we would get about 3,000 requests a month for [medical] exams, but in a 30-day period we only had the resources to do about 800."[238]

"Anything over a year old should be canceled," stated a female official during the meeting. "Canceled or scheduled?" responded a male official.

"Canceled. … Your backlog should start at April '07," the female official replied, later adding, "a lot of those patients either had their studies somewhere else, had their surgery … died, don't live in the state. … It's ridiculous."[239]

Deletion of the files began in March 2009. When Mitchell tried to call attention to the scheme, he was transferred to another department and eventually terminated.[240]

Many other VA employees knew about similar schemes to cover up wait times at other veterans health centers, but they did not "speak out or say anything to anybody about it" because "they will be fired and they know that," according to a retired VA doctor.[241]

Nick Tolentino, a retired Mental Health Administrative Officer at the Manchester VA Medical Center in New Hampshire revealed he and others were expected to lie about medical

> **"…he and other clerks achieved that by falsely logging patients' desired appointment dates to sync with appointment openings… In reality, the clerk said, wait times for appointments could be as long as three months.**

services that were not provided.[242] He said, "We were never to answer that services were not provided. Many of the answers were changed to say that specific (required) services WERE being provided when they weren't. Specifically, we were instructed that the 'fallback' answer was that the services were provided by fee-service, although this was never actually the case."[243]

Mr. Tolentino said VA staff would conspire internally and with other VA centers to find loopholes around performance metrics. He noted, "it was a routine matter for facility and VISN administrators to find and use loopholes to 'meet their numbers' whenever they were confronted with a gap between a performance requirement and a facility's limited capabilities that had adverse implications for their paychecks. Tragically, this 'gaming' of the system meant that veterans too often were not receiving necessary health care services."[244]

When new performance measures are issued, staff then analyzed those measures to determine which ones were "not likely to be met by a facility due to either low demand, lack of resources, etc., and the group brainstorms to find loopholes that can be exploited to game the requirement."[245] Staff then reached out to other facilities, both in the region and nationally, to inquire about their "solutions" to similar problems.[246]

VA performance measures are highly uniform, and expecting all facilities to meet this "one-size-fits-all approach" has likely contributed to the systemic abuse seen throughout the Department.[247] Pressures to mask real wait times surfaced when facilities started struggling to meet sometimes unattainable Department-wide performance measures – especially in cases where medical centers were short-staffed. Looking good on paper had become more important than providing quality care to veterans, creating a health care system plagued by distorted priorities.

Mr. Tolentino said that it "was made clear to us in a meeting that the service line priority needed to be 'quantity' rather than 'quality.' By that she meant to 'have contact with as many veterans as we can, even if we aren't able to help them.' The strategy was an attempt to show workload numbers as a way to justify requests for adequate resources. The upshot, though, was that the facility was enrolling growing numbers of veterans with very real mental health needs, but the mental health clinicians were reporting 'we already have more patients than we can handle.' As a result, veterans began to fall through the cracks."[248]

Brian Turner, a scheduling clerk at a VA health clinic in Texas, describes how his supervisors instructed him to "zero out" one day – a term used to describe the technique schedulers used to cook the books and cover up wait times.[249] "Zeroing out" is a trick VA administrators used to "fool the VA's own accountability system," as it masked the reality of how long patients were waiting to see a doctor.[250]

"This is how it worked: A patient asked for an appointment on a specific day. Turner found the next available time slot. But, often, it was many days later than the patient had wanted. Would that later date work? If the patient said yes, Turner canceled the whole process and started over. This time, he typed in that the patient had wanted that later date all along. So now, the official wait time was . . . a perfect zero days."[251]

According to Turner, this practice was a rampant one at his clinic, one that "wasn't a secret at all."[252] Cheating the system seemed to work, and officials in Washington did not seem to notice.

Good numbers means better pay and bonuses for employees, especially for upper management. "The financial incentive to meet these measures too easily creates a perverse administrative incentive to find and exploit loopholes in the measures that will allow the facility to meet its numbers

The headlines say it all: Delayed care is killing America's war veterans.[256][257]
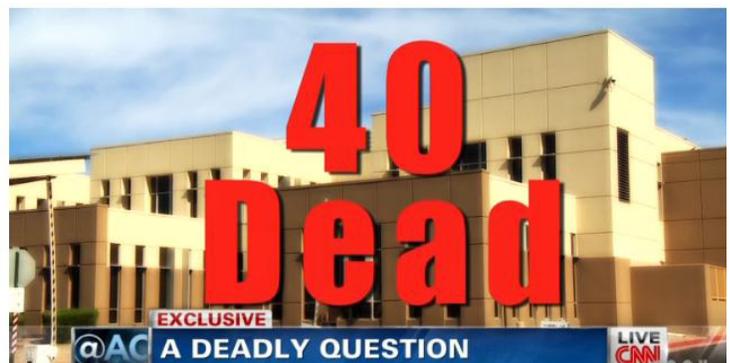
without actually providing the services or meeting the expectation the measure dictates. The upshot of these all too widespread practices is that meeting a performance target, rather than meeting the needs of the veteran, becomes the overriding priority in providing care."[253]

The unreliable data is not merely the result of nefarious schemes and poor record keeping, incompetence and bureaucracy are also factors.

More than half of the VA's 50,000 schedulers do not know how to accurately report the information needed to determine wait times, which includes logging the date a veteran wants to be seen, as well as the actual date of the appointment.[254]

During site visits to four medical centers, GAO "found more than half of the schedulers" that were observed "did not record the desired date correctly, which may have resulted in a reported wait time that was shorter than what the veteran actually experienced."[255]

Last year, the VA adopted GAO recommendations to improve reliability of reported wait times for new medical

significant difficulties to the quality of everyday life. Tinnitus—which is a ringing in the ears—and hearing loss were "the first and second most prevalent service-connected disabilities for veterans receiving compensation" in 2012.[262] The "VA was not timely in issuing new hearing aids to veterans or in meeting its 5-day timeliness goal to complete repair services," according to a review by the OIG.[263] The VHA exceeded this goal by an average of 15 days with 30 percent of veterans waiting more than a month for help.[264] At the VA's Denver Acquisition and Logistics Center (DALC), OIG investigators found "about 19,500 sealed packages of hearing aids waiting for repair and for staff to record the date received from veterans and medical facilities into the production system. Without timely recording of the date DALC received a hearing aid, repair staff cannot identify if the veteran's hearing aid was received or report on the status of the repair."[265]

The VHA offers non-institutional purchased home care services for eligible veterans. Under purchased home care benefits, VHA contracts with outside agencies to provide

> ## "I look back at how they treated me over the years, but what can I do? I'm too old to punch them in the face."

appointments. Using the new tracking method, 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 in 2013.[258] By contrast, in 2012, the VA reported that 90 percent of new primary care appointments and 95 percent of new specialty care appointments had previously met the 14-day standard.[259]

The wait times for audiology services and hearing aid repairs are skewed due to negligence and poor processing. The VA OIG has found "administrative staff entering incorrect desired appointment dates" and "found inconsistencies in how audiology staff determined the desired date when scheduling appointments to issue hearing aids to veterans."[260] The VA has a five-day timeliness goal to complete hearing aid repair services, which is typically exceeded by 15 days, and 30 percent of veterans are forced to wait more than a month.[261]

Many veterans suffer from hearing loss, which can pose

patients with home health aides or other care services in their homes.[266] The IG investigated VHA's management of these home care services, and found that waiting lists for home care services omitted "at least 49,000 Veterans who had purchased home care" and "114 VA medical facilities limited access to purchased home care services through the use of more restrictive eligibility criteria than required."[267] In addition, "VA facilities did not use required waiting lists to track eligible veterans."[268] The OIG concluded the problem was a result, in part, of a lack of oversight in program management and "affected the care received by Veterans and sometimes resulted in the denial of care."[269]

In 2011, Edward Laird, a 76-year-old Navy veteran, noticed two small blemishes on his nose.[270] His doctor at the VA hospital in Phoenix ordered a biopsy, but as months passed, he was unable to get an appointment.[271] After filing a formal complaint as his blemishes continued to grow, Laird saw a specialist nearly two years later.[272] This specialist ruled no biopsy was

necessary.[273] He again appealed – this time, successfully.[274] Unfortunately, it was too late. The blemishes were cancerous, and Laird had to have half of his nose removed.[275]

Laird described his experience with the VA health care system: "I look back at how they treated me over the years, but what can I do? I'm too old to punch them in the face."[276]

The delays felt by veterans seeking care are not confined to waiting for appointments. The VA also can be sluggish in relaying diagnoses to patients. Veteran Larry Wilkinson of Colorado said his doctor never called him with test results after he sought treatment at a VA medical center for a foot infection.[277] Mr. Wilkinson had to have his leg amputated when he still had not heard from his doctor after two months.[278] In describing his experience, he aptly stated, "I feel the VA owes me a leg."[279]

The waiting and delays even occur in the VA facilities. In October 2013, a 78-year-old Navy veteran – who had spent

and that long wait times at the emergency room are not uncommon.[283] The report highlighted problems contributing to an "emergency department struggling with patient flow," including no documentation of required hourly nursing reassessments, failure to meet target wait times, and confusion amongst hospital staff.[284]

While the IG investigation initiated a call to action to the Las Vegas Medical Center to improve its services, not everyone is satisfied with its conclusion. The OIG did not substantiate allegations that hospital staff members in charge of attending to Ms. Niccum were rude and dismissive toward her while she was waiting.[285] A friend who accompanied Ms. Niccum on her hospital visit contends she is "very disappointed" in the OIG's findings, saying they do not adequately represent the disrespectful and inexcusable nature of her friend's emergency room experience.[286]

Sandi Niccum poses in an undated photo during her time serving in the United States Navy.

October 22, 2013: Navy Veteran and VA lifetime-volunteer Sandy Niccum waits for over five hours at VA hospital emergency room in Las Vegas. The 78-year-old woman died three weeks later.

over 5,000 hours of the later years of her life volunteering to help veterans at VA facilities – waited more than five hours in the emergency room at the VA medical center in Las Vegas.[280] Sandi Niccum was experiencing severe abdominal pain and became confused as to why it took so long to be treated.[281] She died three weeks later due to colon complications.[282] The IG conducted an investigation of Niccum's experience in the Las Vegas emergency room and the medical center's emergency room procedures. The investigation concluded, "a wait time of this length was, at a minimum, challenging for this patient"

Lack of Transparency on VA Health Care Quality and Outcomes

VA CARE HAS OFTEN been hailed as a standard among different health care systems. Previous studies have looked at various aspects of medical care in VA and non-VA settings and have formed the basis of these claims. Yet, most studies look at care in the VA before 2000 and are arguably outdated.[287] The VA's own internal quality and outcomes data reveals a different story. "Although it has garnered less attention than the wait-time problems, a disturbing pattern of increasingly uneven quality of care has also evolved in recent years," wrote two former VA employees, including one who previously oversaw the VHA, in the *New England Journal of Medicine*.[288]

The VA itself has known for years that many of its own facilities do not measure up to national standards, especially since implementing a performance program in 2011. Some facilities are far more dangerous than others. Five VA hospitals were immediately recognized as the worst-performing in the VA system, even after adjusting for the severity of certain conditions and risk.[289] These five are still on the list, and several more have been added. The list now encompasses Augusta, Georgia; Little Rock, Arkansas; Providence, Rhode Island; Murfreesboro, Tennessee; Oklahoma City, Oklahoma; Phoenix, Arizona; and Puget Sound, Washington.[290]

More transparency in VA outcomes has the potential to save lives. The Phoenix, Arizona medical center has an IV line bloodstream infection rate of 3.80 per 1,000 cases – a rate that is 11 times greater than those found at the federal health care system's highest-quality hospitals. This is one reason the facility is listed as a one-star facility within the VA internal system.[291] One public database (ASPIRE) lists this same statistic as "N/A."[292] This indicator is as telling as the old-fashioned "canary in the coal mine," one medical quality pioneer told the *Arizona Republic*.[293] Because "Central-line infection-rates are a key indicator of a hospital's overall quality," the VA should make this data available to potential patients, allowing them to make an informed decision as to where they will seek medical care.[294]

The Atlanta, Georgia medical center has an acute-care mortality rate that is 47% higher than that of the highest performing hospitals, a statistic not reported in any of the VA's public databases.[295] Even more astounding is the acute care mortality rate of the VAMC in Puget Sound, Washington.[296] An internal VA document leaked online lists the facility as having a mortality rate over 100% worse than that of a 5-star center like the one in Boston.[297]

In Augusta, Georgia, the Charlie Norwood VA Medical Center has a blood infection rate from use of IV catheters that is twice that of the best VA facilities.[298] Yet, on the Hospital Compare website to which VA is supposed to post data for the public, this indicator of risk is listed as "not available."[299]

The VA had decided to not make much of this information public, even after some managers in charge of the department's data have pushed for more transparency.[300] One former VA executive said, "[VA] patients have little recourse, and they rely on [VA] staff to tell them the truth. We can't forget that medical quality is not just access to care."[301] The Department has used an internal database (called the Strategic Analytics for Improvement and Learning database) to keep tabs on how hospitals are performing and comparing to other facilities.[302] Even though a facility may have been low-performing or much riskier than others, for years veterans had no chance to review the information. Some VA medical centers are ranked internally as providing safe and effective care. The Boston facility, for example, received a five-star rating.[303] Unfortunately, quality care is not as bountiful across the system, and the VA has known it for years. Until after the VA scandal broke, the Department had been withholding this list and other key data that would enable veterans to make their own judgment about the best place for their care.[304] The Department began posting most of the data from the internal outcomes database in June 2014, though it has not published the star rating associated with each medical center.

To try to address adverse events and quality issues, the VA operated a program that would send task forces to visit problematic hospitals. Senior management suspended the program from 2011 to 2013 for unclear reasons.[305] Staff familiar with the situation said the Department's decision-makers were not concerned with quality outcomes.[306] A key position to monitor the level of care in each medical center was left empty during these two years.[307] Fortunately, this program has been restarted.

Some outcomes and quality data are posted across a number of different webpages. Tools available include VA's ASPIRE database, LinKS, and data published on the Hospital Compare website of the Centers for Medicare and Medicaid Services. These services do not have the same amount of detail – or even same numbers – available in VA's internal databases.[308] These sources are also not always available or useful. For example, ASPIRE is one database buried on the VA's website that provides certain metrics for each Veterans Integrated Service Network (VISN). Over half the metrics – mostly those related to timeliness of care and patient satisfaction – are listed

as "not yet available" with no indications of when such data will be published.[309] The LinKS database shows how hospitals are doing in a number of process measures, but the criterion used to determine the score essentially always allows facilities to receive a passing score.[310] VA's own Hospital Compare website provides access to a limited number of measures related to congestive heart failure, pneumonia, and heart attacks. Unfortunately, there is no tool providing a direct comparison of medical centers.

Even with more data transparency by the VA, there is concern about current practices in whether reported data is even accurate. At a VA medical center in New York City, hospital administrators pressured surgeons to admit patients to keep overall patient numbers high. "The practice became so abusive," wrote one former physician at the facility, "that one day a man arrived on the hospital inpatient floor carrying admission papers specifying a diagnosis of appendicitis. When my fellow residents and I asked him what was wrong, the patient said he didn't know; he had come for a routine clinic appointment without complaints, and a woman (the attending surgeon) handed him the paperwork and directed him to go upstairs. He denied having abdominal pain and reported having had an appendectomy 15 years earlier."[311]

The IG has found many instances of falsified outcomes data going back a decade. At the Bay Pines VAMC, nurses intentionally reported false information on dialysis procedures to "cover up mistakes" they made while administering care to patients.[312] Another Florida nurse working in a critical care unit lied about having given insulin to her patients. Concerns about her "pattern of quality of care issues" were reported to her manager, who did not take any action.[313]

Many of the VA's medical centers are not even reporting a significant number of outcome measures to internal department systems. The Tucson Medical Center has not reported almost half of the required outcomes measures in the 12 months prior to the first quarter of 2014.[314] Two medical centers in South Carolina (Columbia and Dublin) had not reported 20 percent of their outcomes.[315] The same problem occurred with the Level 3 medical center in Togus, Vermont.[316] A Martinsburg, West Virginia facility failed to report 35 percent of outcomes records.[317]

"After the VA gained a hard-won reputation for providing superior-quality care 15 years ago, how did cracks appear in its delivery of safe, effective, patient-centered care?," asked a former VA Under Secretary and a current VA staff physician in the recent *New England Journal of Medicine*. He explains, "We believe there are three main causes: an unfocused performance-measurement program, increasingly centralized control of care delivery and associated increased bureaucracy, and increasing organizational insularity.

The performance-measurement program — a management tool for improving quality and increasing accountability that was introduced in the reforms of the late 1990s — has become bloated and unfocused. Originally, approximately two dozen quality measures were used, all of which had substantial clinical credibility. Now, there are hundreds of measures with varying degrees of clinical salience. The use of hundreds of measures for judging performance not only encourages gaming but also precludes focusing on, or even knowing, what's truly important.

In addition, the tenor of management has changed substantially over the past decade. During the reforms of the 1990s, decentralization of operational decision-making was a core principle. Day-to-day responsibility for running the health care system was largely delegated to the local facility and regional-network managers within the context of clear performance goals, while central-office staff focused on setting strategic direction and holding the "field" accountable for improving performance. In recent years, there has been a shift to a more top-down style of management, whereby the central office has oversight of nearly every aspect of care delivery. At the same time, the VHA's central-office staff has grown markedly — from about 800 in the late 1990s to nearly 11,000 in 2012.

Finally, the VA health care system has become increasingly insular and inward-looking. It now has little engagement with private-sector health care, and too often it has declined to make its performance data public. For example, it contributes only a small proportion of its data to the national public reporting program for hospitals, Hospital Compare. It has also declined to participate in other public performance reporting forums such as the Leapfrog Group's efforts to assess patient safety."[318]

The VA should be make all of its outcomes and ranking data available online to provide veterans with as much data as possible. Doing so would also highlight the high quality of care offered at many medical centers, such as those in Ann Arbor, Boston, Cleveland, Minneapolis, Wichita, West Haven, and Newington (CT), which are all identified as five-star facilities by the VA.[319]

Bureaucrats should not be hiding knowledge of how one facility compares to another, especially when it comes to safety and outcomes.

> "At a VA medical center in New York City, hospital administrators pressured surgeons to admit patients to keep overall patient numbers high."

VA Physicians Have Lighter Loads than Private-Sector Counterparts, Productivity Unmeasured

Contributing to the lack of patient access at some VA facilities is that VA physicians take far fewer patients than a typical doctor in the private sector. An average private-sector primary care physician has an average caseload of 2,300, according to a study in the *Annals of Family Medicine*.[320] Yet, the VA targets panel sizes of 1,200 for its physicians – almost half the workload of private-sector providers.[321] Doctors should certainly be able to take the time they need to care for their patients. However, the disparity between the VA and the private sector is dramatic.

First-hand reports from those who have worked at VA hospitals also suggest Department physicians can take on extra work. In New York City, "anesthesiologists routinely cancelled surgeries for personal reasons," said one former VA physician.[322] The practice extended to other types of health care providers as well: "Operating room nurses refused to allow operations to start after 1 PM for fear of having to stay past 4 PM, when their shifts ended."[323]

Facility administrators have also been complicit in the practice, even ensuring surgeons did not take some appointments in the afternoon. "Hospital administrators limited operating time, making sure that work stopped by 3 p.m. Consequently, the physician in charge kept a list of patients who needed surgery and rationed the available slots to those with the most urgent problems," wrote one physician of the VA's practices.[324] The result was surgical facilities being rendered nonoperational and patients going without needed care.

On the other hand, some doctors have taken patients who may not have needed care just to boost hospital numbers. "Administrators regularly instructed attending surgeons working in the clinics to admit patients to the hospital, just to keep census numbers up," one whistleblower reported.[325] He continued: "The practice became so abusive that one day a man arrived on the hospital inpatient floor carrying admission papers specifying a diagnosis of appendicitis. When my fellow residents and I asked him what was wrong, the patient said he didn't know; he had come for a routine clinic appointment without complaints, and a woman (the attending surgeon) handed him the paperwork and directed him to go upstairs. He denied having abdominal pain and reported having had an appendectomy 15 years earlier."[326]

VA Leadership Has Long Resisted Developing Clear Measure of Physician Productivity

The VA has no way to justify whether specific physicians or facilities are delivering more complex care than others, which may result in being able to see fewer patients per day or support a need for hiring more doctors. The Department has long delayed developing a standard methodology to measure physician productivity, a practice standard in private-sector programs and Medicare. Government auditors first made the recommendation to establish this type of standard in 1981. Since then, the auditors (GAO and the IG) have issued another six reports with essentially the same recommendation.[327] Yet, by late 2013, the VA had still not developed an adequate and comprehensive means of measuring physician productivity and determining staffing needs.[328]

Lacking any standard for measuring their staff, individual medical centers and clinics have no way of justifying their needs for workforce and structure. Without establishing a formal standard, the VA on its own cannot identify under-performing doctors. A VA IG analysis found that 12 percent of the VA's specialty physicians have limited productivity, for example.[329]

When the IG looked at the specific staffing plans of five facilities, it found "medical facility officials could not always provide documentation or an adequate workload analysis to justify the need for additional staff."[330] One facility wanted a part-time surgeon, but had no way to justify "total workload, anticipated workload increases or decrease, or an analytical review of the other surgeons' ability to handle more workload."[331]

Patient care may ultimately be harmed by the lack of VA's progress, since clinics and hospitals may not have the appropriate number of doctors. "[The Veterans Health Administration's] lack of established productivity standards for specialty care services limited the ability of medical facility officials to determine the appropriate number of specialty physicians needed to meet patient care needs and to measure productivity of specialty care services," found the VA IG, which has followed the issue for decades.[332] Wait times at many facilities could be alleviated with careful planning and hiring, but adequate management cannot happen without measurement.

"The upshot of these all too widespread practices is that meeting a performance target, rather than meeting the needs of the veteran, becomes the overriding priority in providing care."

Excessive Salaries and Bonus Incentives Skewed Employee Priorities

Reports of prolonged wait times for appointments, denied care, malpractice, and patient deaths at the VA chronicle a sometimes broken and mismanaged health care system. Sadly, it is veterans themselves who are suffering from the often fatal consequences of the Department's poorly-run medical care programs. Often times, instead of acknowledging these problems and increasing efforts to restore adequate health care management, the VA rewards the medical providers, administrators, and bureaucrats responsible for failing conditions and preventable deaths – people who are among the highest-paid employees in the federal government – with bonuses and promotions.[333] Furthermore, many VA employees have had the option of ending their employment – rather than being fired – in order to escape accountability.[334]

Audits of the VA's procedures for awarding bonuses and "retention incentives" reveal patterns of mismanagement and faulty directives. The IG recently conducted an audit of VHA and VA Central Office (VACO) processes for awarding retention bonuses.[335] Retention incentives are prescribed by statute and defined as "compensation flexibilities available to help Federal agencies recruit and retain a world-class workforce."[336] In its review, the IG found VA lacked general oversight and training to effectively administer retention bonuses, concluding that 80 percent of $111 million spent on bonuses in 2010 were inappropriately awarded and poorly justified.[337]

A former VA official revealed the perverse financial incentive for VA employees to earn bonuses by cleverly hiding the number of wait listed veterans:

"First and foremost, the achievement of performance measures is linked to pay and bonuses for Executive Career Field (ECF) employees, most commonly, upper management (myself included). The financial incentive to meet these measures too easily creates a perverse administrative incentive to find and exploit loopholes in the measures that will allow the facility to meet its numbers without actually providing the services or meeting the expectation the measure dictates. The upshot of these all too widespread practices is that meeting a performance target, rather than meeting the needs of the veteran, becomes the overriding priority in providing care."[338]

In 2011, the VA paid over $160 million in bonuses and awards to its employees.[339] The GAO found the Department's performance pay policy has gaps in information needed to appropriately administer it, and there is insufficient oversight to guarantee that VA medical facilities comply with performance pay and award requirements.[340] GAO emphasized that despite very real concerns regarding the quality of care VA facilities deliver, medical staff and providers continue to receive monetary bonuses.[341] Some of the most egregious examples are described in detail below.

1. Director of Phoenix Health Care System Receives System's Largest Bonus Despite Questionable Past and Secret Waiting Lists

The VA Phoenix Health Care System is currently the face of a national scandal upon confirmation that at least 18 veterans died due to delays and scheduling misrepresentations at the area's medical facilities. However, a look at the office's bonus payments gives the impression that it was among the nation's highest-performing VA facilities. An investigation of the health systems records indicate the Phoenix VA paid out close to $10 million in bonuses over the past three years.[342] The largest bonus paid out among the 3,170 employees in the system in 2013 went to the facility's director, Sharon Helman, who received an award of $9,345 – in addition to her annual base salary of $169,900.[343] Helman was also due to receive yet another bonus in February of 2014 – this planned $8,495 award was rescinded.[344]

Even before she came to Phoenix, Helman's track record at the VA was sketchy. Questions regarding Helman's leadership were raised as early as 2007, when she was director of the Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla.[345] Employee morale and quality of medical services at the Walla Walla facility were described as "toxic" during Helman's tenure, and issues arose surrounding the firing of managers with "long, commendable work histories" as possible scapegoats when the medical center began to fail.[346] Later, during her time as director of the VA medical facility in Spokane, Washington, a VA investigation found that the reported numbers of veteran suicides were misrepresented.[347] Despite these red flags, Phoenix hired her anyway.

Helman has denied any knowledge of either a "secret list" or misrepresented patient wait times.[348] But amidst the allegations, she, along with the associate director and one other unidentified Phoenix VA executive, has been placed on administrative leave "until further notice," and has not been fired yet.[349]

2. VA Officials Are Top-Paid Federal Employees

Currently, the ten highest-paid government employees all work at the VA.[350] In 2013, more than 1,100 Department physicians were paid $300,000 or more.[351] Between 2007 and 2013, the VA paid out $136 billion in salaries.[352]

Additionally, in late May 2014, the IG confirmed that "serious conditions" at the VA Health Care System in Phoenix "negatively impacted access to health care."[353] In a place where "veterans were and continue to be at risk of being forgotten or lost," the administrators, doctors, and other executives employed at the Phoenix VA were paid significantly more than other federal employees in Arizona.[354]

In Phoenix, 157 VA employees earned more than $190,000 annually in 2013.[355] All of these employees made twice the salary of the current governor of Arizona, Jan Brewer, who earns $95,000. Thirteen of these workers made over $300,000 – the highest paid employee was orthopedic surgeon George Swartz at $357,428.[356]

3. VA Repeatedly Rewards Employees with Cash for Poor Performance; Meanwhile, Veterans are Dying

To make matters worse, the VA continues to not hold individuals accountable for these mistakes and delays in care and treatment. In reality, it is quite the opposite – irresponsible Department officials and employees are receiving bonuses and awards for their "jobs well done."[357]

Examples of questionable bonuses paid out to VA employees include: $8,216 to a radiologist who was unable to read mammogram and other x-ray images correctly; $11,819 to a surgeon under suspension for leaving surgery early; $7,500 to a doctor who deliberately and unnecessarily made emergency room patients wait for more than six hours; $7,663 to a physician who practiced with an expired license for three months.[358]

4. VA Facility Administrator Who Oversaw the Death of Three Veterans From Preventable Complications in Augusta, Georgia Continues to be Paid Despite His Resignation

Dr. Luke Stapleton, the former chief of staff at the Charlie Norwood VA Medical Center in Augusta, Georgia, resigned in 2013 after looming threats of punishment relating to the deaths of three patients.[359] The VA recently confirmed that Dr. Stapleton, who oversaw the hospitals gastrointestinal clinic, currently remains on the medical center's payroll despite his resignation.[360] In 2012, his salary was $278,267.[361]

Three veterans, all of whom had cancer, allegedly died from preventable complications from delayed endoscopy consultations that occurred under Dr. Stapleton's watch.[362] While Stapleton is currently under investigation by the House Committee on Veterans Affairs, the VA has not been forthcoming about Stapleton's involvement in the deaths and has yet to hold anyone accountable.[363]

5. VA Administrator Received Presidential Award and Bonus After Six Veterans Died Under His Watch

In 2011, six veterans died and 22 fell ill as a result of an outbreak of Legionnaires' disease—a fatal strain of pneumonia—while at a VA nursing facility in Pittsburgh. VA officials initially blamed an old water system for the deadly outbreak.[364] However, audits prepared by the IG in its investigation of the outbreak found employees at the Pittsburgh hospital "failed to document any infection surveillance activities near two hospital construction projects and transported post-operative patients in a dirty freight elevator."[365] Even more recently, emails and internal memos circulated among high-level employees at the facility indicate that they were aware of human mistakes that may have triggered the outbreak.[366]

Former VA regional director Michael Moreland, who oversaw VA health care facilities at the Pittsburgh hospital during this time, received a White House-approved Presidential Distinguished Rank Award at a gala in Washington prior to his retirement in May 2013.[367] This award was accompanied by a $63,000 bonus, in part to recognize Moreland's infection prevention policies.[368] However, in their investigation of the Legionnaires' outbreak, the VA IG found those policies had failed.[369] Some have even compared his tenure at the VA to a "reign of terror."[370]

6. VA Lauds Incompetent Doctors and Underperforming VA Executives with Millions of Dollars in Bonuses and Promotions

In 2011, the backlog of disability claims increased by nearly 300,000.[372] That same year, the VA granted the two executives in charge of the benefits program – Lois Mittelstaedt and Diana Rubens – its top performance award.[373] Over a period of five years, Mittelstaedt received almost $108,000 in performance awards and Ruben's received just under $100,000.[374]

Another example is Carl Hawkins, the Regional Office Director of the Columbia, South Carolina VA medical facility who received close to $80,000 in bonuses even though

Attendees at the Presidential Distinguished Rank Award Banquet, where the President recognizes members of the Senior Executive Service for "outstanding achievements in public service." It is the nation's highest civil service award.[371]

backlog doubled in the region under his leadership.[375]

VA construction chief Glenn Haggstrom, who was in charge of multiple major Department construction projects, who received a $55,000 performance award – even though most projects were delayed and hit with major cost overruns.[376] Overruns of construction costs have reached more than $1.5 billion to build new VA medical centers, and the VA is getting sued for failing to pay contractors for their work.[377] When Haggstrom was asked what he did to earn the bonus, he was unable to explain why he received such a high award.[378] Instead, he responded to Representative Tim Huelskamp's repeated inquiries by stating, "Congressman, those bonuses were not determined by myself, those bonuses were determined by my supervisors and senior leadership at VA, and with all do respect, I'd ask you to take that up with them."[379] Mr. Haggstrom is still employed by the VA.[380]

In certain instances, the carelessness of VA employees has resulted in the direct mistreatment of veteran patients; yet, employees are still financially rewarded. Over a five-year period, more than 1,800 veterans at the St. Louis, Missouri dental center were exposed to HIV and Hepatitis B and C because of unsanitary conditions.[381] The facility director there received close to $25,000 in bonuses.[382] An IG investigation of the St. Louis dental center found VA dental clinic employees "were not always cleaning dental instruments" and "identified 21 unacceptable infection control-related conditions or practices."[383]

An Ohio dental clinic also used unsanitary practices for almost two decades, potentially exposing hundreds of veteran patients to different forms of Hepatitis.[384] The director, Guy

Richardson, collected a bonus of over $11,000 while under investigation, but he also was promoted – after nine of his patients tested positive for Hepatitis B and C.[385] In yet another case, a VA employee in New York received almost $26,000 in bonuses despite supervising the chronic misuse of insulin pens that possibly exposed hundreds of veterans to blood-borne infections.[386]

Veterans bear the burden of these negligent actions, and taxpayers are forced to fund their transgressions. Given the scores of reports of undeserving bonuses, the VA must reassess the way it confers performance awards to employees.

7. Bonus Incentives May Have Pushed VA Executives to "Game the System"

Allegations of VA hospital officials in Texas manipulating patient wait lists paint a disturbing picture of how far employees went to get a bonus. A former VA doctor, who worked in the Texas VA hospital system for 17 years, came forward with evidence indicating not only that hospital employees cooked the books, but also that official investigations have only "hid[den] the problems they were charged to root out."[387]

Describing his VA office as an "organized crime syndicate," the physician said there was "enormous pressure to report favorable wait times for VA patients" at the Texas facilities, even if the wait times were false.[388] Because

compliance with wait time standards account for about half of bonus eligibility at the VA, employees are given incentives to report good numbers.[389] A whistleblower explains how the fraudulent system works: "If [VA] directors report low numbers, they're the outlier. They won't stay a director very long and they certainly won't get promoted. No one is getting rewarded for honesty. They pretty much have to lie, if they don't they won't go anywhere."[390]

8. Director of Colorado Medical Center Blatantly Disobeyed Scheduling Policies, Received Bonus Anyway

An investigation revealed staff members of a VA clinic in Fort Collins, Colorado, tampered with records showing patients' desired dates for appointments to misrepresent wait times.[391] Staff that did not alter records to show wait times of 14 days or less were placed on the center's "bad boy list."[392]

The director at the Fort Collins medical center, Cynthia McCormack, explained there was a "misunderstanding" with her scheduling employees.[393] VA policies, which are included in documents signed by McCormack, required schedulers to ask the patient seeking an appointment time, "What is the first day you would like to be seen?"[394] Instead, staff at Fort Collins told veterans seeking medical attention, "We have an opening on this date, would that work?"[395] After signing the paperwork outlining scheduling policies, McCormack received an $11,158 bonus – despite the fact that her scheduling staff were blatantly failing to comply with them.[396]

9. VA Director Lied On Resume, Received Bonus Anyway

As director of VA's Sierra Pacific Network, Sheila Cullen is in charge of over 50 VA facilities that serve over one million veterans.[397] In 2009, an IG report revealed that Ms. Cullen "claimed in numerous official documents over the years that she'd received a master's degree from Bernard M. Baruch College-Mount Sinai School of Medicine," including her resume.[398] In fact, Ms. Cullen does not hold such a degree, and when asked why she reported having a master's, she responded that "she didn't know who wrote her resume."[399]

Despite the IG's findings, Ms. Cullen received a $21,000 bonus in 2009 and a $23,100 bonus in 2010.[400] While the IG stated that holding a master's degree was unnecessary for Ms. Cullen's position at the VA, her lack of candor – along with VA's apparent dismissal of the situation – is concerning.[401]

Doctor Shortages at VA Medical Centers

EARLY THIS YEAR, the emergency department at the Colmery O'Neil VA Medical Center in Topeka, Kansas was forced to shut down after months of being understaffed.[402] VA requires emergency departments to be staffed by at least one doctor, 24 hours a day, 7 days a week.[403]

For months, Colmery O'Neil was staffed with a physician for only 124 of 168 hours a week – or, only about five out of seven days. Physician assistants staffed the remainder of the time.[404]

Colmery O'Neil will not be able to regain its emergency department until staffing needs are met, which may be some time from now since recruiting quality doctors to work at Topeka's VA medical facility has proven difficult.[405] In the meantime, Colmery O'Neil has established an "urgent care" center, which is not able to provide full-fledged emergency services.[406] Patients with more serious problems are diverted to other Topeka-area hospitals, where "[r]eimbursement and payment for medical services at a non-VA facility are determined on a case-by-case basis."[407]

The shortages of doctors can create an atmosphere of stress and frustration, which some have said is one of the underlying problems in the distressed VA health care system. Senator Richard Blumenthal explained how insufficient physician staffing leads to other problems at VA medical centers, including falsifying wait time data and pressures to excel in annual performance reviews: "The doctors are good but they are overworked, and they feel inadequate in the face of the inordinate demands made on them . . . [t]he exploding workload is suffocating them."[408]

After spending $600 million to construct a VA medical center in Nevada, the Department is struggling to hire enough

doctors to handle the growing influx of patients seeking care.[409] An IG investigation discovered that the VA hospital in Jackson, Mississippi did not have enough primary care doctors to meet large patient loads.[410] This resulted in nurse practitioners handling complex cases beyond their abilities and increasing delays.[411]

How the VA manages its hiring may contribute to this problem. J. David Cox Sr., President of the American Federation of Government Employees, said "the Department spent too much hiring midlevel administrators and not enough on doctors and nurses, a complaint shared by some lawmakers and veterans groups."[412]

Outside, Unchecked Vendors Permitted to Perform Surgery in VA Operating Rooms

In 2013, the House Veterans' Affairs Committee examined GAO's finding that certain VA medical centers were allowing medical equipment vendors to be present in operating rooms during surgical procedures for wounded service vendors.[413] Following an investigation of the allegations, GAO confirmed that not only were the vendors in the room, but they were helping perform the surgeries. In a number of locations, veterans received skin grafts from vendor representatives instead of trained and licensed VA physicians.[414] Furthermore, the VA medical centers did not even maintain information on any given vendor's qualifications, training, or other certifications.[415] Dubbed as

"shocking" by lawmakers holding the hearing, this finding raised serious questions about the quality of patient care at VA medical centers.[416]

Allowing un-vetted vendor representatives to perform serious surgical procedures at VA medical centers likely occurred due to insufficient levels of clinical staff.[417] Staffing shortages at VA medical facilities is a greater problem that needs to be addressed by Department management, however, and it cannot be used an excuse to place veterans in the care of outside, unchecked vendors.

Failure to Heed FDA Warnings of Potentially Contaminated Body Tissue in Biological Implants

The VA also used potentially shoddy skin grafts, despite signs of problems. Over the past three years, the VA has ordered $241 million in cadaver tissue and other material derived from human and animal bodies to replace burned skin, restore broken bones, and treat other conditions.[418] However, some of these body parts apparently came from vendors who had been warned by federal regulators about contamination in their supply chains, according to recent GAO reports.[419]

While the VA contends that there is no evidence any veteran has been harmed by contaminated body parts received as part of medical treatments, the GAO advised the Department to "significantly improve" its tracking and inventory of biological tissue and implants.[420] Specifically, in two cases "VA officials continued ordering tissue from suppliers after federal regulators admonished the vendors for safety deficiencies in FDA warning letters."[421] VA's inability to track the materials it receives from vendors results in donor

recipients not being informed of risk factors and recalls.[422] In some instances, the Department has been unable to verify certain implants were purchased, let alone which veteran they were given to.[423]

Furthermore, a congressional investigation found that some VA doctors may have violated conflict of interest rules by failing to vet biological implant vendors to ensure that they are properly registered with the FDA and meet industry standards.[424] Some of the doctors who chose vendors sit on the boards of some of the Department's major suppliers.[425]

> "Some of the doctors who chose vendors sit on the boards of some of the agency's major suppliers."

VA Fails to Establish Registry of Vets Exposed to Burning Waste

LARGE OPEN-AIR BURN pits were used by the military in Iraq and Afghanistan to dispose of waste. "Insufficient evidence" exists at this time and has prevented "developing firm conclusions about what long-term health effects might be seen in service members exposed to burn pits." But according to the Institute of Medicine, many veterans have health problems "they believe are related to their exposure to the smoke from the burning of waste in open-air 'burn pits' on military bases."[426] These conditions include cancers, respiratory problems, neurological disorders, and Lou Gehrig's disease (ALS or amyotrophic lateral sclerosis).[427] Some have gone as far as likening the burn pits to Agent Orange.[428]

In 2013, Congress passed a bill directing the VA to create a registry of service members deployed in Iraq or Afghanistan "who may have been exposed to toxic chemicals and fumes caused by open burn pits used for disposing solid waste" and to "ascertain and monitor the health effects of such exposure."[429] The bill was signed into law on January 10, 2013, and the registry was to be established within one year.[430] Nearly a year-and-a-half later, the registry has still not been established. The VA's website simply states, "[t]he registry launch has been delayed."[431]

VA's Action Plan: Burn Pits and Airborne Hazards

Registry for Veterans who may have been exposed

VA's Airborne Hazards and Open Burn Pit Registry will allow eligible Veterans exposed to burn pit smoke and other airborne hazards to document their exposures and report health concerns. Veterans will enter information through a web-based questionnaire and have the opportunity to obtain an evaluation. Eligible Veterans include those who served in:

- Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn
- Djibouti, Africa after September 11, 2001
- Operations Desert Shield or Desert Storm
- Southwest Asia theater of operations after August 2, 1990

The registry launch has been delayed. VA needs extra time to design and test the system to ensure functionality, data security and accessibility. Once a firm launch date is established, we will announce how to sign up for it.

The VA Open Air Burn Pit Registry was required to be established by January 2014. The registry's launch has been delayed indefinitely.[433]

"While the necessity for some delay is understandable, the VA has failed to adequately explain why the delay has occurred, which steps remain to be completed before the registry is available for the use of our veterans, and provide specific information on when the registry is expected to be completed," the authors of the law—Senators Bob Corker and Tom Udall—wrote to the Secretary of the VA.

"This delay is deeply concerning, particularly when similar registries exist within the United States government. The lack of urgency and communication from the VA is even more troubling. Our veterans, Congress, and the public deserve to

know why the Open Air Burn Pit Registry has been delayed and when it will be completed. Furthermore, the VA has failed to develop the Open Air Burn Pit Registry after multiple congressional inquiries and letters calling for its timely creation and has not provided detailed information regarding the nature of the delay to Congressional offices who have requested such information."[432]

VA Does Not Properly Screen Incoming Physicians

Several GAO investigations over a number of decades have revealed potential gaps in how VA facilities run background checks on doctors and continue to monitor their performance.

In the late 1980's, a GAO investigation revealed that many VA hospitals were "lax" in performing background checks on doctors.[434] At the time, "fewer than half of the physicians hired between 1986 and 1988 had their licenses properly verified with state medical boards."[435] Further, many of the doctors hired during the same two-year period had prior convictions of selling and using drugs, burglary, and sex offenses.[436] While the investigation found no reports of inadequately screened doctors making mistakes or causing harm, "potential for problems exist[ed]."[437] Without requiring VA screening processes to contain more stringent standards, VA was unable to ensure its patients that the physicians serving them were "appropriately privileged." [438]

Almost 20 years later, VA's process is only somewhat improved, according to GAO's most recent analysis of the department. In 2006 and 2007, for instance, a number of patients died in the Marion VAMC because it was allowing physicians to practice "without evidence of competence to perform the procedures…One surgeon [had] entered into a voluntary agreement with one state medical board to stop practicing medicine in that state," GAO found, but the VAMC had not addressed the situation.[1042] In looking at a number of other medical centers, GAO concluded, "VAMC staff did not consistently follow VA's credentialing and privileging policies…VA policies lacked specificity in describing the

monitoring activities that are expected to oversee VAMCs' compliance with credentialing and privileging policies."[1043] Some VA officials only took 2-3 minutes to review important files detailing doctors' histories and credentials.[1044] Overall, the VA process lacked a consistent "awareness of physicians' experience with malpractice and experience in all states where physicians have practiced."[1045] Several GAO recommendations to improve the process have not yet been implemented by VA over four years later.

These unscrupulous monitoring policies may be harming veterans' care. A top doctor at the Miami VA health care system was forced to surrender his medical license in New York and faced sanctions in Florida one year before he was hired by the VA.[439]

Dr. Vincent A. DeGennaro was alleged to have "misinterpreted his patient's x-rays and failed to do proper follow up" when treating the patient for a torn large intestine, which resulted in the patient's 2003 death.[440] In 2010, DeGenarro was forced to surrender his New York medical license and faced sanctions in Florida as a result of the 2003 death.[441] "He agreed never to reapply for a physician's license or again practice medicine in the state."[442] In 2011, he was hired by the VA, approved by the Department to practice as a senior executive physician at the Miami medical center.[443]

The Florida Board of Medicine could have also suspended his license in Florida, but they instead censured him, fined him $5,000, charged him legal costs, and ordered him to complete 50 hours of community service.[444] DeGennaro still performs surgeries and sees patients at the Miami VA.[445]

Whistleblowing Employees Fear Retaliation at the VA

STORIES OF MISMANAGEMENT and patient abuse at the VA appear to be endless. However, many VA workers say they faced retaliation from high-level bureaucratic officials when they came forward with reports of internal mismanagement and fraud.[446] The Office of Special Counsel received at least 37 complaints of retaliation from VA

employees.[447] In one case, a VA employee boasting two decades of a "spotless record" was suspended after reporting that some patients had been "inappropriately restrained."[448] In another case, an employee says he was demoted for after reporting that other employees were mishandling patient care funds.[449]

OSC described the Department as promoting a "culture that

discourages whistle-blowing."[450] This must change. According to OSC, it is vital that employees feel comfortable relaying candid information about harmful practices to their superiors to identify and fix VA's far-reaching mismanagement problems.[451]

The *New York Times* interviewed at least six former VA employees from different VA hospitals and all reported facing retaliation from senior administrators when they came forward with systemic internal problems.[452] These interviews depict "a culture of silence and intimidation within the department and echo experiences detailed by other VA personnel in court filings, government investigations and congressional testimony, much of it largely unnoticed until now," according to the *Times*.[453]

Kathy Leatherwood, a nurse and unit manager at the Alaska VA Health Care System, describes the retaliation she faced when coming forward with allegations. Ms. Leatherwood said administrators at her medical center instructed her to schedule "phantom" appointments.[454] This practice consisted of scheduling fake appointments for new patients within a 30-day time period and then not telling them.[455] She was then told to mark the appointment as a "no show," and schedule a real appointment for a later date.[456] "That way, the official record would show the veteran was offered a quick appointment within the required turnaround period."[457]

When Leatherwood objected to this, an administrator told her if she did not do it, he "would find someone who would" and threatened to call security if she did not leave his office.[458]

For years, a culture of fear has developed for whistleblowers at the VA. Nurses and doctors want to do everything in their power to help veterans, but the fear of reprisal often deters them from coming forward.

After a former urologist at the Alaska VA Healthcare System in Anchorage raised concerns about being pressured by managers to schedule "phantom appointments" for patients, she was informed that she would be placed on administrative leave and was immediately escorted out the building by security guards.[459]

"It's scary to think that people can try to stand up and do the right thing, and this is the reaction," she said.[460]

At the time, she wrote to senior officials, explaining the only reason to schedule "phantom appointments" was to make "our numbers look good to DC (and the administrators get their bonuses for these numbers)."[461]

> " For years, a culture of fear has developed for whistleblowers at the VA. Nurses and doctors want to do everything in their power to help veterans, but the fear of reprisal often deters them from coming forward. "

VA Unwilling to Hold Misbehaving Employees Accountable

Contributing to the culture of mismanagement within the VA is the Department's failure to properly hold its workforce accountable. Even for serious offenses, ranging from failure to show up at work to inappropriate sexual contact with patients, VA employees are rarely fired. Instead, they are placed on paid administrative leave for extended periods of time. This result is far from discouraging the kinds of problems that hurt veterans. The VA instead effectively rewards bad behavior with what amounts to a paid vacation.

"Part of the problem in Washington is the unwillingness to hold individuals accountable for performance," commented Robert Gates, the former Secretary of Defense. He noted one of the reasons why the poor conditions at Walter Reed—where wounded veterans were living in squalor— "changed almost immediately" was because he "fired the commander at that hospital."[462]

The culture within the VA has for too long been one where employees who put veterans first are punished, and those who show disdain for the Department's mission are tolerated and rewarded.

Many employees accused or caught engaging in unacceptable and sometimes illegal behavior are placed on "administrative leave" by the Department. "Employees placed on administrative leave due to actions related to misconduct or wrongdoing continue to receive regular Federal benefits," according to the VA.[463]

The "VA is unable to determine how many employees were placed on administrative leave due to actions related to misconduct or wrongdoing" or the amount of time these employees received paid leave.[464]

The VA has the authority to suspend without pay or benefits an employee who is accused of misconduct or wrongdoing while charges are examined. As of December 2013, VA had 137 employees who were suspended without pay for misconduct or wrongdoing.[465]

Not all employees placed on administrative leave or suspensions are found to be guilty of inappropriate behavior. In fact, there are several public cases that suggest these practices have been used to punish whistleblowers trying to do the right thing. However, in egregious cases where the facts are clear, suspension, termination, and even legal action seem more appropriate than continuing to pay an employee for skipping work, sexually abusing patients, cooking the books to cover up veteran care delays or deaths, or removing confidential personal information without authorization. In these cases, paid administrative leave is the equivalent of disciplining a misbehaving child by suspending his chores while continuing to pay him an allowance.

Regrettably, there are numerous examples of the VA tolerating or even rewarding misconduct by paying delinquent employees rather than disciplining them.

1. Administrative Leave Used to Punish Whistleblowers and Cover Up Delays in Vets Care

Among those punished by being suspended without pay was Lisa Lee, a former Navy reservist who is now on active duty.[466] Her crime? She was one of the whistleblowers who sparked the Office of Special Counsel's investigation into "cooking the books" scheduling abuses at the Fort Collins VA clinic. "We were sat down by our supervisor ... and he showed us exactly how to schedule so it looked like it was within that 14-day period," Lee told CNN.[467] The VA's response was to suspend Lee without pay for two weeks for refusing to 'cook the books' when scheduling veterans' medical appointments.[468]

Lee and another employee who refused to hide the wait times were also relocated to a VA center in Wyoming with pay cuts. She said her supervisors claimed her "performance had delayed patient care."[469] The administrators "had to punish us, they had to make us an example to the other (schedulers)," Lee claims.[470] "When she started talking with federal oversight agencies, Lee said administrators at the VA offered her a deal that removed the suspension from her record and paid her for those two weeks. The deal was contingent on ending any whistleblowing behavior at the clinic." But, she said, "[i]t was a matter of principle to continue the fight."[471]

By contrast, at least nine VA employees accused of cooking the books to cover up the true extent of the backlog for veterans seeking medical care are on paid leave:

- *Three employees, including the Director, at the Phoenix VA Health Care System were placed on administrative leave on May 1 "until further notice,"[472] after revelations the center had a secret waiting list and that veterans may have died while waiting for treatment.*

- *The Cheyenne Medical Center telehealth coordinator was put on administrative leave after an email he sent June 2013 to other VA employees detailing how to "game" the*

numbers to hide the long delays and make it appear as if veterans were not waiting to see doctors was reported by *USA Today*.[473] For those schedulers who accurately reported wait times, his email warned, "You can still fix this and get off the bad boys list."[474] The Secretary responded by stating, "VA takes any allegations about patient care or employee misconduct very seriously. If true, the behavior outlined in the e-mail is unacceptable."[475] However, it appears that "no disciplinary action was taken despite conclusions by investigators that agency rules were violated and employees instructed at the clinic in how falsify records."[476] The VA said this employee was placed on administrative leave,[477] however, he "answered his office phone when a reporter called him."[478]

▪ Two employees at the Durham VA Medical Center in North Carolina who engaged in "inappropriate scheduling practices" were placed on administrative leave in May 2014.[479]

▪ Three mental health administrators at the Malcom Randall VA Medical Center in Gainesville, Florida were placed on paid administrative leave in May 2014 after the discovery of a handwritten list of more than 200 patients was discovered.[480]

2. Contributing to Patient Delays by Skipping Work

A VA physician assistant (PA) in Maine routinely did not show up for work. The VA "punished" him by making his unapproved paid absences official by placing him on administrative leave.

He "was so unreliable and had so many complaints from staff and veterans" that "an ordinary medical practice would have discharged him long ago," according to a physician who worked at the center and provided medical care to veterans at 13 different VA facilities.[481]

In 2013, the PA was put on "paid administrative leave" because "he had been missing work on a regular basis" and was "absent during working hours and no one knew his whereabouts (it was rumored that he was teaching an unauthorized course at a local college over lunch and saw no problem making vets wait 1½ hours until he returned), and veterans were regularly requesting they be transferred to another provider," according to Dr. Claudia J. Bahorik, a primary care physician for the VA Interim Staffing Program who is a disabled veteran who is receiving VA care.[482] She described: "[t]his physician assistant would not obtain his own DEA license (Drug Enforcement Agency) to prescribe narcotics (he told me he refused to pay for it, insisting the VA should pay for this license), instead, asked the physician in the adjacent office to write narcotic prescriptions on patients he had never met or examined (a violation of DEA prescribing policies). Then it was discovered that the physician assistant had

been documenting that he had been doing extensive physical examinations on many vets who later complained to staff (and myself) that he never touched them (since most of the vets are also of Medicare age, this constitutes Medicare fraud). As far as I could ascertain, when I later covered his panel of vets, the only part of the physical exam for which he reliably performed per the veteran's admissions was the rectal exam.

As I worked with his former patient panel, it became obvious that not only had he not examined patients, he had ignored their complaints, in many cases had misdiagnosed veterans, and in some cases there was a potentially life-threatening delay in diagnosis. He had month after month seen to their narcotic prescriptions, yet never had examined the body part(s) for which they had a pain complaint. I discovered that the problems lists were incomplete or inaccurate, the medications lists were often not updated or accurate, and his notes worthless and unreliable."[483]

As of October 2013, "about eight months later, this physician assistant was still on administrative leave, still getting paid, and the investigating committee could not make a determination as to his disposition. When a system cannot dispose of their own dead wood, how can one expect that system to effectively monitor and police itself?"[484]

A VA employee in Nashville was put on paid administrative leave after being caught charging his jet-setting lifestyle to the VA and only showing up for work when he pleased. He "worked at his own time and pace" so "he could conduct personal business during his VA workday. By his own admission, he took advantage of the lack of supervision."[485] The OIG chronicled how the employee eluded punishment time and time again and instead talked his supervisors into creating a new (and higher-paying) job for him in Washington, DC.[486]

The OIG found he "traveled whenever and wherever he wanted, billing VA for his expenses. He not only traveled to Washington, DC, at will, he took an unnecessary trip to Florida, and in one instance, he withdrew cash from an ATM located in New York City when he was supposedly on travel to Washington, DC."[487] He misused a "Government contractor-issued travel charge card for his own convenience. For example, he used it to entertain female companions, withdraw cash when not on travel, charge over $170 at a Target store for personal items, buy liquor from his hotel room minibar, and for his personal commutes to visit family."[488] In total, the employee's excessive travels cost more than $109,000. Approximately $31,000 of these costs were undocumented, inappropriate, or misused.[489]

He was "absent without being charged leave or absent without leave on more than 25 separate occasions. In 5 of those instances, we found that he requested sick or annual leave from his Washington, DC, supervisor; however, he failed to notify his Nashville supervisors so that he was properly charged leave for that time. In at least 20 instances, [he] was absent without leave during his official tours of duty as a result of his previous night's activities, and admitted that his

misconduct negatively affected his performance."[490]

In addition to the taxpayer costs, his absences from his job had real consequences for veterans as well as his co-workers. He "was expected to process a minimum cumulative average number of 3.5 weighted cases per day," but "he did not review veterans' claims as depicted in his position description, performance plan, or annual appraisal," according to the IG.[491] One of his co-workers said "she became frustrated by" the "situation because she still had to approve his timecards, and he filled a full-time equivalent (FTE) position that they desperately needed to fill with another rating specialist to help relieve a backlog in rating veterans and getting benefits to them. She said that his absence … unfortunately, went 'on and on,' which was not helpful to the veterans."[492]

This employee also "downloaded and installed unapproved software to his VA-issued laptop for the purpose of sexting—defined as the sending of sexually explicit photos, images, text

3. Misusing VA Funds Results in Paid Administrative Leave

Two VA employees were placed on administrative leave for their involvement with a pair of VA conferences in Orlando,[497] which cost more than $6 million. These conferences had "numerous examples of excessive costs, and unnecessary and unsupported expenditures" alongside other questionable behavior identified by the IG.[498]

A VA executive was placed on administrative leave in 2009 after the IG detailed how she engaged in contracting and hiring fraud and also had an "inappropriate personal relationship" with her supervisor.[499] Specifically, the IG "substantiated" that the Deputy Assistant Secretary (DAS) for Information Protection and Risk Management (IPRM), the Office of Information and Technology (OI&T), "misused her position, abused her authority, and engaged in prohibited

> " ... conducting inappropriate pelvic and breast examinations on patients ... "

messages, or emails using a mobile device."[493] He "downloaded the Skype software onto his VA-issued laptop without approval and that he used this software for sexting close personal friends."[494] He admitted to the OIG "he was 'out of control' when he downloaded the unauthorized software and misused his VA-issued laptop to engage in this behavior."[495]

The VA responded by putting the employee on paid administrative leave. "The employee who is alleged to have misused government resources and engaged in other misconduct has been placed on administrative leave as of March 11, pending the determination of appropriate action to be taken in this matter," the Department announced in a statement.[496]

personnel practices when she influenced a VA contractor and later her VA subordinates to employ" a friend, "took advantage of an inappropriate personal relationship" with her supervisor "to move her duty station to Florida even though she spent almost 60 percent of her time at VA Central Office on official travel," and "failed to provide proper contract oversight and did not properly fulfill her duties as a Contracting Officer's Technical Representative (COTR)."[500] In the first nine months after he signed off on the office change, her Washington trips cost taxpayers more than $37,000."[501]

While the IG report was issued August 18, 2009, she was placed on administrative leave in September and fired six months later on February 5, 2010.[502] In April 2011, though, an administrative board "ordered the VA to reinstate" her because she was not given due process and to "pay her attorney's fees and back wages. As a member of the Senior Executive Service with nearly 20 years of work experience in

the public sector, she was paid between $117,787 and $177,000 in 2009 alone." She was "reinstated to her position following the board's decision" on "'non-duty' status, meaning she doesn't report to work," according to a VA spokeswoman.[503] "The board's decision did not make a ruling on the substance of the IG findings."[504] She was then again placed on administrative leave by the VA, "collecting an executive's salary," but not "cleared to return to work."[505]

4. Inappropriate Sexual Contact with Patients

Five female veterans filed sexual misconduct charges against a male neurologist at the Colmery-O'Neil VA Medical Center in Kansas, who was placed on paid administrative leave for two years before pleading no contest to "conducting inappropriate pelvic and breast examinations on patients" and registering as a sex offender.[506] While a Kansas VA official stated sexual abuse allegations are taken seriously by the Department,[507] the doctor continued to collect a salary for nearly two years, although he was not permitted to see patients.[508] He was placed on paid administrative leave in 2011, arrested by Topeka police in May 2012, suspended without pay in July 2012, and finally fired in May 2013.[509] Coincidentally, this doctor's "employment at Colmery-O'Neil overlapped briefly with that of another physician "who was hired within two years of acquittal on Florida charges he sexually abused multiple patients by performing breast and pelvis examinations unrelated to their medical needs. Prosecutors there said 16 patients filed complaints against" him, "but the doctor was welcome at Colmery-O'Neal in 2011 and 2012 before taking a job in Texas."[510]

A VA social worker for the Roseburg VA Medical Center in Oregon was put on paid leave for over a year when it was discovered she had sexual relations with a veteran she counseled who was suffering from post-traumatic stress disorder.[511] She was also sanctioned "for socializing with five clients."[512] Between August 2012 and November 2013, she "remained on the payroll and collected her $65,000 annual salary" but was barred from counseling patients.[513] She was eventually dismissed and "stripped of her license" by the Oregon Board of Licensed Social Workers.[514]

5. Potentially Exposing Patients to Infectious Diseases

The dental chief at John Cochran VA Medical Center was placed on administrative leave in 2010, after more than 1,800 veterans were possibly exposed to infectious diseases due to inadequate sterilization of dental equipment.[515] A former medical supply technician says beginning "in March 2009, she tried to alert VA officials at the St. Louis center and in Washington about the inadequacies, but no one listened."[516]

While no patient was found to be infected as a result, the VA Secretary called the situation "unacceptable, and steps have been and continue to be taken to correct this situation and assure the safety of our veterans."[517] An IG report found improper sterilization practices at the center persisted.[518]

6. Putting Veterans' Personal Information at Risk

As part of a "fascination project,"[519] a VA employee took home without approval a laptop and an external hard disk drive containing the personal data of over 26 million veterans—including names, Social Security numbers and dates of birth—which was then stolen on May 3, 2006.[520] The then-Secretary said the employee "was not authorized to" take the data home, and doing so "was in violation of our rules and regulations and policies."[521] Despite this violation that put the personal information of millions of veterans at risk, the employee continued to be paid while on administrative leave for nearly a month.[522]

It was not until the House Committee on Veteran's Affairs held a hearing on that breach and some members called upon the Secretary to resign[523] that the employee was fired.[524] "At nearly every step, VA information security officials with responsibility for receiving, assessing, investigating or notifying higher-level officials of the data loss reacted with indifference and little sense of urgency or responsibility," the IG concluded.[525] Less than a year later, in January 2007, another VA employee was put on administrative leave for losing a hard drive that may have contained sensitive information on more than half-a-million veterans and 1.3 million doctors.[526]

VA Employees Failing to Show Up For Work

When federal employees fail to show up for work unexcused, the government coins the practice "absence without leave." More commonly referred to as AWOL, the Office of Personnel Management (OPM) defines AWOL as "non-pay status that covers an absence from duty which has not been approved.[527] AWOL can include anything from being late to work to disappearing from the office for months at a time. VA employees were AWOL from their jobs more than any other federal department and agency.

Attendance issues have been cited as one of the most common challenges faced by governmental supervisors.[528] When employees do not show up for work, it dismantles the productivity of the organization, and impacts both employee morale and the general work environment.

In one instance, lack of supervision enabled a VA employee to be absent without leave on more than 25 separate occasions.[529] This employee took advantage of the "unlimited freedom" allowed by his supervisors and "admitted that his misconduct negatively affected his performance."[530]

The VA is no stranger to AWOL problems. Between 2001 and 2007, Department records indicated that the VA (along with the Department of Treasury) boasted the largest amount of total AWOL hours logged among all reporting federal agencies.[531]

Despite awareness of AWOL issues, the number of AWOL employees has increased over the past six years, as seen in the table below.[532] VA tracks leave without pay via an Enhanced Time and Attendance (ETA) system, which is used Department wide.[533]

The total annual number of employees at VA, in each year for which information is requested, is shown in the chart below.

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
VA Total Actual FTE	249,499	271,979	284,824	295,742	301,366	312,841

> " A home health aide for a disabled veteran was convicted of identity theft, exploitation of the elderly or disabled, and transaction card theft. "

Widespread Criminal Activity and Other Staff Misconduct

Whil e the majority of VA employees are dedicated and hardworking, examples of serious misconduct and criminal behavior among the workforce are all too common. Fixing the culture within the VA will require that management do more to root out bad behavior and prevent it from happening in the first place.

1. VA Employee Shares Veterans' Personal Information in Exchange for Crack Cocaine

Our nation's veterans deserve to receive medical services from a system they can trust. In early 2014, however, a former VA employee was sentenced to six years in federal prison for aggravated identity theft.[534] While working at the James A. Haley VA Hospital in Tampa, Florida, David Lewis leveraged his VA position to access veterans' personal information "in exchange for crack cocaine."[535] Lewis knew this personal information would be utilized to file fraudulent tax returns and apply for fraudulent lines of credit.[536] As noted by Monty Stokes, Special Agent in Charge at the VA IG: "Stealing and selling the identity of a war hero is as low as it gets."[537]

VA employees like Lewis pose a serious threat to veterans who trust the Department's medical system with their personal information and medical records. A Florida man was recently sentenced to seven years in federal prison for using VA records to file at least 71 fraudulent tax returns, claiming he purchased the records from a VA employee.[538] Law enforcement found the man had possessed of 54 medical records from the James A. Haley VA Hospital, which contained the names and Social Security numbers of the hospital's patients.[539]

2. VA Employee in Charge of Supervising Veterans Struggling with Substance Abuse Issues Turn Out to be a Cocaine Dealer

In 2011, the IG reported that a VA employee in Massachusetts was arrested for selling cocaine to patients receiving substance abuse therapy whom "he was responsible for supervising."[540] Following complaints that a 28-year-old employee named Patrick McNulty sold cocaine, marijuana and ecstasy to the patients he was treating, he was found to

have sold drugs to a cooperating witness at least three times while on VA property.[541] He was also recorded talking about his drug sales, once stating, "I can get coke like it's nothing. I can get more coke all day."[542] McNulty was sentenced to three months community confinement in a halfway house, followed by three months of home confinement and three years of probation.[543] Prosecutors had recommended a sentence of six months incarceration with three years of supervised release.[544]

3. VA Doctors in Oklahoma Boast Disciplinary Records of Sexual Misconduct, Substance Abuse Issues, and Unlawfully Prescribing Medications

Shortcomings and misconduct of VA staff have contributed significantly to the Department's difficulties and paint a harrowing picture of lax management and careless decision-making at VA facilities nationwide. In Oklahoma, many doctors from the region's VA medical centers have disciplinary records and have been penalized by the state medical licensure board.[545] For example, a doctor at the Norman Veterans Center was previously cited for sexual misconduct. He also was charged with improper prescription writing and has battled painkiller addictions.[546] Another Norman Center doctor has been disciplined for substance abuse issues and lying to state medical boards about rehabilitating and managing her addiction.[547] Other Oklahoma VA doctors were cited for practicing medicine under the influence of drugs and alcohol, as well as unlawful prescription violations.[548]

4. VA Caregiver Steals Personal Information, Re-Directs Veteran's Compensation Benefits to Himself

A home health aide for a disabled veteran was convicted of identity theft, exploitation of the elderly or disabled, and transaction card theft.[549] The caregiver stole almost $18,000 from his patient by accessing his personal and financial information, re-directing the veteran's benefit payments, and using prepaid debit cards in the veteran's name for his personal use.[550] He was sentenced to 15 years in prison.[551]

VA Caregivers are taking advantage of the veterans they are taking care of by stealing their personal and financial information.

5. Widow Alleges VA Police Beat Her Veteran Husband to Death

In 2011, 65-year-old veteran Jonathan Montano had a shunt put in his arm at the Lomas Linda VA medical center in California.[552] Following the shunt procedure, Montano then waited for four hours to receive dialysis treatment at the facility.[553] Montano grew "greatly frustrated" with the long wait and decided to leave the Loma Linda facility. He instead went to seek treatment at a VA medical center in Long Beach.[554]

During the time in which Montano's wife, Norma, went to fetch the car to transport her husband to Long Beach, Montano suffered a stroke and later died.[555] According to Mrs. Montano, her husband was told not to leave the Loma Linda facility, and the nursing staff there called VA police to deter him from leaving.[556] In a lawsuit against the United States alleging police brutality and wrongful death, Norma and her children claim the VA police physically stopped Montano from leaving the hospital by tackling him, kneeing and stomping on his neck, and slamming his head against the floor.[557] According to the complaint: "This kneeing and stomping on his neck by the VA Police Department police officers caused the dissection of his carotid artery, that resulted in immediate (or very soon thereafter) blood clotting, which resulted in [his] suffering a stroke."[558]

6. VA Found Loopholes to Award Government Contracts Reserved for Small Businesses to Big Firm Company

Last fall, the *Washington Post* discovered the VA may have skirted small business contracting rules after an extensive investigation into one of nation's top federal contractors.[559] MicroTech, a Northern Virginia technology and software firm, became one of the most successful "small" contractors in the country through a federal program created to award government contracts to small companies owned by service-disabled veterans.[560]

Pursuant to a government-wide initiative by the Small Business Administration (SBA) to help small and disadvantaged businesses get off their feet by requiring federal agencies to direct a certain percentage of their spending to such businesses, the VA contracted with MicroTech in 2006.[561] MicroTech beat out other firms and won a six-year contract worth up to $394 million – "the largest contract of its kind ever awarded to a service-disabled veteran-owned small business."[562] The VA in turn got credit for directing business to this "small business" – an arrangement that benefited both parties.

In order to qualify as a small business under the program, a company's annual revenue must be less than $25 million. While MicroTech may have initially qualified as a small business, by 2009, the company was bringing in $108 million a year.[563] Furthermore, the company made multiple conflicting statements regarding its annual revenue. In 2010, MicroTech

claimed gross revenue of $185 million in 2009 to win a private sector award.[564] That same year, Microtech reported to the SBA that its average revenue was no more than $14 million.[565]

On top of the misleading statements, the investigation revealed that MicroTech pretended to be a small business when, in reality, 90% of the total contract value went to a big business.[566] Apparently, VA never tracked how much work MicroTech did or how much revenue the firm received.[567] VA offered a "good faith" defense, stating it had reason to rely on MicroTech's reports.[568] However, SBA officials said the VA should have realized MicroTech may not have qualified as "small," given the hundreds of millions of dollars the firm yielded in contract awards.[569]

In December 2013, the SBA debarred MicroTech from future contracting with any federal agency, citing evidence that the company submitted false and misleading statements to the SBA.[570]

This investigation mirrors reports of Department officials instructing employees to fudge and misrepresent wait times at VA medical centers, and it represents yet another episode of the Department shirking its responsibilities to look good on paper.

7. VA Medical Official Participates in Kickback Scheme

A former VA official at the Muskogee, Oklahoma, Medical Center plead guilty to being a public official who received a gratuity.[571] Jeffrey Fisher, when he was the chief of prosthetics in Muskogee, had a medical supply company pay for construction and remodeling work at his personal residence.[572] For almost a year, Mr. Fisher solicited a medical supply company as a public official "to receive and accept something of value personally."[573]

8. One Kansas VA Hospital Doctor Convicted of Sexually Abusing Patients, Another was Hired with History of Sexual Abuse

A former neurologist at the Colmery O'Neil VA Medical Center in Kansas was placed on administrative leave for a year before he was suspended without pay and then convicted of aggravated sexual battery after his female patients complained.[574] An internal investigation found Jose Bejar often "administered full pelvic [and breast] examinations without a chaperone and without any medical necessity."[575] At least five veterans were identified as victims this neurologist in a one-year period.[576] Upon his conviction, Bejar was fired, lost his medical license, and had to register as a sex offender.[577]

At the same hospital, a doctor was hired less than two years after he was acquitted on charges of sexual abuse of patients in Florida.[578] Multiple former patients came forward as victims, alleging Kayode Sotonwa engaged in "inappropriate pelvic contact and unnecessary breast exams."[579] Although he was ultimately acquitted, concerns arose regarding VA hiring processes and the extent of due diligence conducted in Sotonwa's case.[580] He was hired in 2011 and has received numerous promotions and salary increases – he currently is employed by the VA at a hospital in Texas.[581]

VA officials stated that "charges of patient abuse, minus a conviction, wouldn't necessarily disqualify a candidate in the hiring process."[582] They did, however, say "the absence of an unrestricted license to practice medicine" would be an "automatic deal breaker."[583]

9. Engaging in Criminal Conduct Instead of Caring for Veterans

One former VA housekeeping aide murdered someone in the Richmond, Virginia, VA medical center parking lot.[584] A Northport, New York employee assaulted a co-worker in a private office at the VA medical center where they worked.[585] A VA nurse in Phoenix was indicted for elder abuse, fraud, theft, and negligent homicide when an investigation revealed that she provided inadequate care to patients at the assisted living facilities she owned and operated.[586] The state of Arizona ended up condemning the assisted living facilities.[587]

VA employees can also be startlingly callous. A nurse's aide at a VA medical facility near Wilkes-Barre, Pennsylvania was arrested for stealing a 14-carat gold chain with a crucifix off of the neck of a dying veteran who was in hospice care.[588] He attempted to sell the valuable necklace at a jewelry store; the veteran died the next day.[589]

10. VA is Wrongly Denying Emergency Care to Veterans

The Millennium Act gives the VA authority to pay for non-VA emergency care of veterans for conditions unrelated to the veterans' service. In response to growing concerns about emergency care for veterans, the GAO examined allegations regarding the VA's failure to administer proper coverage of emergency room care for veterans.

The VA spent more than $418 million on Millennium Act emergency care claims in 2012, and the Department estimates this number will increase $580 million by 2015.[590] Despite the amount of money being spent on these claims, the VA is inappropriately denying claims and holding veterans financially liable due to weak Departmental oversight,

according to GAO. Often, veterans are not even aware of their rights to appeal these denials.[591]

In a study of four VA medical centers in Texas, South Dakota, Vermont, and Washington, DC, GAO found the Department wrongly denied over half of received claims (66 of 128), and even more (83 of 128) lacked documentation informing the claimant that they had a right to appeal the denial of medical coverage.[592] With so much money earmarked for emergency care, it is essential that the VA improve claims oversight and implement GAO's recommendations to ensure facilities comply with applicable requirements and properly notify veterans of denials.[593]

11. VA Rehires Employee After He Drives Drunk and Kills His Co-Worker

In 2010, Jed Fillingim, a VA financial manager, attended a business trip in Addison, Texas. During that trip, Fillingim was arrested after drinking and driving while using a government vehicle, during which his colleague, Amy Wheat, fell from the moving vehicle and died.[594] After drinking at a local bar all night, which included jaeger bombs, beer, and vodka, Fillingim admitted to driving while intoxicated when his co-worker fell out of the car to her death.

Fillingim resigned from his job following the incident, but the VA rehired him – to a different position in a different office – just months after his resignation.[595] He has remained at that job ever since, making over $100,000 a year, despite being the subject of an ongoing criminal investigation into the Texas incident.[596] The VA has repeatedly ignored questions and congressional inquiries regarding its decision to rehire him.[597]

12. VA Employees Caught Accessing Child Pornography with Department Resources

On more than one occasion, employees at multiple VA medical centers were found to have used their work computers to watch child pornography. Just this year, a former VA employee in New York plead guilty to accessing child pornography websites using VA systems after an IG and local police investigation.[598] A Dallas VA medical center employee was caught doing the same thing a few years earlier, when he was found using a work computer to access and view child pornography while on the job.[599] In 2012, an investigation found a VA employee in Los Angeles possessed child pornography on the grounds of the medical center where he worked.[600] Finally, when the IG was investigating yet another allegation that a VA employee was accessing child pornography at work, the investigation revealed that the VA facility where the employee worked offered free Wi-Fi service.[601]

> **The bone-chilling conduct alleged in this complaint is a chronicle of sadism and depravity that includes the defendants' very real steps to carry out their plans to kidnap, torture, rape, and kill the women and children they targeted.**

VA Police Force Officers Engage in Questionable Practices

1. VA Police Chief Plots to Kidnap, Rape, and Murder Women and Children with Cannibal Cop Cohort

The chief of police of the Bedford VA Medical Center was arrested and convicted of conspiring with a member of a cohort of the New York "Cannibal Cop" to kidnap, rape, and murder women and children. Arrested by the FBI for "plotting to kidnap, torture, rape, and kill women and children" in 2013, Richard Meltz pled guilty January 2014 and "now stands convicted of serious federal crimes for his role in two sadistic kidnapping, rape, and murder conspiracies."[602]

Meltz and two others—Robert Asch and Michael Van Hise—"planned the kidnapping, torture, and murder of Van Hise's wife and other members of Van Hise's family,"[603] including his sister-in-law, her children, and his step-daughter.[604]

Meltz "engaged in detailed discussions about kidnapping and brutalizing the proposed victims and ultimately assisted Van Hise and Asch in planning a kidnapping, rape, and murder."[605] In an electronic message, Meltz wrote "we go over there she know you let's [sic.] us in we choke her out tie her up throw her in the back of your car take her someplace and [rape and torture her]."[606]

Meltz provided "examples of the techniques" for "the avoidance of toll roads, using rental cars, paying for 'tools' in cash, looking for victims in desolate areas who are engaged in other activities (such as talking on the phone), abducting victims at night, and using disguises when first approaching a potential victim."[607] He also provided advice on "how best to dispose" of the victim's "body, including how to transport it from the crime scene to a desolate location in the woods in upstate New York." He noted, "wild animals would likely find and destroy it before law enforcement could find it."[608]

Asch had "a bag of materials to be used during the kidnapping and torture," which included a ski mask, hypodermic needles, leather ties, chrome forceps, a three-page gun show itinerary, documents relating to a 'leg-spreader' and 'dental retractor' that Asch claimed to have purchased, and the liquid form of doxepin hydrochloride, commonly used as a sleep agent."[609]

"The co-conspirators ceased active planning of the kidnapping when the FBI arrested New York City Police Officer Gilberto Valle for a related kidnapping conspiracy and began investigating Van Hise."[610] Valle became known as the "Cannibal Cop" for his 2013 conviction for "plotting to kidnap, cook and eat women,"[611] and "imagining his victims

roasted, cooked, barbecued and rotisseried."[612] Van Hise was "a cohort of NYPD 'Cannibal Cop,'" but his plot with Meltz "didn't include allegations of cannibalism."[613] Manhattan U.S. Attorney Preet Bharara noted:

"The bone-chilling conduct alleged in this complaint is a chronicle of sadism and depravity that includes the defendants' very real steps to carry out their plans to kidnap, torture, rape, and kill the women and children they targeted. Allegedly, Richard Meltz and Robert Christopher Asch assiduously planned their plot in detailed conversations and alternately served as advisers and facilitators of the plan—Meltz provided 'strategic advice,' and Asch conducted surveillance and provided supplies including leather ties, a sleeping agent, instruments of torture, and a Taser gun. The only thing that stood between these alleged kidnappers and their horrifying plot was the outstanding investigative teamwork of the FBI and the prosecutors in this office."[614]

2. VA Police Sergeant Says Police at the C.W. Bill Young Medical Center Use Bully Tactics "Verging on Criminal"

The police force at the C.W. Bill Young VA Medical Center (formerly known as Bay Pines VA Medical Center) "has endured its share of controversy in the past several years," with patients complaining about aggressive police behavior.[615] A sergeant at the medical center even stated that some of the officers "should not even be wearing the badge."[616]

Patients "complained of verbal abuse by police or said officers were sometimes overbearing or discourteous," according to police Chief Robert Shogren in 2011.[617] "He tried to get officers to understand that patients were" at the center "for treatment. That might mean not arresting an unruly veteran seeking treatment for mental health issues. An arrest, he said, puts the veteran further from treatment."[618]

Some of the officers "don't want to come to work, don't want to do their job, use bully police tactics and … make arrests that are on the verge of criminal," according Police Sergeant Thomas Horton, a shift supervisor who previously worked for the VA Police Department in Little Rock, Arkansas. He said, "I have never worked with more people that think they are 'above the law' than I have here…we have staff that could not write a proper…incident report if their job depended on it and fight every effort to…improve."[619]

In 2009, a police officer at Bay Pines "was accused of assaulting another cop in the office."[620]

"We want to create an environment where veterans feel comfortable and safe," Chief Shogren said.[621]

The Chief's goal is important since there have been a number of incidents in recent years, including at the C.W. Bill Young VA Medical Center, where violent threats have been made and the police have had to shoot the perpetrators. Since Fall 2013, when police shot a man who walked into the center with a knife and claiming to have a bomb, "the hospital opted to increase its police force by 17 percent."[622]

3. Minority Employees at Waco VA Police Department Subjected to Racial Harassment

A noose placed on the desk of a minority employee of the Waco VA Medical Center Police Department is just one of the incidents that led "the National VA office in Washington D.C." to conclude "there was credence to claims of racism and that management in Waco never took measures to stop it."[623]

A number of minority employees of the Center's Police Department filed a complaint in 2009, claiming "they were subjected a hostile environment and racial harassment" which included racist jokes and slurs, the noose, and even "spying on minority employees."[624]

After reviewing the allegations of one of the employees, the VA wrote to that employee, determining he was "discriminated against because of [his] race and protected EEO activity in connection with unwelcome degrading, insulting, hostile and intimidating conduct."[625]

4. VA Police Unlawfully Detain Photographer on VA Medical Center Campus

Earlier this year, the body of a deceased veteran was found in the parking lot at the North Las Vegas VA Medical Center.[627] During the investigation of the death, a photographer from the Las Vegas Review-Journal arrived at the scene.[628] While he was in a public area "shooting photos behind the tape," the photographer was "detained by three VA police officers who threatened to arrest him if he did not delete photographs from his camera."[629]

According to the General Counsel of the Las Vegas Review-Journal, federal regulations "allow photography on federal property from publicly accessible spaces."[630]

A photograph of the noose left on the desk of a minority employee at the Waco VA Medical Center Police Department was obtained by Waco News Channel 25.[626]

" ... there was credence to claims of racism and that management in Waco never took measures to stop it. "

# VA Security Weaknesses Cause Leak of Veterans' Personal Information

Earlier this year, an information security glitch caused the personal data of 1,300 individuals to be seen by over 5,000 users of the VA's eBenefits system.[631] The leaked information included financial and medical records of veterans and their dependents.[632]

According to the GAO, the Department has experienced long-standing challenges in "effectively implementing security controls over its systems and information."[633] Despite consistent urging from lawmakers to heighten security controls throughout the Department, the VA has struggled to protect sensitive information. Some of the Department's challenges are warranted, given the ever-changing nature of technologies, cyber threats and business practices in a world governed by information technology.[634]

The VA had the most security incidents of any government agency last year, reporting 11,368 in 2013.[635]

"Security incidents" include anything from a stolen laptop to a computer virus download to the mishandling of documents.[636] Since the VA is such a large Department, this fact does not necessarily mean the VA is the "least secure" – but it still raises cause for serious concern.[637]

In fact, the GAO has found flaws in the VA's internal security systems for the past seven years. Last year was the twelfth consecutive year in which auditors said "VA's information security controls constituted a material weakness."[638] At a recent House Committee on Veterans' Affairs hearing, the GAO emphasized that information security program controls are a "major management challenge" at the VA.[639] Furthermore, VA information security incidents reached a peak in 2013.[640] It is imperative that the VA take action to address its security issues to ensure the privacy of the veterans it serves.
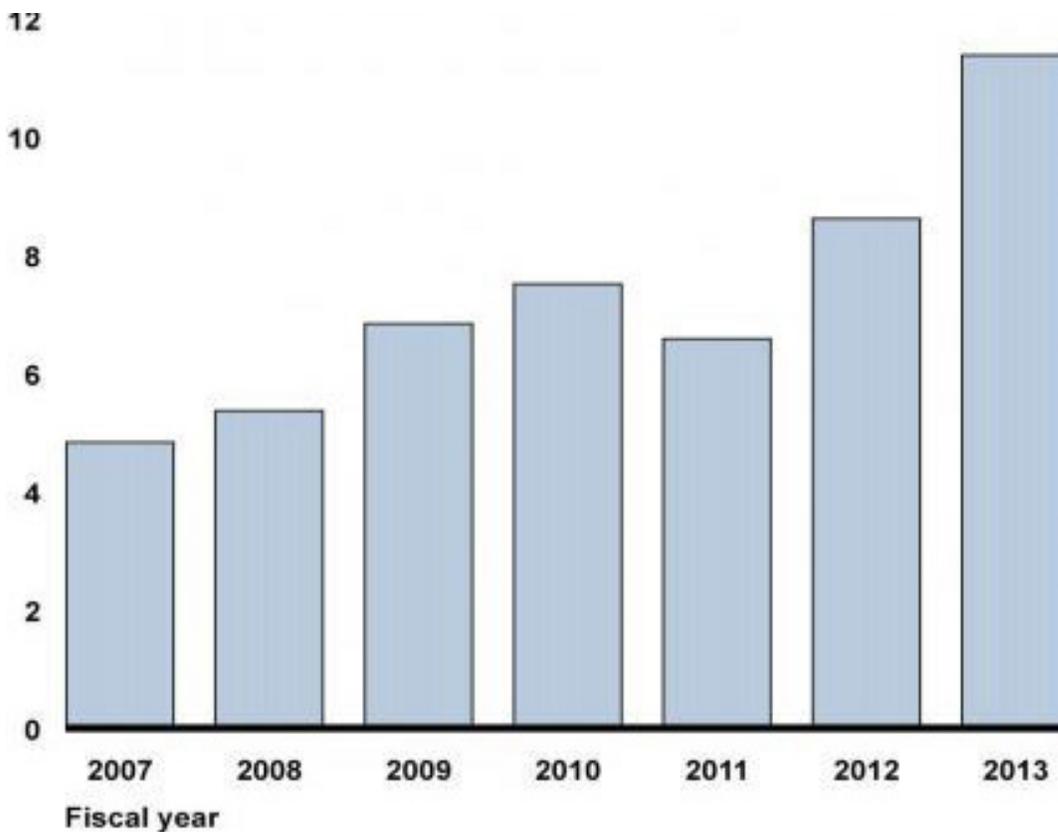
Source: US-CERT.

This graph shows that VA information incidents have generally risen over the past seven years, from 4,834 incidents reported in 2007 to 11,382 incidents reported in 2013.[641]

Congressional Mismanagement: Congress Has Not Done Enough

"ONE OF THE PRINCIPLE CULPRITS" for the failure to get veterans the care they need in a timely manner is Congress, according to former Secretary of Defense Robert Gates. "Congress has micromanaged veterans affairs in such a way that changing anything that has to do with dealing with veterans requires literally an act of Congress."[642]

"We would try pilot programs where we would try to expedite disability evaluations and things like that … to be able to get them done in 100 or 150 days rather than a year or two years or three years or more, but we couldn't expand that, once we showed it would work, without a change in the law, and that proved almost insurmountable," Secretary Gates said.[643]

Congress micromanages decision-making at the VA because Washington politicians are more interested in claiming credit for establishing new benefits or VA centers than making sure veterans are getting the care they were promised and earned. Since 2010, Congress has created at least 12 new veterans' programs.[645] Regardless of the merits, the focus on expanding programs has done little to ensure the benefits, including basic quality health care, promised to veterans are being provided on a timely basis. Cutting ribbons at new VA medical centers and issuing press releases about new veterans' programs are far more appealing to politicians running for re-election than holding Department officials accountable for mismanagement. This is one of the key reasons why we are here today.

Ensuring that laws are properly administered and holding federal agencies accountable through oversight are the most important responsibilities of Congress.

Oversight can be done in several ways, but at its core it requires congressional action to monitor federal agencies to ensure they are doing the jobs properly. Passing laws is meaningless if those responsible for administering the law ignore it, overstep it, mismanage money and resources, or fail to accomplish the intended mission or purpose.

Committee hearings are a vital oversight tool. Hearings give lawmakers a public forum for elected officials to question those in Washington who have been entrusted with the responsibility of administering the laws and carrying out federal programs, such a providing veterans' care and benefits.

The Senate Committee on Veterans' Affairs was alerted to many of the problems at the VA—including poor care, gaming numbers to hide problems, and a lack of oversight—at a hearing in 2012. "While patients truly fell through the cracks, there was no effective oversight to detect that and to address the deep systemic problems," a former VA employee testified two years ago.[646] He revealed there was a perverse incentive for VA managers to earn bonuses by cleverly covering-up the number of veterans seeking but not receiving care.[647] He recommended "much more extensive oversight" be done "into how care is actually being provided to ensure the funds actually go to the programs that they are intended."[648] It took more than two years for the Senate Committee to act on any of these revelations with oversight hearings or legislative remedies to hold the VA accountable and protect veterans.

By any measure, the Senate Committee on Veterans' Affairs has done little oversight on this or other areas where the VA has either fallen short or demonstrated a need for stronger accountability.

> "One of the principle culprits" for the failure to get veterans the care they need in a timely manner is Congress, said Robert Gates, who served as Secretary of Defense under both Presidents Barack Obama and George W. Bush. [644]

The Senate Veterans' Affairs Committee has held just 28 hearings in the 113th Congress (2013- 2014).[649] Only two of these were described as oversight hearings according to the Committee – one on April 30, 2014, and the other on May 15, 2014.[650] The most recent oversight hearing, "The State of VA Healthcare," was held only after growing pressure from members of Congress amidst a breaking scandal that veterans may have died while waiting for appointments at VA medical centers.[651] "Minority members and staff have requested multiple oversight hearings since the beginning of the 113th Congress with none of the requested hearings taking place and no response."[652] Prior to the April 30, 2014 oversight hearing, the last oversight hearing held by the Senate Committee on Veterans' Affairs was four years ago on May 5, 2010.[653]

During the May 15, 2014 hearing, former Secretary Eric Shinseki testified that the although the allegations against the VA made him "mad as hell," he was unwavering in his defense of the Department's health care system, describing it as a "good system" and claiming that the manipulation of wait times were "isolated" incidents.[654]

Additionally, the Senate Veterans' Affairs Committee held two field hearings during the 113th Congress, one in Alaska ("The State of Veterans Services in Alaska," 8/26/13) and the other in Georgia ("Ensuring Veterans Receive the Care They Deserve - Addressing VA Mental Health Program Management," 8/7/13).[655] However, despite years of reports

from the IG and GAO on inappropriate scheduling practices, no hearings were held on areas experiencing delays or deaths resulting from poor VA care until May 2014.[656]

The Senate Committee on Veterans' Affairs was featured in *Wastebook* in 2012 for being among the most idle committees in the entire Congress due to the number of hearings held. The Committee conducted just 16 hearings in 12 months, fewer than all but seven other committees in both chambers of Congress.[657] None of these were oversight hearings, according to the committee's own admission.[658]

Debra Draper, who heads investigations of the VA for the GAO says "a key problem is a lack of oversight."[659] Along with the GAO, Draper has brought many of the issues at the VA to the attention of Congress for years.

The House Veterans' Affairs Committee, in contrast to its Senate counterpart, has been very aggressive with efforts to protect veterans and hold the VA accountable. The Committee has held over 80 hearings in the 113th Congress, of which more than half were oversight in nature.[660] These include hearings on the effectiveness of VA programs, delays and cost overruns of VA projects, transparency, assessment of preventable deaths, and even the actions taken by the VA in response to congressional oversight. The House Committee also reported out a bill (H.R. 2189) to help resolve the backlog of disability claims at the VA that was overwhelmingly approved by the House of Representatives by a vote of 404 to 1 last year. The

The U.S. Senate Committee on Veterans Affairs has shown little interest in conducting oversight of the Department on Veterans Affairs.[668] The committee held no oversight hearings for four years, according to the website.[669]

bill was referred to the Senate Committee on Veterans' Affairs in October, where it has been waiting for attention, much like the veterans who are waiting for the VA services the bill seeks to address.

The recent controversies over unexplained deaths at VA facilities are nothing new.[661] During the spring and summer of 1992, there was a mysterious increase in veteran deaths in one part of the Harry S. Truman Memorial Veterans Hospital in Columbia, Missouri.[662] In February 1993, the VA IG received serious allegations that the Hospital Director and others had attempted to cover-up these deaths.[663] A hospital employee, Dr. Gordon Christensen, brought these concerns to law enforcement and the IG, but his confidentiality was compromised by the IG, and he was vilified for making these problems public.[664]

This is a tragic story of federal bureaucrats more concerned about their career track than the health of their patients.

At a congressional hearing on the matter, Congressman Terry Everett, then Chairman of the Subcommittee on Oversight and Investigations, House Committee on Veterans Affairs, stated the problem is the "culture that exists within the VA. Frankly I think it's a cancer that consuming the VA. It's a culture that defies oversight-congressional oversight-we've seen time and time again hospital directors that defied, not only their superiors, but congressional oversight also," and if it does not change, it "will destroy the organization."[665]

Other lawmakers were aghast at how this could happen in the first place. Congressman Frank Mascara (D-PA) said, "How anybody could continue to allow this to happen boggles my mind. I mean, it doesn't take a rocket scientist – even a person in medical field could figure out there's something wrong."[666]

A decade later, after ten first-degree murder charges were filed against a former nurse, the victims families finally got answers. A new test determined that the veterans were killed by a powerful injection of a paralyzing drug. The whistleblowers believe that the nurse, Richard Allen Williams, may have killed up to 42 people.[667]

It is the responsibility of the VA to provide timely, quality care to veterans, and it is the duty of Congress to ensure that is occurring. For decades, both have too often fallen short of these roles. Congress needs to better hold the VA accountable, while at the same time stop micro-mismanaging efforts by the VA to improve. The Senate Committee on Veterans' Affairs, specifically, should focus more attention on the actual outcomes of veterans' care that has already been promised rather than continuing to expand a broken system that has long lacked accountability and failed thousands of veterans.

"This is a tragic story of federal bureaucrats more concerned about their career track than the health of their patients."

MONEY IS NOT THE PROBLEM: VA WASTES BILLIONS OF DOLLARS

The overwhelming examples of deaths, delays, and overall mismanagement discussed above illustrate the severity of the broken VA system and set the stage for necessary and immediate reform. While some believe that more money is needed for this to happen, the VA has enough money to institute a much-needed Department-wide culture change. This section of the report highlights areas where the Department wasted or squandered billions of dollars that could have been instead used to help veterans receive the medical care they deserve.

Care Delays Are Not the Result of a Lack of Money

FORMER SECRETARY OF DEFENSE Robert Gates says the delays in veterans care is "not for a lack of money."[670] In fact, the Veteran's Health Administration budget this year is $57.28 billion, which is equal to $6,300 per veteran served.[671] This funding goes toward Veterans' medical care, improvements in the delivery of mental health care, specialized care for women veterans, benefits for Veterans' caregivers, and medical care collections.[672]

Calls to fix the failing VA health care system hit a crescendo following the reports of botched scheduling practices and Secretary Eric Shinseki's resignation. However, opinions on how to restore VA health care vary. In fact, most in Washington think that the answer is simple: more cash.[673] However, a closer look at VA data and spending practices indicate that the Department has plenty of money. An analysis of collected data on budget, costs, number of acute in-patients treated, and the total number of VA patients reveals that "[e]ven when you take medical inflation into account, the VA budget still grew faster than its patient base since 2000."[674]

More than 20 veterans have died or are dying due to late diagnosis and treatment of cancer at the Williams Jennings Bryan Dorn Veterans Medical Center in Columbia, South Carolina. "The documents obtained by CNN show that only a third of that $1 million from Congress was used for its intended purpose at Dorn: to pay for care for veterans on a waiting list."[678]

The VA is sitting on tens of billions of dollars left unspent from year to year. At the conclusion of Fiscal Year 2013, the VA held over $34 billion in unspent funds.[679] This amount included $25.6 billion that was obligated but unspent and another $8.8 billion that had not yet even been obligated.[680] The Department is projected to end 2014 with a larger sum of unspent money, including nearly $5.9 billion in unobligated funds.[681] To give this amount some perspective, the entire annual budget of the National Institutes of Health (NIH) is $30.1 billion[682] -- billions of dollars less than the excess amount the VA leaves unspent at the end of every year.

The second largest department in the federal government,[683] the VA's total annual budget exceeds $134 billion.[684] This is spent on a variety of benefits, including health care, disability, housing, and education, as well as construction, administration, and information technology. Medical programs make up about 40 percent of the Department's annual appropriation.[685]

While most of this money does go towards veterans services, hundreds of millions appear to be wasted. From unwarranted and excessive bonuses for staff (in 2013, when much of the federal government was furloughing employees as a result of sequestration-imposed budget cuts, the VHA paid $27.3 million in bonuses[686]) to construction projects way over budget to unnecessary duplicative programs and paperwork, the VA should better focus on its resources towards services for veterans.

Many of VA's medical facility projects under construction or

recently completed are over budget.[687] The costs of just four of these construction projects were nearly $1.5 billion more than originally planned.[688] The Denver project alone has increased from "$328 million in 2004 to $800 million in November, 2012," and the "VA's primary contractor on the project has expressed concerns that the project will ultimately cost more and take more time to complete."[689]

Since 2001, the VA has paid out a total of $36.4 million to settle 167 claims in which the words "delay in treatment" were used to describe the alleged malpractice.[691] While this represents a small portion of the $845 million in malpractice costs, it indicates that at least $36 million could have been directed to actually care for veterans if it did not have to cover the costs of the VA's shortcomings.[692] These payouts could have covered the immediate non-VA care treatment for patients stuck in waiting lines.

The VA also wastes millions of dollars every year processing excessive paperwork from veterans seeking services. There are more than 600 forms from 18 agencies for veterans to fill out, according to a study by the American Action Forum. "[T]here is no shortage of figurative red tape in the VA system. Eighteen different agencies administer more than 600 forms, imposing 43.4 million hours of paperwork. To put that paperwork burden in perspective, it would take approximately 21,750 employees working 2,000 hours a year to complete one year of paperwork."[693] Streamlining the application process and reducing red tape and unnecessary paperwork would save millions of dollars and make veterans interactions with the VA less cumbersome.

Despite all of this, the VA will receive more money for its health care system than it is able to spend for the fifth fiscal year in a row.[694] The Department has carried over left-over money for at least the past four years, and it appears that it will also do so next year.[695] The VA will move $450 million in medical-care unobligated balances from fiscal year 2014 to fiscal year 2015, according to VA budget documents.[696] The Department is also receiving more money than ever before. Congress appropriated $54.6 billion for medical care to the VA this fiscal year – "more than $10 billion more than it received four years ago."[697]
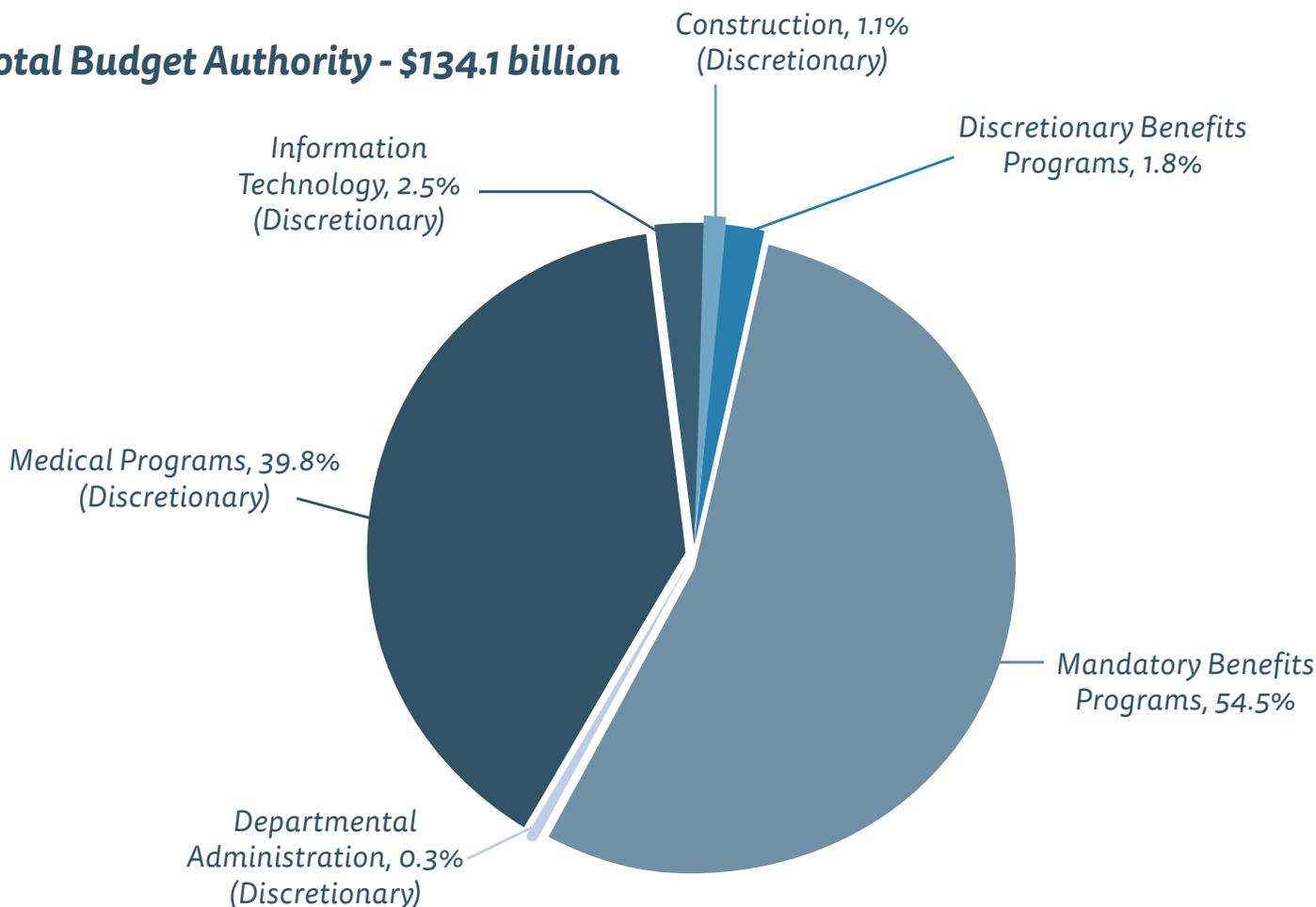
VA Major Medical-Facility Projects Cost Increases

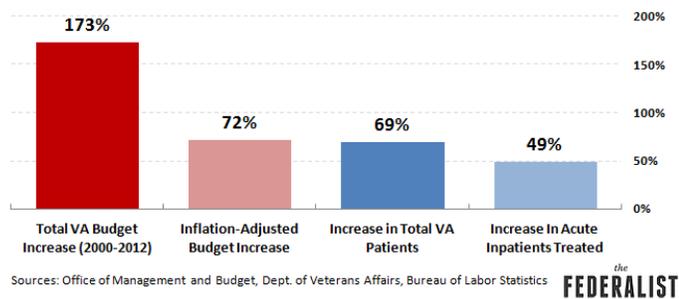| Project location	Initial total estimated costs	Total estimated costs	Percent increase
Las Vegas	$325 million	$585 million	80
Orlando	$254 million	$616 million	143
Denver	$328 million	$800 million	144
New Orleans	$625 million	$995 million	59

Source: GAO Analysis of VA data.

The VA's four largest medical-facility construction projects are all significantly over-budget, resulting in cost overruns of nearly $1.5 billion.[690]

Total Budget Authority - $134.1 billion

Construction, 1.1% (Discretionary)

Discretionary Benefits Programs, 1.8%

Information Technology, 2.5% (Discretionary)

Medical Programs, 39.8% (Discretionary)

Mandatory Benefits Programs, 54.5%

Departmental Administration, 0.3% (Discretionary)

The annual budget of the VA exceeds $134 billion, making it the second largest department in the federal government.[698] It ends every year with over $34 billion left unspent, more than the entire annual budget of the National Institutes for Health.[699]

Even After Adjusting For Inflation, VA Funding Growth Outstripped Patient And Acute Treatment Growth

173%	Total VA Budget Increase (2000-2012)
72%	Inflation-Adjusted Budget Increase
69%	Increase in Total VA Patients
49%	Increase In Acute Inpatients Treated

Sources: Office of Management and Budget, Dept. of Veterans Affairs, Bureau of Labor Statistics

the FEDERALIST

This chart illustrates how the VA health care system budget increases should be able to account for the increase in patient demand. Between 2000 and 2012, VA's budget grew from $45 billion to $124 billion, almost tripling in size.[675] Adjusted for health care inflation, the VA's budget still grew by 72 percent over a 12-year period.[676] Over that same time, the number of total VA patients increased by 69 percent (from 3.3 million to nearly 5.6 million) and the number of treated acute inpatients increased by 49 percent.[677]

Wasteful Spending, Fraud, and Abuse of Funds

1. *Employees Paid Not To Work, While Veterans Wait for Care*

Mismanagement at the VA is symbolized by the way the agency muddled its priorities during the government shutdown last fall. The Department halted many of its services during the government shutdown while furloughing high-level employees.[700] For example, it stopped providing rehabilitation and counseling assistance and closed centers that offer help to veterans struggling to understand their benefits.[701] The backlog for disability claims, which had previously been progressing, stalled.[702] However, during this same two-week period, the Department furloughed 1,406 employees who were paid an annual salary of $100,000 or more – resulting in $5.6 million paid to VA workers for not performing any duties.[703]

Survival rates for colon cancer dramatically increase when caught in early stages through regular screenings

http://www.cdc.gov/cancer/colorectal/basic_info/screening/

2. *VA Fails to Spend Funds Allocated Specifically to Improve Care for Veterans; Patients Awaiting Colonoscopies Develop Cancer Due to Delays*

At the Williams Jennings Bryan Dorn Veterans Medical Center in Columbia, South Carolina, at least six veterans have died because their cancers were not caught in time.[704] Backlogs to undergo simple gastrointestinal procedures, like colonoscopies, are allowing veterans cancerous symptoms to progress before they can receive necessary care.[705] A September 2013 IG investigation found that of the 2,500 colonoscopy consultations that were backlogged at the hospital, 700 of them were deemed "critical."[706] Part of the reason for this was insufficient staffing, as "[Gastrointestinal] staffing was not optimal and critical nursing positions went unfilled for months."[707] The IG also described the management of gastrointestinal services as "chaotic," likely because non-clinicians were making clinical decisions.[708]

Once medical investigators acknowledged the deadly consequences of the hospital's growing delays, the VA asked Congress for money to help fix the problem.[709] As a result, the VA received over $1 million to resolve the backlog of gastrointestinal procedures.[710] However, the IG discovered that only $275,000 was actually used for this purpose.[711] Hospital officials were unaware these funds were obligated to accelerate colonoscopy procedures and used their discretion to distribute the money elsewhere.[712]

3. VA Spends Nearly $3 Billion Overpaying for Prosthetics

The VA's procurement process for biologics and other medical materials has faced scrutiny in the past concerning overspending and giving purchasing agents "pretty much a free hand on procurements" of tissue for implants and bone grafts.[713] Instead of purchasing these materials through a competitive process, the agency bought prosthetics on the open market, at a cost of nearly $3 billion.[714]

These cases make clear that the VA must improve the way it sources, manages and controls biological products, not only to save money, but also to protect the veterans it serves.

4. VA Pays $200 Million To Veterans' Families for Wrongful Deaths

The VA has spent over $200 million in the last ten years in an attempt to compensate victims for its mistakes.[715] More than 1,000 veterans needlessly died under the VA's watch, and the Department in turn paid these veterans' families $200 million in wrongful death settlements – the median payment per victim was $150,000.[716] Most families of the victims agreed it was not about the money; they just wanted the VA to be held accountable for its actions.

Examples of VA actions that caused these unnecessary deaths include leaving patients unattended and prescribing escalated doses of painkillers while failing to monitor their consumption.[717] Even worse, the victims' families are not always compensated for their losses. In one case, a veteran, husband, and father of two shot himself in the head after the VA denied his disability claim for post-traumatic stress disorder (PTSD).[718] His wife filed a wrongful death lawsuit against the VA in 2010.[719] Four years later, the case is still pending.[720]

The VA has answered the uproar by noting that wrongful death payments to 1,000 veterans in ten years represent a very small percentage of the veterans it serves.[721] However, this number is likely not representative of the VA's shortcomings, because some people may never file a claim. Filing a malpractice claim against the VA is slow and arduous – families of victims who die under VA care must exhaust a months-long administrative review process before even making a legal

claim.[722] Unlike the private sector, it is difficult to file a claim against the federal government, which likely discourages many qualified victims from ever pursuing a monetary settlement. Additionally, malpractice claims against the federal government are capped at $250,000 – an amount that may not fully compensate victims in cases of real malpractice.[723]

Barry Coates, a 44-year-old army veteran testified recently before the House Veterans' Affairs Committee that "gross negligence" and "crippling backlog epidemic" has "not only handed me a death sentence, but ruined the quality of life I have in the meantime."[724] Coates waited over a year for a routine colonoscopy at a VA medical center and was eventually diagnosed with terminal colorectal cancer – a fate that could have been avoided had he undergone the procedure when he requested it.[725]

The $200 million in wrongful death payments is not the sole indicator of the agency's blunders. Over the past ten years, the agency paid around $845 million in malpractice claims in general – not all veterans die at the VA's expense, but many are still harmed.[726]

It is arguable that this malpractice tab could be higher if the VA was more forthcoming with its own negligence. Because the VA operates under a disclosure policy that informs patients when the hospital or doctors made a mistake, many claims may go unreported.[727] In other words, patients and families may never even know if something went wrong if the VA did not self-report it.[728]

5. VA Spends $5.1 Million Purchasing Software Licenses, Then Never Uses Them

The VA Office of Information and Technology (OIT) spent millions of dollars on encryption software licenses to improve data security and let them sit dormant for years, never activating or installing them.[729] Between 2006 and 2011, approximately 400,000 software licenses were purchased to install on VA employee computer workstations.[730] In 2012, the IG found the VA had only activated and installed around 65,000 of these licenses – only 16 percent of the licenses acquired.[731]

Around 335,000 purchased licenses were never activated, amounting to $5.1 million in questioned costs.[732] OIT never tested the software on office computers and did not take

measures to ensure all the encrypting software was properly and timely installed.[733] In addition to wasted money, VA laptop and desktop computers remained unencrypted, leaving classified veterans' data at risk.[734]

In 2006, a hard drive containing personally identifiable information for over 26 million veterans was stolen from the home of a VA employee.[735] In response to the theft, the VA Secretary mandated all laptops must be encrypted for security reasons.[736]

6. VA Spends Almost $500 Million on Conference Rooms and Curtains

The recent firestorm that has erupted at the VA over numerous allegations of delayed care and intentional manipulations of data by Department employees has captured the nation's attention –and appropriately so. These allegations and ongoing investigations are the focus of mismanagement at the VA, and getting to the bottom of those problems is

imperative to revive the VA health care system to one of quality and integrity.

However, in order to carry out its mission of providing veterans with quality medical care and services, the VA is appropriated hundreds of millions of dollars from Congress each year. VA's budget has increased significantly over recent years.[737] Specifically, since 2009, the Department's discretionary spending budget has increased by 35 percent – deemed necessary by President Obama – to give veterans the health care they deserve.[738]

As the VA's budget continues to rise (President Obama requested an increase of four percent for FY 2015), records show that a large chunk of its allotted federal funds goes to office renovations, furniture, and decorating.[739] Over a four-and-a-half year period, the VA spent $489 million on embellishing its office spaces.[740] Highlights of these "office makeovers" include $6.8 million to construct one conference room in Illinois, $1.8 million on office furniture in Puerto Rico, and $10.7 million on curtains and draperies nationwide.[741]

2010	2011	2012	2013	2014
121.6 M	124.4 M	107.2 M	113.9 M	17.7M*

Amount Spent On Furniture Per Year

As of May 2014 | http://www.usaspending.gov

7. VA Employees Spend $650,000 on Unauthorized and Undocumented Purchases Using Prepaid Government Debit Cards

Engineering employees at the Ralph H. Johnson Medical Center in Charleston, South Carolina used government debit cards to make nearly $650,000 in unauthorized or undocumented purchases.[742] These employees attempted to be sneaky by splitting purchases amongst cards to avoid each card's $3,000 limit, subsequently evading competitive bidding requirements.[743]

The purchase cards are available to federal agencies through the General Services Administration's (GSA) SmartPay2 program, a payment tool designed to simplify acquisition procedures and streamline the procurement process.[744] However, without proper oversight, this program is susceptible to abuse. The IG, who conducted the investigation, concluded the VA medical center's "weak purchase card controls created an environment vulnerable to misusing purchase cards and to the ineffectiveness of an important system of procurement checks and balances."[745]

8. VA Spends Millions to Fund VA Employment Call Centers; Handle Two Calls Per Day

In July 2011, the VA established two employment call centers with OPM to support the Department's Veteran Employment Services Office (VESO) in recruiting and retaining more veteran employees.[746] However, an IG investigation conducted to determine whether VESO's acquisition of the call centers was "appropriate and justified" concluded the Department acquired more than was necessary, considering the low volume of calls coming to the centers.[747]

In the first 13 months the call centers were open, each call center employee handled an average of 2.4 calls per day.[748] Despite the low volume of calls, VESO kept both call centers open 24 hours a day, seven days a week.[749] The IG described this capacity "excessive" and concluded call center operations were overstaffed by at least 50 percent.[750]

The IG concluded VESO spent $2.2 million in 2012 to operate its contracted call centers, and estimated $1.1 million of this was unnecessary due to lack of oversight, duplication of programs, insufficient performance measures, and inadequate data calls from the contractors.[751] This could amount to $13.1 million in unnecessary spending over the next two-year period if VESO does not take corrective actions.[752]

VA Spends Billions on IT With Mixed Results

V A RELIES ON A HOST of IT systems to manage everything from appointment scheduling to electronic medical records and educational benefits to disability benefits claims processing. It requested $3.9 billion for IT in its FY15 budget request, of which:

- $2.3 billion will be used for operation and maintenance of existing systems

- $531 million will be used to develop new system capabilities

- $156 million will be used for information security

- $1 billion will be used to support nearly 8,000 IT personnel[753]

Since FY 2010, the VA IT budget has increased by over $600 million, or 18 percent.

The Federal IT Dashboard shows the VA has spent $3.9 billion on 32 IT investments this fiscal year,[754] many of which are behind schedule and over cost, though the data is limited because of inconsistent updates and discrepancies within the VA's internal project management dashboard.[755] In 2007, an investigation by the Senate Federal Financial Management Subcommittee found the VA had the worst track record in the entire government for estimating the cost of IT projects. Over 90 percent of the time, VA IT projects ran over their initial budget estimates, driving up costs. [756] Whenever this happened, the Department would simply increase the estimated cost of a project in a process called "rebaselining."

This meant that future cost overruns would be measured against the newly inflated estimates, rather than the initial estimate on which the decision to invest in the program was made. "These are very concerning figures, especially VA," Senator Coburn said at the time, "If anywhere in the private sector had these change rates, they would fire the people responsible."[757] As the chart below shows, no other agency even came close to VA in using rebaselining to mask IT system cost growth.

GAO has testified that "historically, VA has experienced significant IT development and delivery difficulties."[758] In 2010, the GAO reported that a VA project to modernize its outpatient scheduling system begun in 2000 had spent $127 million without implementing "any of the planned system's capabilities" because of project management weaknesses and lack of oversight.[759] The Scheduling Replacement Project was designed to replace the VA's aging system that was directly contributing to scheduling delays because of issues coordinating between the various VA sites, but it remains in use today.

The VA's core medical information system, VistA, is a Government-off-the-shelf (GOTS) Electronic Healthcare Record (EHR) system that is over 25 years old and "consists of 104 separate computer applications; including 56 health provider applications; 19 management and financial applications, 8 registration, enrollment, and eligibility applications; 5 health data applications; and 3 information and education applications."[760] Customized to each of the VA's 128 sites' particular needs, the system is costly to maintain. In 2001, VHA began a project to modernize VistA that was terminated in 2010 when it was estimated it would require an additional $11 billion to complete the planned upgrades, after having already spent nearly $600 million. In 2013, with the announcement that VA and the Department of Defense (DOD) would no longer cooperate to develop a shared, interoperable EHR, VA launched the VistA Evolution program to complete the system enhancements and announced it would compete for the DOD electronic health record contract expected to be announced in the fourth quarter of this fiscal year. The FY15 request includes $269 million for the VistA Evolution program.[761]
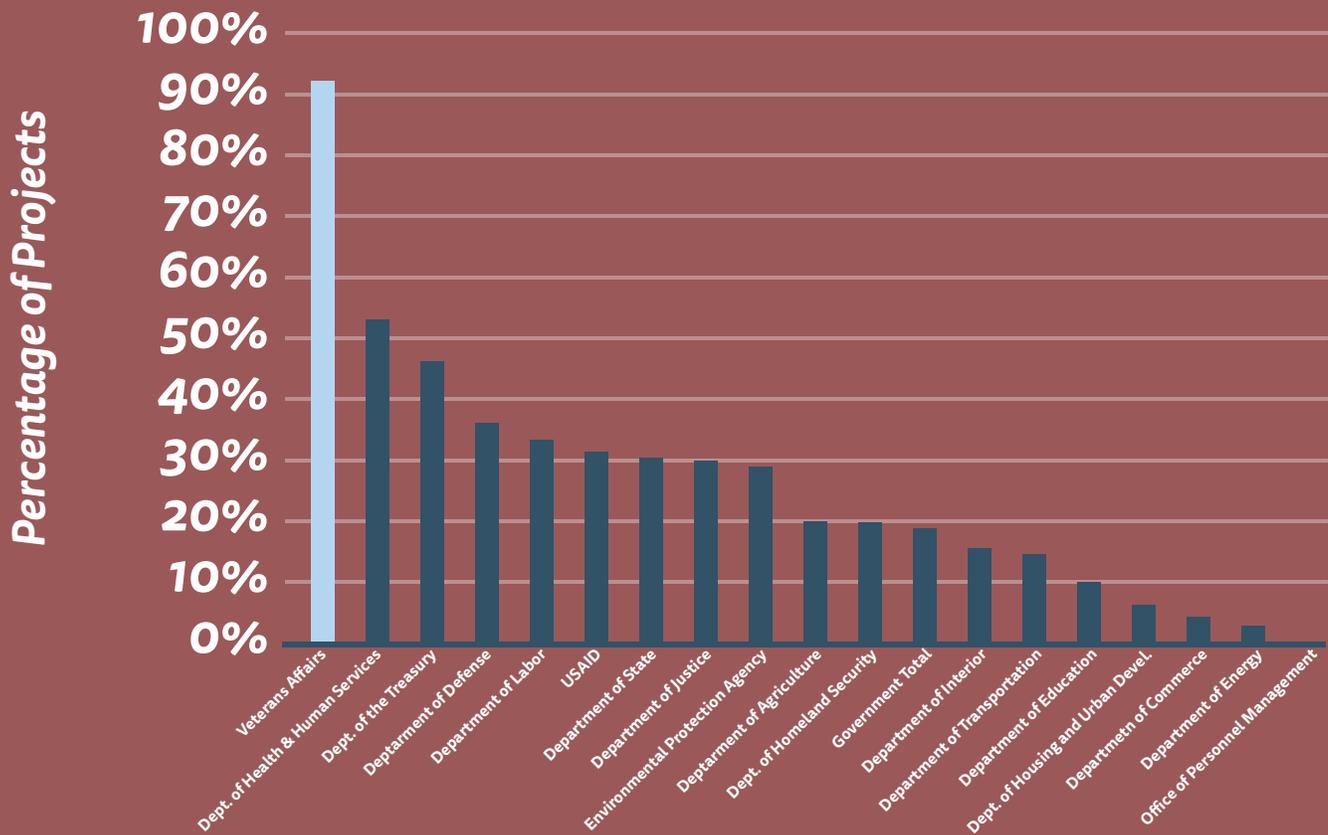
Despite this, the VA is also not training employees well enough to utilize the IT scheduling systems that are available to them. 70 percent of VA facilities do not use the standard scheduling software system.[762]

The VA has spent over $300 million[763] on its Veterans Benefits Management System (VBMS) paperless claims processing system, which it calls the "cornerstone of VA's technology information strategy,"[764] and the VA claims it will be the key to reducing the Department's backlog on disability benefits claims. The system has been deployed to all VA regional offices, but it has been dogged by performance issues such as latency problems and "spontaneous system shutdowns."[765] In January of this year, the system was shut down and users were directed to resume processing claims in legacy systems because of an interruption in service caused by a java script issue.[766]

The VA continues to suffer information security challenges. Both the VA OIG and the GAO have cited weakness in VA's information security controls, and GAO has reported that VA had a higher number of incidents than any of the 23 other major federal agencies between 2007 and 2009.[767] The VA has also recently suffered high profile security violations and data breaches. In March 2013, the VA OIG reported that it had substantiated an allegation that sensitive data, including veteran's Personally Identifiable Information (PII), electronic health records, and internal IP addresses, had been transferred between VA facilities over an unencrypted network.[768] Additionally, the unprotected internal router information left the VA vulnerable to hackers, putting its mission-critical systems at risk of disruption. During a software update in January of this year, the VA's eBenefits portal, the website where veterans and VA beneficiaries apply for benefits and monitor their status, comingled user data and routed users to accounts other than their own, compromising sensitive information.

> **"If anywhere in the private sector had these change rates, they would fire the people responsible."**

Percentage of Projects Rebaselined - By Agency

Percentage of Projects

Bar chart showing percentage of projects rebaselined by agency, with values from 100% down to 0%:

- Veterans Affairs: ~92%
- Dept. of Health & Human Services: ~53%
- Dept. of the Treasury: ~46%
- Deptartment of Defense: ~36%
- Department of Labor: ~33%
- USAID: ~31%
- Department of State: ~30%
- Department of Justice: ~30%
- Environmental Protection Agency: ~29%
- Deptartment of Agriculture: ~20%
- Dept. of Homeland Security: ~20%
- Government Total: ~19%
- Department of Interior: ~15%
- Department of Transportation: ~14%
- Department of Education: ~10%
- Dept. of Housing and Urban Devel.: ~6%
- Departmetn of Commerce: ~4%
- Department of Energy: ~2%
- Office of Personnel Management: ~0%

VA Pays Department Employees Millions to Perform Union Duties

Many VA employees spend their days not caring for veterans, but rather themselves. "Official time" is a statutory entitlement under the Federal Service Labor-Management Relations Act for certain federal employees that allows paid time off for government workers from assigned governmental duties in order to represent a union or its bargaining unit employees.[769] Because there is no law or regulation requiring agencies to report how much time federal employees who are union members spend on union duties while they are simultaneously being paid by the federal government, it is highly susceptible to abuse.[770] Although agencies that employ official time have a responsibility to ensure it is authorized and only used in appropriate situations, taxpayers end up paying for government employees to do work unrelated to the government jobs they were hired to do.

At the VA, any bargaining unit employee is eligible to become a union representative acting pursuant to official time without going through competitive hiring practices.[771] This includes Department physicians, police officers, and electricians, among others.[772] When an employee at the VA is on 100 percent official time, the Department usually hires another employee to perform that person's duties.[773]

While union representatives on 100 percent official time are not eligible for performance bonuses or promotions, they are entitled to the statutory pay-grade increases and other government benefits all federal employees on the General Schedule receive.[774] In addition, most of these official time employees perform their union duties full-time from VA offices.

At one point, the Department employed 85 nurses who were in 100 percent official time status.[775] At the very same time, the Department recruited more nurses on USAJobs.com.[776] Last year, in a letter from my office to the VA, I asked "to know how so many employees can be spared to serve the interest of outside groups, instead of carrying out jobs that are essential to the health, safety and transition of our nation's veterans."[777] This inquiry was motivated by the discovery that in a one-year period, 188 VA employees were paid full-time salaries to do union-related work.[778]

As of February 2013, there were 277 VA employees performing as union representatives on 100 percent official time.[779] In 2011, the VA spent $42,565,000 in costs related to maintaining official time employees (this number includes payroll costs, salary, and benefits).[780]

While legal, it is clear that the VA endures significant costs to fund employees on 100 percent official time along with the employees they hire to replace them. Given the hundreds of thousands of veterans that continue to suffer due to delays, insufficient staffing, and widespread mismanagement, official time costs could be better spent elsewhere.

Overlap and Duplication of VA Programs

UNNECESSARY DUPLICATION OR OVERLAP occurs in the federal government when two or more agencies or programs are engaged in the same activity, or provide the same services, to the same beneficiaries.[781] Essentially, taxpayers are paying two to three times more than necessary for a single program or service. Eliminating or consolidating duplicative programs government-wide will not only save money, but also increase the efficiency and effectiveness of government services. Opportunities to reduce the cost of government operations exist at the VA, and many of the Department's programs often duplicate other federal, state, and local programs that provide services to veterans.

1. VA Pays Out Improper Pensions, Could Save $4 Million Annually

The GAO recently found that the VA could save $4 million each year by restructuring the survivor benefits pension program.[782] The VA pension program is meant to provide increased benefits to the poor. GAO discovered, however, that some veterans applying for pension benefits transfer their assets below fair market value before submitting an application.[783] As a result, the VA is paying out pensions to certain individuals with high incomes, when the program is intended to help low-income

veterans.[784] Because of this overlap and unnecessary spending, GAO recommended this program be reassessed to ensure that only those in financial need receive benefits and to align it more closely with other federal programs for low-income individuals.[785]

There are other areas the VA should review to ensure the agency is not spending taxpayer money on services that are readily available elsewhere. For example, VA's 2013 budget included $1.4 billion for programs for homeless veterans.[786] These programs include, but are not limited to: National Call and Drop-in Centers, Grant and Per Diem Program, Healthcare for Homeless Veterans (HCHV), VA Assistance to Stand Downs, Compensated Work Therapy, VBA-VHA Special Outreach and Benefits Assistance, Supported Housing, and VA Excess Property for Homeless Veterans Initiative – just to name a few.[787]

Spending towards combating homelessness continues to rise dramatically at the VA, and many of the Department's programs may duplicate other federal, state, and local initiatives designed to help homeless veterans get back on their feet when they return from service.

One of the biggest duplication issues facing the VA is dual enrollment in health care services. A recent study found the federal government spends a considerable amount of money on two separate health care programs to treat the same individuals. Specifically, duplicative costs amounted to $13 billion between 2004 and 2009 for veterans who were enrolled in Medicare Advantage plans and also used the VA for services.[788] Dual enrollment in the VA Health Care System and Medicare can

create a problem because the enrollment plans assume covered individuals are not covered elsewhere. "If enrollees in [Medicare] plans simultaneously receive Medicare-covered services from another federally-funded hospital or other health care facility, and this facility cannot be reimbursed, then the government has made 2 payments for the same service."[789] This creates the potential for unnecessary duplication.

2. Federal Government Spends Billions on Job Training Programs for Veterans, Many of Which Are Overlapping, Duplicative, and Ineffective

As the wars in Iraq and Afghanistan wind down, there are more young veterans returning home than ever. Over 2.6 million American troops have served and fought in the longest war in history.[790] To assist these heroes adjust back to civilian life, there are also more employment programs for veterans than ever.[791] In the private sector, there is Hero2Hired, Hire a Hero, Hire Heroes USA, Operation Hire Our Heroes, Hire America's Heroes, just to name a few.[792]

The federal government also sponsors and provides funding ($1.2 billion in 2011) for six veteran job training programs – the Department of Labor (DOL) administers five of these programs and the VA administers one.[793] Despite these efforts, due to a lack of program metrics, many veterans are frustrated with how difficult it is for them to find work when their service expires, and unemployment rates among veterans remain high.[794] The Bureau of Labor Statistics reported a nine percent unemployment rate for veterans in 2013.[795] This represents a decreased from 9.9 percent the year before, but it is still "well above overall civilian unemployment levels of around 7 percent over the same period."[796]

In 2012, GAO found some of these programs overlap with other veterans' programs and civilian employment programs.[797] Specifically, the DOL's Disabled Veterans' Outreach Program is most likely to overlap with other federal employment programs.[798] This program seeks to prioritize employment services for the veterans who need them most.[799] However, the audit found the DOL did not provide much guidance on how to prioritize veterans, nor does the program adequately monitor states' implementation of the employment services.[800]

As a whole, GAO concluded employment and training programs for veterans need to be more transparent in order to effectively measure their potential for success rates.[801] It is important that the government is committed to assisting veterans find gainful employment, but both the DOL and the VA must implement metrics to determine which programs are working, which programs are not working, and which programs can be consolidated government-wide to save taxpayer funds and better serve veterans.[802]

> " It is important the government is committed to assisting veterans find gainful employment... "

Improper Payments

THE OFFICE OF MANAGEMENT AND BUDGET (OMB) defines an improper payment as "any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements."[803] The OMB mandates that each federal agency's OIG review improper payment reporting to determine if an agency complies with the Improper Payments Elimination and Recovery Act – also known as IPERA.[804]

1. VA Wastes $2.2 Billion in Mistaken Payments in 2012

The VA is well-known for mismanaging the very large amount of money it receives from the federal government each year. In 2013, the Department made $2.2 billion in improper payments because it did not comply with four of seven IPERA requirements and reported approximately.[805] Specifically, the VHA did not report gross improper payment rates less than ten percent for all reportable programs and did not meet a

reduction target for one of its program.[806] Additionally, the Veterans Benefits Administration (VBA) did not use valid methodologies to calculate improper payment estimates and did not report recapture amounts for VBA programs.[807]

Unfortunately, this meant less money was available to serve veterans in 2012, "many who remain languishing in the system awaiting help on everything from medical care to education and job training."[808] For example, the Department's IG reported for "unexplained reasons," VA medical facilities paid approximately $42.5 million more in beneficiary travel than the facilities approved.[809] The IG also found certain benefit program methodologies "were not statistically valid" to catch improper payments before the money was spent.[810]

Of the $2.2 billion lost, the VA was only able to recover $18.6 million – less than one percent – after the money was spent.[811] In response to the IG's investigation, the VA vows it has taken the agency's erroneous payment problem seriously.[812] However, VA has also acknowledged it "remains years away from getting a handle on the core problems that have plagued its payment systems."[813]

2. VA Missed Opportunities to Bring In Third-Party Revenue of $152 Million Annually

In 2012, the VA OIG conducted an audit of the VHA's Medical Care Collections Fund Program.[814] While the audit found that VHA had improved in its collection of funds from third-party insurers, it continued to miss many opportunities to be more efficient.[815] Specifically, the VHA did not adequately implement policies to identify and monitor patients who held third-party insurance, and opportunities to increase third-party revenue by at least $152 million over the course of one year were missed.[816] This amounts $760 million over a five-year period.[817]

The IG identified examples instances of poor VHA oversight in 2004, 2008, and 2011, each year enabling some companies to benefit at the expense of veterans.[818] In 2011, the IG discovered VHA was not billing private insurers 46 percent of the time when health care costs should have been covered by third parties.[819] VHA has said it is committed to improving billing practices to more consistently identify veterans who carry third-party insurance. Progress has been made – third-party revenue collections increased from $1.3 billion in 2007 to $1.8 billion in 2011.[820]

The DoubleTree Paradise Valley Resort in Scottsdale, Arizona, site of an 11-day conference for over 40 VA employees.

Millions Spent on Employee Travel and Lavish Conferences

1. VA Spends Millions on Employee Conferences at Luxurious Resorts

The VA's track record of extravagant spending for lavish conferences has put the agency under scrutiny for years. While veterans suffer waiting to receive medical care, benefits, and other services, VA employees are squandering funds appropriated to the Department. In 2011, the Department spent over $220,000 on an 11-day conference VA employees at a Scottsdale, Arizona resort.[821] Travel costs to fly more than 40 people to the Doubletree Paradise Valley Resort exceeded $90,000, lodging costs reached about $30,000 and the contractor who organized the event was paid close to $100,000.[822]

Two more conferences the same year prompted the IG and Congress to get involved. The IG released a report highlighting two 2011 training conferences in Orlando, costing a combined $6.1 million, with at least $762,000 wasted.[823] At the Orlando conferences, located at the Orlando World Center Marriott, VA officials in charge of the events were unable to substantiate some of the costs.[824] Even further, the Department's "accounting and spending controls [were] so lax that investigators couldn't determine the total cost of the events."[825]

Questionable purchases for the conferences included karaoke machines and artisan cheese displays, $184,000 worth of breakfast sandwiches (as employees simultaneously received reimbursed for all meals), $16,500 for the production of "happy face" videos featuring daily recaps of conference events (an expense that was "improperly authorized"),[826] close to $100,000 worth of promotional favors (such as water bottles and notebooks), and around $50,000 for the production of a video parody.[827] The VA hired a professional actor and production company to make the video, a parody which featured a take on the opening sequence in the movie "Patton."[828]

John Sepulveda, the former human capital executive in charge of the conferences, lied when asked if he knew about the production of the expensive videos.[829] He claimed he had no knowledge of the videos, but VA officials and records confirmed Sepulveda previewed the videos during conference planning and he even "requested some minor changes he wanted made to the videos."[830] The IG confirmed Sepulveda lied "to protect himself from fallout from the conference scandal."[831] He resigned one day before the IG released its report.[832]

> **Given this higher-than-average population of hungry veterans, it raises question as to whether the Department is feeding the right people.**

While VA employees are lining up in buffet lines at conferences in luxury hotels, more than one in four veterans who served in Iraq and Afghanistan are going hungry. A recent study conducted by the University of Minnesota and the Minneapolis Department of Veterans Affairs surveyed 922 United States veterans and shockingly discovered that 27 percent reported they were not able to feed themselves three times a day.[833] This number is "drastically higher" than the 14.5 percent national average.[834] Given this higher-than-average population of hungry veterans, it raises question as to whether the Department is feeding the right people.

The House Veterans' Affairs Committee charged that the VA "conference planners spent taxpayer dollars recklessly and unapologetically."[835] They focused on the Committee's year-long investigation on wasteful conference planning practices at the VA and confirmed the IG's findings of waste and mismanagement. The former VA official who oversaw the conferences refused to testify at the hearing.[836] The Committee,
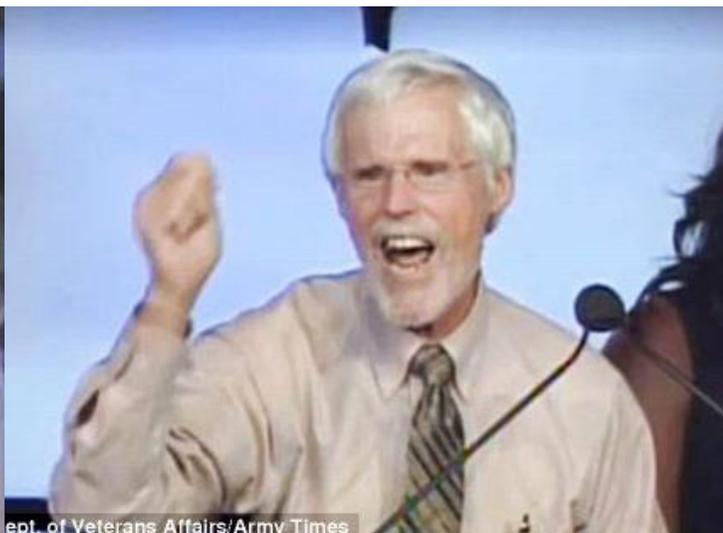
The Orlando World Center Marriott, home of the VA conference featuring breakfast sandwiches, reimbursed meals, karaoke, promotional favors, and a $50,000 video parody.

Attendees of the VA conference in Orlando enjoy themselves while dancing to the electric slide.

An emcee at the VA conference in Orlando pumps up the attendees. "Is this the BEST CONFERENCE EVER?!"

These images illustrate the striking disconnect of VA priorities. While many veterans are homeless and hungry, the Department is sending its employees to conferences, spending hundreds of thousands of dollars to treat attendees to breakfast buffets and other sumptuous meals.

however, was steadfast in its contention that VA is not spending taxpayer dollars properly by adding a host of concerns to the IG's report. VA planners made multiple scouting trips and enjoyed perks such as meals, spa visits, and limo and helicopter rides from the hotels.[837] Even more concerning, the Committee discovered that the agency actually awarded these planners for taking "actions to minimize conference costs" with cash bonuses and time off.[838]

The IG offered 49 recommendations in their report investigating the Orlando conferences, yet reported later that the agency had yet to implement over half of them.[839] Additionally, when news of the conferences' overindulgences began to leak to the press, VA officials attempted to hide photos taken at the events.[840] This type of management is failing our nation's veterans, and the VA must increase its oversight and accountability practices to ensure money is not so carelessly wasted in the future. VA employees should report for duty at their desks to ensure veterans' services are being delivered, rather than run off to unnecessary and extravagant conferences.

2. VA Improperly Pays for Employee's Travel Commute from Arkansas to Washington, D.C.

In 2010, Charles Gephart, the director of IT field security operations at the VA's Office of Information continued to live in Arkansas after he was promoted to a higher-paying job in Washington, D.C.[841] This enabled Mr. Gephart to collect a higher locality pay while simultaneously receiving thousands of dollars to pay for his travel expenses.[842]

According to the IG, the "VA does not have the authority to pay Mr. Gephart the Washington, D.C. locality rate of pay and also reimburse him for travel expenses to commute to and from his assigned duty station in Washington, D.C."[843] Because the VA allowed Mr. Gephart to travel on the Department's dime instead having him telecommute, he collected more than $41,000 in improper wages. He retired before the VA took any action to recover the costs.[844]

3. Senior VA Official Bills Federal Government More Than $130,000 For Weekly Commute, Hotel Stays, and Meals in Washington to Avoid Relocating

In 2010, the VA spent $80 million on travel-related expenses for its employees.[845] VA spending on employee travel was brought to light in 2011 when the IG revealed that a senior VA administrator billed the federal government more than $130,000 for his weekly commute to Washington.[846] The VA not only paid for the official's weekly commute, but it also picked up hotel and meal expenses so the individual would not have to relocate.[847] The Department said paying for the employee's commuting tab was necessary, and it felt his presence in D.C. was essential to "ensure continuity of operations [for his position]."[848]

According to the IG, the VA could have forced this employee to move to D.C. to continue his job, and "a permanent change of station would have been a one-time expenditure, whereas, frequent travel costs to Washington, DC, have been ongoing for over 3 years and continuing indefinitely."[849] Instead, the Department misused its authority to pay for travel costs.

4. VA Spends Almost $2 Million in Questioned Costs on Items for Training Conferences

In 2010 and 2011, the VA spent $15.5 million on financial management training conferences alone.[850] In 2013, the IG investigated these expenditures, finding the VA relied on OPM to complete these purchases through an interagency agreement without monitoring the conference-related purchases.[851] The VA's failure to supervise OPM's spending resulted in $1.1 million that could have been better spent and close to another $1 million in questioned costs.[852]

Renovations and Office Equipment Excesses

1. VA Spends Millions on Historic Preservation Renovations

The VA is planning to spend between two and five million dollars to renovate a 250 year-old vacant building to use for conference and office space by the Perry Point VA Medical Center in Maryland.[853] The historic Perry Point Mansion House and Grist Mill will be acquired as part of this renovation. The Perry Point structures have been owned by the United States government since 1918, and were listed on the National Register of Historic Places in 1975.[854] The mansion and mill "serve as fine reminders of a past era."[855] As part of its renovations, the VA plans to install a new water wheel on the exterior of the building, which will "mimic, as closely as possible, the original."[856]

While it is laudable the VA is committed to historic preservation, ensuring higher quality care for veterans does not involve spending money on decorative water wheels.

2. VA Spends Over $500,000 on Artwork and Photographs to Decorate Its Facilities

In 2013, the VA purchased $562,000 worth of artwork to decorate various agency facilities.[857] A VA spokesperson described the art as "motivational and calming, professionally designed to enhance clinical operations."[858] With the purchase of the artwork, the VA was guilty of succumbing to the "use it or lose it" notion that the agency must spend any remaining funds left in their budget at the end of the fiscal year.[859] The system of appropriations set up by Congress requires federal agencies to spend all their apportioned funds by September 30, the end of the federal fiscal year; if they fail to do so, the money becomes worthless to them.

The VA plans to spend millions to renovate the Grist Mill as part of the Perry Point VA Medical Center in Maryland.

While it is laudable the VA is committed to historic preservation, ensuring higher quality care for veterans does not involve spending money on decorative water wheels.

Construction Woes

1. VA Construction Projects Are Overwhelmingly Behind Schedule, Billions Over Budget

In 2013, VA's construction program came under fire amid reports of widespread delays and excessive costs. GAO scrutinized four of the VA's largest medical-facility construction projects in Las Vegas, Orlando, Denver and New Orleans.[860] All four projects ended up costing significantly more than projected, accounting for combined cost overruns of nearly $1.5 billion.[861] Scheduling delays for the four projects ranged from 14 to 74 months.[862] On average, each VA medical facility construction project is 35 months late and $360 million over budget.[863]

The construction of a regional VA hospital in Aurora, Colorado offers a glaring example of how painstaking and expensive the process to build one hospital can be. Originally scheduled for opening in February 2012, the latest opening date is now May 2015.[864] The original plan was to integrate a veterans' care facility into the top floors of the University of Colorado in Denver.[865] Initial costs were projected to be between $185 and $200 million, which eventually rose to $328 million.[866] However, hindered by setbacks and disagreements regarding cost savings versus the potential staggering costs involved in building a brand new facility, Congress instead approved construction of a stand-alone facility that would cost an estimated $800 million.[867] As such, costs to construct

the Denver facility increased by 144 percent since the project's origin.[868]

These construction setbacks do not only impact the VA's budget.[869] Contracting snafus and under-budgeting also end up hurting veterans themselves, many of whom cannot physically afford to wait for health care from the medical centers that are not open because of scheduling delays.[870] The VA is involved in approximately 50 major construction projects, and the Department must take actions to improve internal management processes to avoid cost increases and delays associated with these projects.[871]

2. Recently Completed $1 Billion VA Medical Center in Nevada Instantly Requires Millions in Improvements

Some VA construction woes linger even after buildings are completed. The VA's highly-anticipated "new, state-of-the-art" medical center in North Las Vegas opened in August 2012, after eight years and hundreds of millions in the making.[872] The hospital, which was initially reported as costing only $600 million,[873] offered some long-awaited relief for many Nevada veterans who had to travel long distances to receive VA treatment.[874] However, a short year and a half after opening its doors, the Nevada hospital is already facing new challenges.

Specifically, after spending close to $1 billion to construct the new medical center, the VA is now paying an additional $16 million to expand the emergency room.[875] VA officials realized during construction that the original ER was too small and lacked an ambulance drop-off ramp.[876] Additionally, many patients have come forward with complaints of long waits and poor experiences.

While some have dismissed the hospital's difficulties as "growing pains," forcing veterans to wait for quality care and spending millions to repair a brand-new building indicate do not represent such minor glitches.[877] The struggling hospital is also located in Nevada – the state with the largest veteran disability claims backlog in the United States.[878]

3. VA Proposes Construction of New Medical Clinic in Tulsa, Oklahoma Despite Declining Number of Area Veterans

Since 2000, the VA has created two veterans Community Based Outpatient Clinics (CBOCs) in the Tulsa area.[879] Now, supporters want to replace the leases on these facilities with a new 190,000 square foot facility, despite a declining number of veterans in the area.[880]

Instead of spending millions more on a new facility that is not guaranteed to enhance veterans care – and would almost take five years to complete[881] – many think spending on doctors and primary health care choices for veterans is a better investment. "Perhaps it would be better to spend the 13 million on the badly needed medical care for the veterans rather than on buildings. Many of our vets need medical care now and cannot afford to wait for years while new facilities are being constructed," according to an online Tulsa World reader comment, responding to a story about the proposed expansion.[882]

One of the current Tulsa clinics even has a Starbucks built into it, according to Tulsa World.[883] Some veterans find the addition of the trendy coffee house to be unnecessary, and the money used to fund it should instead be spent on efforts to directly help veterans receive more timely and quality medical care.[884] "I don't see how that is a benefit to the veteran," says Danny Dill, a 64 year-old Purple Heart veteran who is 100 percent disabled and suffers from post-traumatic stress disorder.[885] "Most of us don't drink Starbucks. We're not that fancy."[886]

The Administration has requested $13.27 million for the replacement clinic.[887] This is part of the $288 million in new leases that the VA is seeking authorization from Congress this year.[888] The total lifecycle cost of the new facility is $833 million, which is more than $150 million than the current two facilities.[889]

The 21 physicians that work at the Tulsa VA medical facilities receive a combined $3.8 million in salaries, according to federal employment salary data from 2013.[890]

4. VA Engages in Suspect Leasing Practices

The VA may be wasting hundreds of millions of dollars due to its decisions to lease many of its clinics and health centers rather than acquire land and build federal facilities. In many cases, the VA pays more in rent than the appraised value of the buildings and land are even worth. Even a small amount of waste in the way VA has contracted for each facility could easily mean over a billion dollars in taxpayer dollars lost that could have paid for veterans' essential medical care. The VA is one of the largest property owners of any federal agency. The VA has almost 2,000 leases, almost double what the department had in 2004.[891] Most of the leases are for health care facilities and together have liabilities of $5.5 billion.[892]

In Savannah, Georgia, for example, the VA has been leasing a 34,760 square foot space since 1991, and now pays $1.1 million a year for that space, with an annual increase to account for inflation.[893][894] The assessed value of the property is under $4 million, according to county records.[895] After leasing the facility for 20 years, the VA may have wasted over $10 million compared to what it may have cost to buy the facility (or a similar one) originally.

Dubious cost-effectiveness pervades the leases of other existing VA clinics as well:

- In Tulsa, Oklahoma, the VA paid a private developer $5 million in 2006 for nine years' rent, for a facility whose market value was most recently determined by the county assessor to be just $5.2 million (for both the land and the building).[896][897] The VA can extend the lease over five years through 2020, making the potential waste from this lease higher by millions of dollars.[898]

- In Gilbert, Arizona, the department is leasing a brand-new outpatient clinic for an annual rent of $1.95 million (and is subject to increase because of inflation).[899] Yet, the building and land was recently sold from one developer to another for $29.5 million. Over 20 years, the VA may waste at least $10 million compared to the cost of buying both land and building its own facility. The department could have broke even on its investment after 14 years.

- In Billings, Montana, the combined construction costs and land value of a new VA clinic were under $7 million.[900][901] But the VA is set to repay the developers more than five-fold what they invested in the project. The department will pay $1.8 million in annual rent for 20 years.[902] Owning the facility would have saved the department money after just 3-4 years.

- In McAllen, Texas, developers may reap twice their investment in a new outpatient clinic as the VA rents the facility for 20 years. Construction costs were reported at $20 million, and the market value of the building and land acquisition is now assessed at $9 million.[903][904] The VA will pay an annual rent of $2.0 million for 20 years, a potential waste of at least $20 million compared to owning over the same time period.

- *In Wilmington, North Carolina, one clinic could yield an ROI as high as 100 percent for its property owners. Total cost for to build and design the clinic was $25 million, and the VA will pay an annual rent of $3.2 million over 20 years.[905] [906]*

- *In Huntsville, Alabama, a new outpatient clinic will cost private developers about $15 million to build, but the VA will pay $1.9 million a year for at least 20 years to rent the space.[907] [908]*

VA leases may not only be overpriced, but almost always cost more and take longer to implement than VA reports to Congress. Of the department's 41 ongoing projects to lease outpatient facilities, 39 are behind schedule by an average of 3.3 years. VA only has complete cost data for 31 of the ongoing projects, and costs have increased for all of them compared to what VA originally reported to Congress.[909] For these 31 projects alone, the estimated annual rent increased a total of $690 million over 20 years from what VA told Congress the clinics would cost.[910]

These increased costs stem from incomplete information provided to Congress early in the process. VA officials do not develop detailed space requirements for the leases before submitting proposals to Congress for authorization.[911] Later in the process, the VA has often expanded the scope for each project, delaying the process and adding to the price tag.[912] For example, for the 31 projects with complete data, total size increased by 203,000 square feet after Congress approved the projects for different specifications.[913] The VA decided to build bigger facilities than were originally intended by Congress.

The VA received authorization in 2011 from Congress to seek a new lease in Savannah to replace the old one. Authority was granted in October 2008 for a $3.2 million clinic with 38,900 net usable square feet and an annual rent of over a million dollars.[914] However, after Congress authorized the 38,900 clinic, the VA expanded the project without notifying Congress or seeking additional authorization, seeking to lease a clinic with net usable square feet of 55,193.[915] VA's FY 2013 budget included the same authorization amount and the same net usable square feet, when in reality the VA was moving forward with a very different proposal.[916] In 2012, the House Committee on Veterans' Affairs questioned VA's construction contracting practices, contending that the Department was "exceeding the size and scope of requested authorizations, conducting haphazard due diligence, and not being forthcoming about its actions to Congress."[917] Years after the Congressional authorization, the department has still not moved forward with a new clinic.

VA management has essentially left its employees to figure out the leasing process for themselves. VA's guidance to instruct employees on how to manage the lease process is completely outdated, according to analysis from GAO.[918] "This guidance is so out of date that it no longer adequately reflects the roles and responsibilities of the various VA organizations involved in major medical facilities leasing projects…The policy, planning criteria, and business plan format were developed based on an old planning methodology that VA no longer uses," found GAO.[919]

> **"…the Department was 'exceeding the size and scope of requested authorizations, conducting haphazard due diligence, and not being forthcoming about its actions to Congress.'"**

When recommending to Congress that it proceed with leases rather the new construction of a federally owned facility, the VA appears to have a practice of inflating the cost of land acquisition and construction as much as possible. For example, in its FY2015 budget submission, the VA requested authorization to move forward with a new 20-year lease in Tulsa, Oklahoma, for an outpatient clinic.[920] The annual rent for the new facility was estimated to be about $5.6 million – over $100 million for the duration of the lease. Constructing and owning its own building, VA projected, would require about $1,000 per square foot for a 140,000 square foot facility. VA used a similar estimate when recommending not to build its own facilities in Tyler, Texas; West Haven, Connecticut; Worcester, Massachusetts, and nearly all other locations.

Yet, medical construction nationwide is rarely so expensive, leaving much to question about the VA's consistent recommendation to lease. A regularly updated commercial medical construction estimator places costs around $300 per square foot.[921] Indeed, even VA's own construction office has found average costs for construction of outpatient clinics is under $300 in much of the nation.[922] Using these more

realistic numbers in the VA's congressional budget submission would make construction a more favorable option, and raise significant questions about the VA's congressional submissions.

The leasing process at the VA needs a top-to-bottom examination and should be rebooted with appropriate controls and practices that actually lead to right-sized facilities that are delivered on schedule and in line with congressional authorizations.

Unneeded and Unused Properties

1. *VA Pays For the Upkeep of Abandoned and Vacant Properties – Including a Pink Monkey House*

The VA has not been particularly economical in its management of federal real property. Federal real property is real property owned and leased by the federal government, and includes over 900,000 buildings and structures with a combined area of over 3 billion square feet.[923] The VA is one of the largest federal property holding agencies, and VA maintains thousands of buildings throughout the country.[924] Many of these buildings are empty, unused, or too rundown to utilize – some of them are even considered to be health hazards.[925] Despite this, the VA continues to shell out millions of dollars to maintain these abandoned and dilapidated buildings, including a pink octagonal monkey house in Dayton, Ohio.[926]

GAO estimated the Department spends approximately $175 million a year to sustain these vacant properties.[927] While demolishing or refurbishing the buildings may be expensive,

using taxpayer dollars to fund abandoned properties – which have become home to rats, vermin, bird nests, and exposed asbestos – is not a smart use of VA's resources.[928]

However, recent data indicates the VA continues to spend significant amounts of money on underutilized and abandoned federal property. In 2013, VA estimates it spent approximately $20.2 million on 922 vacant and underutilized properties.[929]

"Once upon a time, this pink, octagonal, 325-square-foot structure was used to house monkeys for the zoo on the grounds of the Dayton VA Medical Center in Ohio. The animals have long gone, but the VA is still paying to keep up the maintenance on this 1870 historic monkey house." [930]

2. *VA Spends $2.3 Million to Build Dormant Wind Turbine*

In December 2009, the VA excitedly announced the Department would be installing a series of renewable energy systems at the VA Medical Center in St. Cloud, Minnesota.[931] This project included construction of a 600-kilowatt wind turbine with the purpose of providing up to 16 percent of the facility's electricity.[932]

Five years later, all that remains of the wind turbine project is a 245-foot structure that has been inoperable for a year and a half. While there were initial attempts to fix the malfunctioning turbine, the repairs failed, with no further action to fix it.[933]

The VA spent $2.3 million of federal stimulus funds to construct this 245-foot wind turbine at a St. Cloud, MN VA medical facility. Due to poor planning and unsuccessful attempts at repairs, the now-defective structure stands dormant and inoperable, with nothing being done to fix it.[934]

> " **While some believe that more money is needed for this to happen, the VA has enough money to institute a much-needed Department-wide culture change.** "

ACTION MUST BE TAKEN TO REFORM VA HEALTH CARE AND PROVIDE QUALITY, TIMELY CARE TO VETERANS

MEN AND WOMEN WHO SERVED our country have unique medical needs, especially those living with the physical and mental scars earned on the battlefield. Our nation made a commitment to provide that care. As "the largest integrated health care system in the U.S.," the VA works to fulfill much of that promise to millions of veterans.[935]

While recent headlines have unmasked some of the VA's shortcomings that have long existed, many employees at the Department are outstanding public servants committed to our nation's wounded warriors and tending to their needs.

But even with 152 hospitals, 820 community-based outpatient clinics, and 126 nursing homes staffed by VA doctors and nurses,[936] the Department has been unable to ensure timely access to quality care for thousands of veterans, which has resulted in the unnecessary and untimely deaths of too many.

The average wait time for a patient in the U.S. to see a physician is about 18.5 days, according to a survey of physician practices taken in 15 areas of the country last year.[937] This wait time has declined over the past decade from 20.9 days in 2004.[938]

It is impossible to know for sure how long most veterans have to wait to see a doctor, because the VA has cooked the books to cover up true size and scope of the backlog in dozens of its facilities. A GAO review concluded, "It is unclear how long veterans are waiting to receive care in VA's medical facilities because the reported data are unreliable."[939]

"Inappropriate scheduling practices are a systemic problem nationwide" within VA facilities, according to a recent review by the VA OIG.[940] This has been a widely documented for many years – at least 21 IG and GAO reports have been issued over the past 13 years that highlight internal scheduling issues.[941] Six years ago, for example, the OIG "reported that the problems and the causes associated with scheduling, wait times, and wait lists, are systemic throughout VHA."[942] Why has it taken over a decade for people to pay attention to such a widespread, heavily documented problem?

A significant part of the problem is that many veterans are locked into a system with a finite number of doctors and facilities. These patients not only have to wait long periods to see a doctor, but in many cases have to travel long distances to get to those doctors. This is not only inconvenient and onerous on the patient, but in some cases, these delays meant the difference between life and death.

While the VA runs its own system of doctors and health care centers, other government run health care programs like TRICARE and Medicare allow beneficiaries to choose among private health providers and institutions. And the federal health plans for members of Congress and federal employees allow each beneficiary to annually choose from a range of private health insurance plans.

Ironically, the individuals who protect our nation's freedom are not given the freedom to choose their own health

care. The VA is the most restrictive federal health insurance program, with the least flexibility for patients to make their own choice in doctors.

The VA's VHA does have the authority to allow veterans to go outside of its network. Yet, the VA—as evidenced by the long waiting times—is not leveraging this option enough to reduce backlogs and expedite care for veterans. Last year, the VHA spent less than ten percent of its budget for medical care at non-VA hospitals and clinics.[943]

The VA ends every year with hundreds of millions of dollar in untapped funds intended for medical care that can be utilized to provide better medical options for veterans. The VA will move $450 million in medical-care unobligated balances from fiscal year 2014 to fiscal year 2015.[944] This is the fifth year in a row that the VA has carried over funding for medical care.[945]

Giving veterans a choice of doctors is not a radical concept. In fact, "the majority of veterans' care is received external to the VHA because of location and other system limitations," according to a study by the RAND Corporation.[946] While some of this care is covered by the VA, it is largely a result of veterans having other types of public or private coverage. "Nearly all elderly (age 65+) veterans have Medicare coverage, and a majority of younger veterans (more than 75 percent) also have coverage options other than the VHA system," and "those percentages are expected to rise further."[947] Many veterans utilized both options, and this

"overlapping system use creates the potential for duplicative, uncoordinated, and inefficient use."[948]

Additionally, some veterans have been receiving care at private health systems "in remote parts of Arizona, Kansas, Maine, Montana, and Virginia" under a pilot project begun in 2011 that is "set to expire later this year."[949]

Same-day primary care and other medical services will be available to veterans in southern New Jersey beginning July 1, 2014 as part of a "VIP" initiative being launched by Cooper University Health Care.[950] Currently, new VA patients in New Jersey must wait more than three weeks for a primary care appointment.[951] "Cooper board Chairman George E. Norcross III said veterans deserve to be first in line for treatment. Dedicated navigators will coordinate care and request reimbursement from the VA, Medicare, Medicaid or private insurers.[952]" This may be "the first program in the country to guarantee same-day primary care."[953]

Younger veterans are more reliant on the VA for medical service. Yet, they only "obtain about 25-33 percent of their inpatient care through the VHA system, while older veterans obtain only about 10 percent of their inpatient care through the VHA system."[954]

So, the question is not whether veterans should be allowed access to health care outside of the VA, as most already do. Rather, how can veterans care be better coordinated to ensure timely and appropriate access to affordable care?

The VA Cannot Hire Its Way Out of Its Shortage of Doctors

THE HEADLINE SAYS IT ALL: "Shiny, new VA hospital suffers from longtime Nevada malady: doctor shortages."[955] When the North Las Vegas Veterans Affairs Medical Center opened in 2012:

"[I]t was hailed by local and national leaders as a major step forward for delivering health care in the valley. The $600 million, 1-million-square-foot building, which is stocked with state-of-the-art technology and provides a centralized location for a variety of specialized clinics, is expected to improve the quality of care for veterans and will allow the VA to increase the number of Southern Nevada patients it serves by a third to 60,000. The only problem: There aren't enough doctors on staff to handle the influx of new patients. A doctor shortage has long been plagued Nevada, which consistently ranks near the bottom nationally in doctor-to-patient ratios. In 2011, the most recent figures available, Nevada had 171 physicians for every 100,000 of its residents."[956]

The completed medical center was originally reported to cost $600 million, but later reports indicate the actual cost was closer to $1 billion.[957]

The VA can construct state of the art medical facilities and has no shortage of patients to use them, but the doctors to care for them are lacking.

The VA faces a growing population of patients, both is size and diversity, as a result of the wars in Afghanistan and Iraq and aging veterans from the Vietnam War era. Realistically, no one can expect the VA to be able to hire enough doctors, nurses and providers to tend to all of the medical needs of America's veterans.

"In the past three years, primary-care appointments have leapt 50 percent while the department's staff of primary care doctors has grown by only 9 percent."[958]

There are 18,718 full time physicians employed by the VA.[959]

Demand for primary care appointments at the VA is increasing. In the past three years, primary care appointments have increased by 50 percent, but the Department's staff of primary care doctors has only increased by 9 percent.[960] Each primary care doctor is only supposed to be responsible for "about 1,200 patients each, but many now treat upward of 2,000."[961]

While the VA "is trying to fill 400 vacancies to add to its roster of primary care doctors, which last year numbered 5,100,"[962] the Department faces a shortage of more than just primary doctors.

Consider the growing need for mental health services. Of the veterans who left active duty in Iraq or Afghanistan, of those who used VA care, "48 percent were diagnosed with a mental health problem," according to the Department. This includes as many as 18 percent of veterans who served in Afghanistan and Iraq, who are "likely to have PTSD after they return."[963] These service members also are "at risk for other mental health problems. Although studies vary widely in terms of methods used, estimates of depression in returning troops range from 3 percent to 25 percent."[964]

To try to meet this need, "the number of mental health professionals the VA employs has gone up, from almost 14,000 in 2005 to well more than 21,000" in 2011.[965] That still was not enough. In August 2012, the President issued an Executive Order directing the VA to accomplish a goal of "recruiting, hiring, and placing 1,600 mental health professionals."[966]

Nearly two years later, the shortages persist. "At some VA medical centers, qualified mental health professionals, nursing staff and bed space are in such short supply that some mental health patients are discharged early."[967]

"The turnaround on patients has gotten faster – there's a lot of pressure to get them in and out and a lot of them aren't ready to leave," according to a VA psychiatric nurse, who noted "patients are sometimes discharged 'AMA' — against medical advice."[968]

"This senior nurse, a 23-year Army veteran who serves at a major VA medical center, said she had a mental health patient who was discharged without his medication, without a discharge plan and without transportation."[969]

"I just happened to find him sitting in our lobby with his stuff, with nowhere to go," the nurse said. "I sat with him three or four hours until his mother came."[970]

Even if the President's hiring goals "were achieved, meeting the full range of needs in this population necessarily involves both VHA and non-VHA institutions (including the DOD and community-based provider organizations)," concluded an analysis by RAND.[971]

Veterans who run into roadblocks when they are seeking care take differing approaches.

Some wait.

Max Gruzen, who has been rated 100 percent disabled by the VA, says "I'll pick up the phone in a heartbeat and call my senator and get what I need right away."[972]

A VA psychiatric nurse admitted to using her "VA employee identification to secure an appointment" with the VA. "Without that, I'd be waiting five, six months. I've seen that happen."[973]

Air Force veteran Marc Schenker said he had "given up on the Veterans Affairs hospital in Miami after waiting months to get the procedure scheduled and had turned to a private surgeon instead, using Medicare." [974]

Army veteran Claude D'Unger of Corpus Christi, Texas, said, "he had all but stopped seeking care at the department after he could not get a timely CT scan to check a nodule on his lung. After calling for an appointment and being told that he would have to wait at least two months, Mr. D'Unger

Max Gruzen, who has been rated 100 percent disabled, says when the VA is not responsive, "I'll pick up the phone in a heartbeat and call my senator and get what I need right away."[976] Veterans should not have to call Washington politicians or VA bureaucrats to be granted access to a doctor.

said, he contacted a private doctor who performed the scan the next day."[975]

Not all vets have these options or choices, but perhaps it is time that they do.

Richard Worsley of Grand Junction, Colorado, was experiencing symptoms of a heart attack and "he wanted to go to the VA Medical Center."[977] The Grand Junction VA Medical Center, however, "can't accept cardiac emergencies because it is a level two facility and doesn't have the proper resources."[978] He was instead sent to St. Mary's Hospital and Medical Center. Worsley later "received a bill for more than $8,000" because the VA "can't cover patient visits outside the VA when they aren't related to service ."[979]

Veterans like Worsley shouldn't be penalized for the inability of the VA to maintain an appropriate mix of medical providers, especially when a patient is experiencing an emergency that could be life-threatening. There are over 5,000 hospitals in the U.S., yet there are only 152 VA hospitals.[980] Part of the solution is to make every hospital a VA hospital, so when the VA cannot provide treatment, it will provide coverage for a veteran to receive medically necessary care elsewhere.

The reality is the VA cannot hire its way out of this problem.

Doctors are already in short supply throughout many parts of the country. They generally earn more in the private sector than from the VA. According to an analysis of 2013 federal government employment data, the median salary for a physician at the VA is $203,000,[981] compared with "private-sector primary care physicians whose total median compensation was $221,000 in 2012, according to the Medical Group Management Association."[982]

While there are no shortages of medical horror stories and unnecessary deaths resulting from shoddy or delayed VA care, VHA "has been shown to provide excellent quality of care in many areas."[983] The VA should therefore continue hiring the health care professionals needed to better meet the needs of veterans. But allowing every doctor to be a VA doctor allows the Department to better focus on hiring specialists and other health care professionals necessary to treat specific service related conditions, while also greatly expanding the availability of primary and specialty doctors for veterans.

In fact, more veterans are receiving care outside of the VA system. The "VA's fee basis care utilization also increased from about 821,000 veterans in fiscal year 2008 to about 976,000 veterans in fiscal year 2012."[984]

Veterans already may receive VA coverage of emergency care at non-VA facilities, even for conditions that are not service-connected.[985] The VA, however, is frequently sticking veterans with the bill instead. The GAO reviewed a select number of VAs and found "veterans whose claims have been inappropriately denied may have been held financially liable for emergency care that VA should have covered, and they may not be aware of their rights to appeal these denials."[986] Even though this coverage has been available for 15 years, GAO found "veterans still lack knowledge about their eligibility. For example, VA officials reported that because some veterans were

> **Part of the solution is to make every hospital a VA hospital so when the VA cannot provide treatment it will provide coverage for a veteran to receive medically necessary care elsewhere.**

uninformed about their eligibility, these veterans may have delayed or avoided seeking treatment at local non-VA providers, choosing instead to go to a less accessible VA facility."[987]

Furthermore, non-VA health providers are willing to do their part to serve veterans. A local civilian hospital in Pensacola, Florida, for example, is now welcoming veterans seeking urgent care, because the Pensacola Naval Hospital emergency room closed on June 1, 2014.[988] The VA, which had a "resource-sharing" arrangement with the Navy, is now directing "veterans in the Pensacola area with medical emergencies [to] go to the nearest civilian emergency room or call 911." [989] "We should not have any difficulty accommodating additional patients at Sacred Heart who might have used Naval Hospital's emergency department in the past," said a spokesman for the civilian facility. "We welcome all of the military patients to Sacred Heart and look forward to collaborating with their health care team."[990]

"Veterans could receive VHA care for the aspects of care in which the VHA particularly excels and non-VHA care for areas in which that sector excels."[991] This would improve veterans care by allowing the VA to "focus on its relative strengths and act in a more complementary manner, rather than a substitutive one," according to RAND.[992] Furthermore, better coordination could reduce overuse and duplicative use providing opportunities for "pure savings from the perspective of the VHA."[993]

Veterans deserve timely access to health care. Likewise, medical decisions should be made by veterans with their doctors. Whether it is private insurance company or government bureaucrats, nobody wants a middle-man who has not even met the patient making or delaying decisions that can result in loss of life or limb. The VA is described as "an impenetrable and unresponsive bureaucracy" by many veterans.[994] The current VA system unnecessary allows bureaucrats to stand between veterans and doctors.

If the VA is unable to offer a patient timely care, it has an obligation to coordinate with another entity to ensure veterans are receiving appropriate treatment in a timely manner.

Distance Creates Barriers to Health Care Access For Many Vets

"Traveling long distances for medical care is often impractical for veterans, particularly those receiving ongoing outpatient medical care, such as dialysis or radiation therapy for cancer," according to the GAO.[995] And, a large proportion of veterans live in rural areas the VA does not effectively serve, which requires driving far distances for medical care.

More than one in four veterans lives in rural areas.[996] Of the 6.1 million veterans who live in rural areas, 3.1 million are enrolled in the VA system.[997] Nearly one-third of Iraq and Afghanistan veterans who are returning to civilian life live in rural areas.[998]

Veterans living in rural areas "must travel an average of 63 miles to receive care," while others living in rural areas travel about 30 miles to reach a doctor, according to the National Rural Health Association.[999]

The Biloxi VAMC located in Mississippi:

"[S]erves veterans from four states along the Gulf Coast, including many who live more than 300 miles from the facility. Officials from the Biloxi VAMC explained that the significant distance that some veterans face when traveling from their homes to the VAMC for care is burdensome and may not be appropriate for all veterans. As a result, these officials said that their VAMC frequently refers veterans to fee basis providers within the veterans' own communities to reduce this burden. Similarly, officials from the Alexandria VAMC explained that many times they also refer veterans to fee basis providers in veterans' own communities to lessen the travel."[1000]

The average distance traveled by veterans in Vermont to the White River Junction VA Medical Center (VAMC) is 54 miles.[1001] Veterans there "agreed that travel to the VAMC is difficult for

many patients and has been exacerbated by recent gas price fluctuations and the recent economic downturn."[1002] Also, "chronic, disability, and acute emergency situations," as well as "severe weather conditions and the lack of adequate rural road infrastructure in the region," create additional challenges for many veterans.[1003]

Distance is not just an inconvenience; it is a cost for veterans and the VA. Veterans who are unable to drive must find transportation, and those who can drive may have to take days off from work to travel to a medical appointment. The Department provides transportation services and financial support to those who must travel, at a cost of nearly one billion dollars per year, but not all are eligible to receive reimbursement, and the program has been very susceptible to fraud.

"Under VA's beneficiary travel program regulations, veterans are eligible for travel reimbursement only if they meet one of several criteria—including having a service-connected disability rating of 30 percent or more, or an annual income below a specified threshold."[1004]

The VA's Beneficiary Travel Program (BTP) spent $966.1 million last year to cover transport veterans to medical centers.[1005] This amount has nearly tripled since 2008.[1006]

In Nevada, taxpayers spent almost one million dollars between April 2013 and January 2014 on airfare to send veterans out of state for medical care.[1007] During this ten-month period, at least 1,173 VA patients seeking treatment from the Department's Nevada health care system had to go elsewhere to receive medical services.[1008] Despite a brand new, $600 million dollar VA hospital in North Las Vegas that has been described as "the Crown Jewel of the VA Healthcare System," many veterans have

> "One of the principle culprits" for the failure to get veterans the care they need in a timely manner is Congress, said Robert Gates, who served as Secretary of Defense under both Presidents Barack Obama and George W. Bush.

to travel long distances for treatments and procedures – on the taxpayers' dime.[1009]

Ron Duda must fly from Las Vegas to San Diego every two months to have a series of surgeries to remove cancer from his eye.[1010] The VA pays for his flight, his accommodations, his meals, and for a caregiver to travel with him.[1011] A spokesperson for the Department stated it is "unreasonable" for veterans to expect to be able to get "any and every type of care" at local medical facilities, because not every healthcare system can provide all "complex sub-specialty services."[1012] The Department also contends it is cheaper to pay for veterans to fly to other states for medical care than to make local services available.[1013]

But veterans have been sent out of state for things as routine as a knee replacement, and continuing to pay for plane tickets will become expensive.[1014]

While providing transportation to disabled veterans is essential to ensuring access to medical care, the program has "inadequate financial controls," making the program highly susceptible to fraud.[1015]

Investigations into VA-related travel fraud "has soared nationally since 2008, when the VA's rate for mileage reimbursement jumped from 11 cents, where it had been set for 30 years, to 41.5 cents," according to the Assistant Inspector General for Investigations.[1016] Before the change, there was only one investigation per year for three years in reimbursement fraud. In the following 18 months, "the VA's Office of the Inspector General has opened 225 investigations of benefit travel fraud and made 125 arrests."[1017]

"VA medical facilities paid approximately $89 million more in beneficiary travel than the facilities approved" between January 2010 and March 2011.[1018] While most of the discrepancy was a result of "miscoded expenses," $42.5 million "remained unexplained" according to a review by the VA OIG.[1019]

In just one case, a group of individuals in Cleveland, Ohio scammed the VA for nearly $250,000 in bogus re-imbursements.[1020] "Each of the individuals submitted false claims for travel reimbursement to the Veterans Affairs Office, utilizing false or no-existent addresses representing a greater distance of travel than he or she had actually traveled."[1021] The U.S. Attorney for the Northern District of Ohio stated, "This money should have been used for legitimate medical care for veterans, particularly our returning combat veterans."[1022]

In Seattle, ten people, including two VA employees who ran a kickback scheme, were busted for ripping off more than $180,000 from the travel reimbursement program.[1023] The employees were "recruiting veterans to submit false mileage forms" to claim they had traveled hundreds of miles to the VA. They would then receive vouchers, "go to another window and walk away with cash," and meet "in the restroom, or a stairwell, or the VA canteen — and fork over half the money" to the VA employees.[1024]

A veteran who lived just three miles from the VA Maine Healthcare System-Togus facility said he traveled hundreds of miles to get to the facility, filing 156 bogus travel reimbursement claims to fraudulently collect $17,725.[1025]

In addition to the funds lost to fraud, allowing veterans to travel shorter distances to hometown doctors means savings from lower travel reimbursements.

"Evidence that veterans use more non-VHA services when they are farther from VHA facilities or when they have non-VA coverage suggests that they choose between systems, to some extent, based on convenience," according to a RAND analysis.[1026]

Beneficiary Travel Obligations FY2008- FY2013
($ in Millions)[1027]

	FY 2008	FY 2009	FY2010	FY2011	FY2012 (estimate)	FY2013 (estimate)
Mileage	$ 116.8	$ 314.8	$431.5	$484.8	$540.2	$567.9
Inter-Facility	$ 59.7	$ 69.9	$71.8	$63.2	$70.4	$74
Other than Mileage*	$ 196.4	$ 244.3	$242	$276.8	$308.4	$324.2
Total	$ 372.9	$ 629	$745.3	$824.8	$919	$966.1

Inter-Facility Travel. Includes all travel costs associated with the transfer of a patient from one facility to another when the transfer is necessary for the continuation of care. The transfer may occur between VA facilities, non-VA facilities or any combination as long as the treatment is at VA expense. Modes of travel, other than by ambulance, are authorized if medically acceptable and savings can be realized.

Beneficiary Travel – Other than Mileage. All beneficiary travel charges, except mileage. This includes items such as ambulance service for beneficiaries, tokens, and tickets.

Beneficiary Travel - Mileage. Only costs for mileage payments will be charged to this account.

RECOMMENDATIONS

What Do We Do Now? The Veterans Choice Act

To restore confidence and better accomplish its mission, the VA must make timely access to quality care for eligible veterans its foremost priority. This commitment must be set and reinforced by the Secretary and shared by every employee throughout the Department, whether doctors and nurses or schedulers or service representatives, as well as Congress. The current culture of cover up and manipulation at the VA must be purged and replaced with transparency and accountability and service.

Health care is both art and science and there is an ever growing need for health care practitioners. To ensure quality care, the Department must partner with non-VA providers to ensure vets can choose the doctors that are the best match for their personal health needs as soon as possible. This will end the pressure to manipulate or hide the numbers to show minimal wait times and optimal outcomes.

When General Omar Bradley took the helm of the VA after World War II, he pledged to hold regular press conferences "to keep news sources and through them veterans and the public informed of what the Veterans Administration was doing."[1028] In the current information age, there are so many more ways to share information, provide answers, and ensure an ongoing dialogue with those providing and receiving services. Veterans should be able to quickly access information to see how long wait times are and what outcomes are at a nearby hospital and compare those to other VA and non-VA facilities so they can select the best available care at the most convenient time and setting.

The Congress and the Administration must also pay attention to how veterans are being cared for to ensure the lives of vets are never again unnecessarily lost by being denied timely access to quality care. Passing legislation is not enough. In fact, Congress has been too willing to make new promises to veterans without ensuring previous promises have been kept. The Senate Veterans' Affairs Committee, in particular, must begin exercising its oversight role to act as an advocate of taxpayers and veterans. Congress has known for decades about the problems at the VA but has ignored them and in some cases exacerbated them.

History shows even when Congress takes action and passes legislation, aggressive oversight is needed or else gains are lost or new challenges arise and go unnoticed and unaddressed. Consider this:

"[B]y the mid-1990s, VA health care was widely criticized for providing fragmented and disjointed care of unpredictable and irregular quality, which was expensive, difficult to access, and insensitive to individual needs. Between 1995 and 1999, the VA health care system was reengineered, focusing

especially on management accountability, care coordination, quality improvement, resource allocation, and information management. Numerous systemic changes were implemented, producing dramatically improved quality, service, and operational efficiency."[1029]

Nearly 20 years has passed since Congress passed and the VA "implemented a series of sweeping reforms,"[1030] but once again veterans are suffering from many of the same problems.

The following recommendations would dramatically improve the type of care veterans receive from the VA, and better ensure gains are sustainable rather than temporary.

Greater Health Care Freedom for Veterans Enrolled in VA Care

NOT ALL VA HOSPITALS provide the same level of care, as many are often in inconvenient locations or have long waiting times to see doctors. The easiest way to address these problems is to make every hospital a VA hospital. Veterans with combat related injuries should have the freedom to choose what doctors they want to see, where and when—regardless of whether the hospitals are associated with the VA.

The Department already has the authority to allow vets to access services outside the VHA, but that decision is made by VA administrators rather than the patient. Veterans should be empowered to make their own health care decisions rather than the bureaucrats who run the system. If they choose, veterans should be able to schedule a check-up with a hometown doctor instead of driving hours to the nearest VA medical facility or waiting months until a VA doctor is available.

VA should pay non-VA providers the Medicare rate for services. For those patients with other forms of coverage, such as private insurance or Medicare, the VA should make arrangements to ensure those other insurers pay their appropriate portion of provided care while avoiding redundant or duplicative payments.

Enhance Transparency of VA Health Performance Measures

WHETHER IT IS WAITING TIMES, performance outcomes, or patient satisfaction, the most accurate and up to date information about health care facilities is essential to assist patients with personal health care decisions.

The VA currently tracks numerous outcomes and even maintains a five-star rating system for its hospitals. The VA should disclose this information and provide greater transparency of health outcomes and performance data for its hospitals. The VA should be required to post online—while protecting patient personal information—updated statistics regarding quality of care, infection rates, acute care mortality rates, and patient safety as well as up to date waiting times regarding when an appointment can be made to see a doctor.

The IG should conduct regular reviews to ensure data is not being falsified, manipulated, or omitted. Inaccuracies or questionable data should be immediately reported to the VA Secretary and Congress, including the Veterans Affairs Committees, and, if necessary, the Department of Justice.

This information would allow veterans to make the most informed decisions about when and where to access health care while holding the VA accountable for providing the most optimal and timely care at every facility. It would also allow the VA to improve care by identifying emerging issues sooner and make better informed decisions on staffing and resource allocations.

Prioritize Vets With Combact Related Disabilities

INDIVIDUALS WHO "served in the military, even during peace time, and were honorably discharged," most "likely qualify for VA care" and "can receive VA hospital and outpatient care for any ailment, service connected or not," as long as they are enrolled in the VA health care system.[1031] The VA does provide "enhanced eligibility status" to certain veterans such as former Prisoner of War (POW) and Purple Heart and Medal of Honor recipients and those with a service-connected disability or lower income.[1032] However, despite the growing waiting lists to see a doctor across the country, the VA expanded eligibility to "higher-income veterans who have no conditions that are disabling," nearly 90 percent of which "had other health care coverage," including private health insurance.[1033]

The non-partisan Congressional Budget Office notes that reducing eligibility for higher income individuals who do not have service-related medical needs "would refocus VA's attention and services on its traditional group of patients—those with the greatest needs or fewest financial resources."[1034] It would also save tens of billions of dollars over the next decade.

A former POW who was disabled by a war injury with modest income should not have to wait months to access a VA doctor behind others with private insurance, higher incomes, and no service related injuries. Likewise, those experiencing severe conditions – such as pain or bleeding – or those seeking mental health or substance abuse treatment should never be forced to wait to receive medical care.

Congress and the VA should act to once again make sure that those veterans who are listed as priority patients are in fact treated as priorities by ending enrollment for individuals without service-related medical needs who are not poor and do not have other "enhanced eligibility status."

Increase the Number of Patients Seen by VA Doctors

VA PHYSICIANS SEE far fewer patients than a typical doctor. An average primary care physician has an average caseload of 2,300, according to a study in the Annals of Family Medicine.[1035] Yet, the VA targets panel sizes of 1,200 for its physicians – almost half the workload of private-sector providers.[1036]

The Department has long delayed developing a standard methodology to measure physician productivity, a practice standard in private-sector programs and Medicare. Government auditors first made the recommendation to establish this type of standard in 1981. Since then, both GAO and the VA OIG have issued another six reports with essentially the same recommendation.[1037] Yet, by late 2013, the VA had still not developed an adequate and comprehensive way of measuring physician productivity and determining staffing needs.[1038]

Setting such expectations is not intended to reduce the amount of time doctors spend with a patient to provide necessary care or set an arbitrary number of patients a doctor must meet as a daily quota. It is intended to ensure greater and timely access to care for more veterans and to improve Department resource allocation and hiring decisions.

Lacking any standard for measuring their staff, individual medical centers and clinics have no way of justifying their needs for workforce and structure. Without establishing a formal standard, the VA on its own cannot identify under-performing doctors. A VA IG analysis found that 12 percent of the VA's specialty physicians have limited productivity.[1039] Wait times at many facilities could be alleviated with careful planning and hiring, but adequate management cannot happen without measurement.

The Department should establish such standards immediately to ensure VA doctors and other providers are seeing an optimal number of patients each day. These guidelines should not include perverse financial incentives that might undermine care or manipulation of data as has been the case with scheduling.

Read Veterans Their Health Care Rights

VA enrollees, Department staff, and even health care providers are often unaware of veterans' coverage. For example, a March 2014 GAO report noted: "[T]hat gaps exist in veterans' knowledge about eligibility criteria for Millennium Act emergency care, and communication weaknesses exist between VA and non-VA providers. Specifically, GAO found that veterans' lack of understanding about their emergency care benefits under the Millennium Act presents risks for potentially negative effects on veterans' health because they may forgo treatment at non-VA providers, and on veterans' finances because they may assume VA will pay for care in situations that do not meet VA criteria. Despite VA's efforts to improve communications, some non-VA providers reported instances in which VA facilities' claims processing staff were unresponsive to their questions about submitted claims."[1040]

Veterans enrolled in the VA need to be made aware of their health care coverage rights on a regular basis. These include benefits provided by the VA, any restrictions on services, access to coverage from non-VA benefits including emergency services and urgent care, and the right to appeal denials of coverage. These rights should be in plain everyday language and should be posted on VHA's website and mailed to enrollees.

End Abuse of Good Employees and Fire Vindictive Administrators and Other Bad Employees

The whistleblowers who came forward to expose the problems at the VA clearly demonstrated that there are many employees within the Department who are dedicated to veterans and are willing to put their livelihood at risk to ensure our nation's heroes are getting the care they were promised. Without their courage, more VA patients may have died, and Washington would have continued to ignore systemic problems while veterans suffered.

Many VA employees involved in cover-ups and manipulation of wait times were following their manager's instructions that broke VA rules and policies. In these cases, the managers should be held accountable and should be immediately fired.

The VA has shown a willingness to fire and punish employees it considers troublesome. Many who have been terminated, however, were standing up against the improper practices encouraged by VA managers. For decades, the VA has silenced, harassed, and retaliated against whistleblowers who were merely trying to fulfill the commitment to veterans that is the mission of the VA.[1041] Meanwhile others who cooked the books or abused their positions received financial bonuses and other rewards.

This inverse scale of rewards and punishment must end. Those who step forward to call attention to problems should be heard and encouraged to speak up when they see, hear, or witness inappropriate, improper, or illegal behavior. Managers who harass employees or encourage bad behavior should be immediately fired. Other employees who break the law, steal from taxpayers and veterans, fail to provide the level of care expected, sexually harass patients or co-workers, or skip work for extended periods without approval should be replaced. Paid administrative leave should not extend beyond one month for those who may have engaged in questionable activities, while at the same time ensure due process for those who are suspended or fired.

Ensuring VA Doctors Provide Top Notch Care

As a physician who has cared for veterans at VA facilities, I understand that many veterans prefer accessing treatment at VA hospitals and that many of the health care providers and staff are committed to providing the best possible care for our nation's heroes.

There are, however, VA health care providers with sketchy backgrounds, including criminal histories and loss and suspension of medical licenses.

Before hiring potential doctors and other officials, the VA should extend background checks to screen out those who have questionable histories or a record of substandard care.

In order to bring increased awareness and confidence of the patients, veterans should have greater transparency regarding the level of training and track record of the quality of care provided by VA health professionals. Veterans should have the ability to check the credentials of the doctors they are going to see when scheduling an appointment with the VA.

Congress Must Ensure Promises Made to Vets are Kept

Congress has been aware of nearly all of the problems detailed in this report and reported in the media for decades. Yet, they have chosen to largely ignore these problems or, in many cases, make them worse.

When the VA was experiencing backlogs, for example, Congress expanded coverage eligibility putting more patients in lines that were already too long. When VA construction projects were behind schedule and over budget, Congress added new projects. When veterans were not receiving the benefits they were promised, Congress promised more benefits.

The House Committee on Veterans' Affairs under the leadership of Jeff Miller, however, must be commended for an unmatched dedication to conducting oversight to root out problems and seek solutions to hold the VA accountable to better serving our nation's warriors.

Passing a bill is only one part of the role of Congress. It must be followed up with a commitment to congressional oversight to make sure the law is properly carried out. Congress has ignored its oversight role because it requires hard work—asking tough and often uncomfortable questions of government officials, examining budgets, listening to whistleblowers and constituents, and standing up against special interest groups. Unlike breaking ground on a new VA health center, there is no ribbon cutting ceremony for politicians if they stop a government boondoggle in their state, but sometimes this can do just as much good—or more.

Right now, veteran access to VA doctors and VA hospitals is hindered by long waiting lists and a widespread culture of mismanagement. If Congress wants to keep the promises made to veterans, we need to be sure the care given to them inside the hospitals is as state-of-the-art as the facilities themselves.

It is important to note that while this report provides an extensive overview of many of the challenges and shortcomings of the VA, it is not all encompassing. There are many areas untouched by this report that are deserving of further congressional questioning and investigation, including the need for restructuring and consolidating the VA's medical administrative functions, failures in IT development and contracting, and the cost effectiveness of the community outpatient-based clinics.

"A nation reveals itself not only by the men it produces, but also by the men it honors, the men it remembers."

- *John F. Kennedy*

Major GAO and IG Reports on VA Patient Wait Times (2000 – 2014)[1047]

Date	Report Title	Entity	Description	Link
May 2000	VA Needs Better Data on Extent and Causes of Waiting Times	GAO	VA lacks data on patient wait times and many veterans do not have access to timely care.	http://www.gao.gov/assets/240/230347.pdf
August 2001	Audit of the Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network	IG	Patients had to wait as long as 730 days for appointments at a sleep disorder program clinic.	http://www.va.gov/oig/52/reports/2001/99-00057-55.pdf
August 2001	More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress	GAO	Many veterans continue to experience long waits for appointments. VA still does not have a framework for identifying root causes of long waiting times.	http://www.gao.gov/new.items/d01953.pdf
July 2004	VA Needs to Improve Accuracy of Reported Wait Times for Blind Rehabilitation Services	GAO	VA reported inaccurate and/or incorrect data about wait times at Blind Rehabilitation Centers.	http://www.gao.gov/assets/250/243419.pdf
July 2005	Audit of the Veterans Health Administration's Outpatient Scheduling Procedures	IG	Schedulers did not receive adequate training and did not follow procedures when selecting type and date of appointment.	http://www.va.gov/oig/52/reports/2005/VAOIG-04-02887-169.pdf
September 2007	Audit of the Veterans Health Administration's Outpatient Waiting Times	IG	Schedulers still not following procedures for making and recording medical appointments. 72% of studied appointments had "unexplained differences" between the desired date of care in medical records vs. scheduling records.	http://www.va.gov/oig/52/reports/2007/VAOIG-07-00616-199.pdf
May 2008	Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3	IG	"[L]ittle to no progress has been made to address the long-standing and underlying causes of inaccurate waiting times and incomplete electronic waiting lists."	http://www.va.gov/oig/52/reports/2008/VAOIG-07-03505-129.pdf
December 2008	Audit of Veterans Health Administration's Efforts to Reduce Unused Outpatient Appointments	IG	VHA did not have an effective method to measure and report unused appointments. As a result, patients were waiting for care even though appointments were available. VA could have better put to use $76 million annually.	http://www.va.gov/oig/52/reports/2009/VAOIG-08-00879-36.pdf
February 2009	Mammography, Cardiology, and Colonoscopy Management Jack C. Montgomery VA Medical Center Muskogee, Oklahoma	IG	Patients at the center "did not consistently receive mammograms in a timely manner." Cardiology consultation requests were not always scheduled within the required timeframe.	http://www.va.gov/oig/54/reports/VAOIG-08-01866-62.pdf
June 2011	Delays in Cancer Care West Palm Beach VA Medical Center	IG	Delays in treatment for renal cancer patients. Management was aware but did nothing. No mechanism to ensure patients referred to another VA medical center received timely treatment.	http://www.va.gov/oig/54/reports/VAOIG-11-00930-210.pdf
July 2011	Electronic Waiting List Management for Mental Health Clinics Atlanta VA Medical Center	IG	Mental health electronic waiting lists are "inherently problematic" as they impaired veterans' access to timely and quality medical care.	http://www.va.gov/oig/54/reports/VAOIG-10-02986-215.pdf
January 2012	Select Patient Care Delays and Reusable Medical Equipment Review Central Texas Veterans Health Care System	IG	Many patient consults required action – but no evidence of patient harm due to inaction. Many gastrointestinal wait times were longer than VHA requirements, and appointments were routinely made incorrectly.	http://www.va.gov/oig/pubs/VAOIG-11-03941-61.pdf

Major GAO and IG Reports on VA Patient Wait Times (2000 – 2014)(cont.)[1047]

April 2012	Review of Veterans' Access to Mental Health Care	IG	VHA does not know if patients are receiving timely access to mental health care services. VHA overstated success in providing treatment and many patients were not given an evaluation within 14 days as required.	http://www.va.gov/oig/pubs/VAOIG-12-00900-168.pdf
August 2012	Access and Coordination of Care at Harlingen Community Based Outpatient Clinic VA Texas Valley Coastal Bend Health Care System	IG	Patients seeking emergency care at the clinic are not seen in the timeframe as requested, have difficulty getting prescription medications, and experience long wait times.	http://www.va.gov/oig/pubs/VAOIG-12-01906-259.pdf
September 2012	Consultation Mismanagement and Care Delays Spokane VA Medical Center	IG	"[R]equests for consultations were inappropriately cancelled or discontinued, and [sic] patients consequently had unnecessary delays in the amelioration of symptoms."	http://www.va.gov/oig/pubs/VAOIG-12-01731-284.pdf
October 2012	Delays for Outpatient Specialty Procedures VA North Texas Health Care System	IG	A dialysis patient waited more than 4 months for permanent vascular access. A cardiac patient waited 3 months for ambulatory monitoring. Other patients also experienced excessive wait times.	http://www.va.gov/oig/pubs/VAOIG-12-03594-10.pdf
December 2012	Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement	GAO	VHA reported unreliable outpatient appointment wait times and employs inconsistent scheduling policies. "[L]ong wait times and inadequate scheduling processes at VHA medical facilities have been long-standing problems."	http://www.gao.gov/assets/660/651076.pdf
April 2013	Patient Care Issues and Contract Mental Health Program Mismanagement Atlanta VA Medical Center	IG	There was inadequate coordination, monitoring, and staffing for oversight of mental health patient care at the center. This "contributed to patients falling through the cracks."	http://www.va.gov/oig/pubs/VAOIG-12-02955-178.pdf
September 2013	Healthcare Inspection Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina	IG	The center had a backlog of 2,500 delayed GI consults – 700 of which were deemed "critical." The center received $1.02 million to address this backlog, but the money was used for other things.	http://www.va.gov/oig/pubs/VAOIG-12-04631-313.pdf
May 2014	Interim Report: Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System	IG	"[S]ignificant delays in access to care negatively impacted the quality of care at this medical facility." There are "serious conditions" at Phoenix and at least 1,400 veterans were not included on electronic waiting lists as required.	http://www.va.gov/oig/pubs/vaoig-14-02603-178.pdf
June 2014	System-Wide Review of Access: Results of Access Audit Conducted May 12, 2014, through June 3, 2014	VA	Scheduling processes are "overly complicated" and result in "high potential to create confusion among employees." 57,000 veterans waited more than 90 days for an appointment.	http://www.va.gov/health/docs/VAAccessAuditFindingsReport.pdf

Endnotes

1 Aaron Glantz, "VA pays out $200 million for veterans' wrongful deaths," Center for Investigative Reporting, April 3, 2014; http://www.philly.com/philly/health/VA_pays_out_200_million_for_veterans_wrongful_deaths.html#eOwWXbeLjq0GCBHX.99.

2 Josh Sweigart and Aaron Diamant, "Paying the price; VA's malpractice tab: $845M in 10 years," Cox Media Group/WSB-TV Channel 2, November 12, 2013; www.wsbtv.com/VA-lawsuits/#sthash.QyrMiCBD.dpuf.

3 Mark Flatten, "Veterans Affairs purged thousands of medical tests to 'game' its backlog stats," Washington Examiner, February 25, 2014; http://washingtonexaminer.com/veterans-affairs-purged-thousands-of-medical-tests-to-game-its-backlog-stats/article/2544580.

4 Darcy Spears, "Veterans being forced to travel out of state for treatment," KTNV Channel 13 Action News, February 25, 2014; http://www.jrn.com/ktnv/news/contact-13/you-paid-for-it/Veterans-being-forced-to-fly-out-of-state-for-care-247059851.html.

5 Erin Bagalman, "The Number of Veterans That Use VA Health Care Services: A Fact Sheet," Congressional Research Service, June 3, 2014

6 Josh Sweigart and Aaron Diamant, "Paying the price; VA's malpractice tab: $845M in 10 years," Cox Media Group/WSB-TV Channel 2, November 12, 2013; www.wsbtv.com/VA-lawsuits/#sthash.QyrMiCBD.dpuf.

7 Erin Bagalman, "The Number of Veterans That Use VA Health Care Services: A Fact Sheet," Congressional Research Service, June 3, 2014;

8 Erin Bagalman, "The Number of Veterans That Use VA Health Care Services: A Fact Sheet," Congressional Research Service, June 3, 2014

9 Sidath Viranga Panangala and Erin Bagalman, "Health Care for Veterans: Answers to Frequently Asked Questions, Congressional Research Service, February 25, 2014

10 "Veterans Health Administration – About VHA," U.S. Department of Veterans Affairs, accessed June 18, 2014; http://www.va.gov/health/aboutVHA.asp; Erin Bagalman, "The Number of Veterans That Use VA Health Care Services: A Fact Sheet," Congressional Research Service, June 3, 2014

11 Sidath Viranga Panangala and Erin Bagalman, "Health Care for Veterans: Answers to Frequently Asked Questions, Congressional Research Service, February 25, 2014

12 David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," Rand Corporation, 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

13 Erin Bagalman, "The Number of Veterans That Use VA Health Care Services: A Fact Sheet," Congressional Research Service, June 3, 2014

14 Erin Bagalman, "The Number of Veterans That Use VA Health Care Services: A Fact Sheet," Congressional Research Service, June 3, 2014

15 "Health Benefits – Veterans Eligibility," U.S. Department of Veterans Affairs, accessed June 18, 2014; http://www.va.gov/healthbenefits/apply/veterans.asp.

16 Sidath Viranga Panangala and Erin Bagalman, "Health Care for Veterans: Answers to Frequently Asked Questions, Congressional Research Service, February 25, 2014

17 Sidath Viranga Panangala and Erin Bagalman, "Health Care for Veterans: Answers to Frequently Asked Questions, Congressional Research Service, February 25, 2014

18 Sidath Viranga Panangala and Erin Bagalman, "Health Care for Veterans: Answers to Frequently Asked Questions, Congressional Research Service, February 25, 2014

19 "Health Benefits – Veterans Eligibility," U.S. Department of Veterans Affairs, accessed June 18, 2014; http://www.va.gov/healthbenefits/apply/veterans.asp.

20 Sidath Viranga Panangala and Erin Bagalman, "Health Care for Veterans: Answers to Frequently Asked Questions, Congressional Research Service, February 25, 2014

21 "Health Benefits – Combat Veterans," U.S. Department of Veterans Affairs, accessed June 18, 2014; http://www.va.gov/healthbenefits/gateway/combat_vets.asp.

22 Sidath Viranga Panangala and Erin Bagalman, "Health Care for Veterans: Answers to Frequently Asked Questions, Congressional Research Service, February 25, 2014

23 "Health Benefits – Returning Servicemembers (OEF/OIF/OND)," U.S. Department of Veterans Affairs, accessed June 18, 2014; http://www.va.gov/healthbenefits/apply/returning_servicemembers.asp.

24 Sidath Viranga Panangala and Erin Bagalman, "Health Care for Veterans: Answers to Frequently Asked Questions, Congressional Research Service, February 25, 2014

25 "Health Benefits – Priority Groups Table," U.S. Department of Veterans Affairs, accessed June 18, 2014; http://www.va.gov/healthbenefits/resources/priority_groups.asp.

26 "Health Benefits – Priority Groups Table," U.S. Department of Veterans Affairs, accessed June 18, 2014; http://www.va.gov/healthbenefits/resources/priority_groups.asp.

27 "Health Benefits – Priority Groups Table," U.S. Department of Veterans Affairs, accessed June 18, 2014; http://www.va.gov/healthbenefits/resources/priority_groups.asp. 28 "Health Benefits – Priority Groups Table," U.S. Department of Veterans Affairs, accessed June 18, 2014; http://www.va.gov/healthbenefits/resources/priority_groups.asp.

29 "Health Benefits – Priority Groups Table," U.S. Department of Veterans Affairs, accessed June 18, 2014; http://www.va.gov/healthbenefits/resources/priority_groups.asp.

30 "Health Benefits – Priority Groups Table," U.S. Department of Veterans Affairs, accessed June 18, 2014; http://www.va.gov/healthbenefits/resources/priority_groups.asp.

31 "Health Benefits – Priority Groups Table," U.S. Department of Veterans Affairs, accessed June 18, 2014; http://www.va.gov/healthbenefits/resources/priority_groups.asp.

32 "Health Benefits – Priority Groups Table," U.S. Department of Veterans Affairs, accessed June 18, 2014; http://www.va.gov/healthbenefits/resources/priority_groups.asp.

33 "OPTIONS FOR REDUCING THE DEFICIT: 2014 TO 2023: End Enrollment in VA Medical Care for Veterans in Priority Groups 7 and 8," Congressional Budget Office, November 13, 2013; http://www.cbo.gov/budget-options/2013/44902.

34 "OPTIONS FOR REDUCING THE DEFICIT: 2014 TO 2023: End Enrollment in VA Medical Care for Veterans in Priority Groups 7 and 8," Congressional Budget Office, November 13, 2013; http://www.cbo.gov/budget-options/2013/44902.

35 "OPTIONS FOR REDUCING THE DEFICIT: 2014 TO 2023: End Enrollment in VA Medical Care for Veterans in Priority Groups 7 and 8," Congressional Budget Office, November 13, 2013; http://www.cbo.gov/budget-options/2013/44902.

36 "OPTIONS FOR REDUCING THE DEFICIT: 2014 TO 2023: End Enrollment in VA Medical Care for Veterans in Priority Groups 7 and 8," Congressional Budget Office, November 13, 2013; http://www.cbo.gov/budget-options/2013/44902.

37 "OPTIONS FOR REDUCING THE DEFICIT: 2014 TO 2023: End Enrollment in VA Medical Care for Veterans in Priority Groups 7 and 8," Congressional Budget Office, November 13, 2013; http://www.cbo.gov/budget-options/2013/44902.

Endnotes

38 "OPTIONS FOR REDUCING THE DEFICIT: 2014 TO 2023: End Enrollment in VA Medical Care for Veterans in Priority Groups 7 and 8," Congressional Budget Office, November 13, 2013; http://www.cbo.gov/budget-options/2013/44902.

39 Scott Bronstein and Drew Griffin, "A fatal wait: Veterans languish and die on a VA hospital's secret list," CNN, April 24, 2014; http://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/.

40 Scott Bronstein and Drew Griffin, "A fatal wait: Veterans languish and die on a VA hospital's secret list," CNN, April 24, 2014; http://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/.

41 Aaron Glantz, "VA pays out $200 million for veterans' wrongful deaths," Center for Investigative Reporting, April 3, 2014; http://www.philly.com/philly/health/VA_pays_out_200_million_for_veterans_wrongful_deaths.html#eOwWXbeLjq0GCBHX.99.

42 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/index.html?hpt=hp_t2.

43 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/index.html?hpt=hp_t2.

44 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/index.html?hpt=hp_t2.

45 Bryant Jordan, "Shinseki Fires Phoenix Leaders as Last Act at VA," Military.com News, May 30, 2014; http://www.military.com/daily-news/2014/05/30/shinseki-fires-phoenix-va-leaders-others-to-follow.html.

46 Dennis Wagner, "Acting VA secretary: 18 vets on Phoenix wait list died," USA Today, June 6, 2014; http://www.usatoday.com/story/news/nation/2014/06/05/va-scandal-sloan-gibson-phoenix/10033543/.

47 "Statement from Acting Secretary of Veterans Affairs Sloan D. Gibson," U.S. Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, June 5, 2014; http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2551.

48 Dennis Wagner, "Acting VA secretary: 18 vets on Phoenix wait list died," USA Today, June 6, 2014; http://www.usatoday.com/story/news/nation/2014/06/05/va-scandal-sloan-gibson-phoenix/10033543/.

49 Dennis Wagner, "Acting VA secretary: 18 vets on Phoenix wait list died," USA Today, June 6, 2014; http://www.usatoday.com/story/news/nation/2014/06/05/va-scandal-sloan-gibson-phoenix/10033543/.

50 Scott Bronstein, Nelli Black and Drew Griffin, "Hospital delays are killing America's war veterans," CNN, November 20, 2013; http://www.cnn.com/2013/11/19/health/veterans-dying-health-care-delays/.

51 Nelli Black and Scott Bronstein, "VA hospital in Georgia apologizes for deaths after delayed care," CNN, November 22, 2013; http://www.cnn.com/2013/11/22/health/veterans-dying-health-care-delays/.

52 Wesley Brown, "Gastrointestinal backlog reported at second east Georgia VA hospital; Legion's town hall meeting on quality of care today," January 28, 2014; http://chronicle.augusta.com/news/metro/2014-01-28/gastrointestinal-backlog-reported-second-east-georgia-va-hospital?v=1390934934.

53 Wesley Brown, "Gastrointestinal backlog reported at second east Georgia VA hospital; Legion's town hall meeting on quality of care today," January 28, 2014; http://chronicle.augusta.com/news/metro/2014-01-28/gastrointestinal-backlog-reported-second-east-georgia-va-hospital?v=1390934934.

54 Wesley Brown, "Gastrointestinal backlog reported at second east Georgia VA hospital; Legion's town hall meeting on quality of care today," January 28, 2014; http://chronicle.augusta.com/news/metro/2014-01-28/gastrointestinal-backlog-reported-second-east-georgia-va-hospital?v=1390934934.

55 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/index.html?hpt=hp_t2.

56 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/index.html?hpt=hp_t2.

57 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/index.html?hpt=hp_t2.

58 Howard Altman, "Bay Pines VA facility turns away state inspectors," Tampa Tribune, April 8, 2014; http://tbo.com/list/military-news/bay-pines-va-facility-turns-away-state-inspectors-20140408/.

59 Howard Altman, "State inspectors denied records at Tampa VA hospital," The Tampa Tribune, April 9, 2014; http://tbo.com/list/military-news/state-inspectors-denied-records-at-tampa-va-hospital-20140409/.

60 Howard Altman, "Bay Pines VA facility turns away state inspectors," Tampa Tribune, April 8, 2014; http://tbo.com/list/military-news/bay-pines-va-facility-turns-away-state-inspectors-20140408/.

61 "Statement from AHCA concerning VA Hospital Inspections," Florida Agency for Health Care Administration press release, April 8, 2014; http://ahca.myflorida.com/Executive/Communications/Press_Releases/archive/docs/2014_2013/apr14/Statement_concerningVAhospital_inspections4-8-14.pdf.

62 Tia Mitchell, "Florida sues feds to gain access to VA hospitals," Miami Herald, June 5, 2014; http://miamiherald.typepad.com/nakedpolitics/2014/06/florida-sues-feds-to-gain-access-to-va-hospitals.html.

63 "Statement from AHCA concerning VA Hospital Inspections," Florida Agency for Health Care Administration press release, April 8, 2014; http://ahca.myflorida.com/Executive/Communications/Press_Releases/archive/docs/2014_2013/apr14/Statement_concerningVAhospital_inspections4-8-14.pdf.

64 "Gov. Scott Renews Call for Transparency from Federal VA," Florida Governor Rick Scott news release, April 9, 2014; http://www.flgov.com/2014/04/09/gov-scott-renews-call-for-transparency-from-federal-va/.

65 Scott Bronstein and Drew Griffin, "A fatal wait: Veterans languish and die on a VA hospital's secret list," CNN, April 24, 2014; http://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/.

66 Scott Bronstein and Drew Griffin, "A fatal wait: Veterans languish and die on a VA hospital's secret list," CNN, April 24, 2014; http://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/.

67 Dennis Wagner, "Acting VA secretary: 18 vets on Phoenix wait list died," USA Today, June 6, 2014; http://www.usatoday.com/story/news/nation/2014/06/05/va-scandal-sloan-gibson-phoenix/10033543/.

68 Greg Jaffe, "FBI opens criminal investigation into VA," The Washington Post, June 11, 2014; http://www.washingtonpost.com/world/national-security/fbi-joins-review-of-allegations-into-va-misconduct/2014/06/11/7f750b02-f177-11e3-914c-1fbd0614e2d4_story.html?hpid=z4.

69 Jennifer Hewlett, "Multiple factors cited in VA deaths," Lexington Herald-Leader, October 11, 2009; http://www.kentucky.com/2009/10/11/972883/multiple-factors-cited-in-va-deaths.html.

70 Jennifer Hewlett, "Multiple factors cited in VA deaths," Lexington Herald-Leader, October 11, 2009; http://www.kentucky.com/2009/10/11/972883/multiple-factors-

cited-in-va-deaths.html.

71 Jennifer Hewlett, "Multiple factors cited in VA deaths," Lexington Herald-Leader, October 11, 2009; http://www.kentucky.com/2009/10/11/972883/multiple-factors-cited-in-va-deaths.html.

72 Jennifer Hewlett, "Former Lexington VA nurse gets no prison time in overdose case; She spent about 9 days in jail in 2009," Lexington Herald-Leader, April 30, 2011; http://www.kentucky.com/2011/04/30/1724052/former-lexington-va-nurse-avoids.html.

73 Jennifer Hewlett, "Nurse linked to 2 other VA deaths," Lexington Herald-Leader, October 9, 2009; http://www.kentucky.com/2009/10/09/968999/nurse-linked-to-2-other-va-deaths.html.

74 Jennifer Hewlett, "Nurse linked to 2 other VA deaths," Lexington Herald-Leader, October 9, 2009; http://www.kentucky.com/2009/10/09/968999/nurse-linked-to-2-other-va-deaths.html.

75 Jennifer Hewlett, "Nurse linked to 2 other VA deaths," Lexington Herald-Leader, October 9, 2009; http://www.kentucky.com/2009/10/09/968999/nurse-linked-to-2-other-va-deaths.html.

76 Wendy Mitchell, "Maria Whitt gets 8 days in jail for Jesse Chain death," Ledger Independent, May 3, 2011; http://www.maysville-online.com/news/local/maria-whitt-gets-days-in-jail-for-jesse-chain-death/article_fa081722-75c6-11e0-921b-001cc4c03286.html.

77 Department of Veterans Affairs Office of Inspector General, "Healthcare Inspection: Unexpected Patient Death in a Substance Abuse Residential Rehabilitation Treatment Program, Miami VA Healthcare System, Miami, Florida," Report No. 13-03089-104, March 27, 2014; http://www.va.gov/oig/pubs/VAOIG-13-03089-104.pdf.

78 Department of Veterans Affairs Office of Inspector General, "Healthcare Inspection: Unexpected Patient Death in a Substance Abuse Residential Rehabilitation Treatment Program, Miami VA Healthcare System, Miami, Florida," Report No. 13-03089-104, March 27, 2014; http://www.va.gov/oig/pubs/VAOIG-13-03089-104.pdf (p. 3).

79 Department of Veterans Affairs Office of Inspector General, "Healthcare Inspection: Unexpected Patient Death in a Substance Abuse Residential Rehabilitation Treatment Program, Miami VA Healthcare System, Miami, Florida," Report No. 13-03089-104, March 27, 2014; http://www.va.gov/oig/pubs/VAOIG-13-03089-104.pdf (p. 3-4).

80 Department of Veterans Affairs Office of Inspector General, "Healthcare Inspection: Unexpected Patient Death in a Substance Abuse Residential Rehabilitation Treatment Program, Miami VA Healthcare System, Miami, Florida," Report No. 13-03089-104, March 27, 2014; http://www.va.gov/oig/pubs/VAOIG-13-03089-104.pdf (p. 4).

81 Department of Veterans Affairs Office of Inspector General, "Healthcare Inspection: Unexpected Patient Death in a Substance Abuse Residential Rehabilitation Treatment Program, Miami VA Healthcare System, Miami, Florida," Report No. 13-03089-104, March 27, 2014; http://www.va.gov/oig/pubs/VAOIG-13-03089-104.pdf (p. 4-5).

82 Department of Veterans Affairs Office of Inspector General, "Healthcare Inspection: Unexpected Patient Death in a Substance Abuse Residential Rehabilitation Treatment Program, Miami VA Healthcare System, Miami, Florida," Report No. 13-03089-104, March 27, 2014; http://www.va.gov/oig/pubs/VAOIG-13-03089-104.pdf (p. 6).

83 Rajiv Chandrasekaran, "A Legacy and Pain and Pride," The Washington Post, WashingtonPost.com, March 29, 2014; http://www.washingtonpost.com/sf/national/2014/03/29/a-legacy-of-pride-and-pain/.

84 Statement of John D. Daigh, Jr., M.D., Assistant Inspector General for Healthcare Inspections Office of Inspector General Department of Veterans Affairs before United States House of Representatives Committee on Veterans' Affairs hearing, "A Continued Assessment of Delays in VA Medical Care and Preventable Veterans Deaths," April 9, 2014; http://www.va.gov/oig/pubs/statements/VAOIG-statement-20140409-daigh.pdf.

85 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/.

86 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/.

87 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/.

88 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/.

89 "West Virginia doctor claims patients on VA waiting list committed suicide," Fox News, May 19, 2014; http://www.foxnews.com/politics/2014/05/19/west-virginia-doctor-says-patients-suicide/.

90 "West Virginia doctor claims patients on VA waiting list committed suicide," Fox News, May 19, 2014; http://www.foxnews.com/politics/2014/05/19/west-virginia-doctor-says-patients-suicide/.

91 "West Virginia doctor claims patients on VA waiting list committed suicide," Fox News, May 19, 2014; http://www.foxnews.com/politics/2014/05/19/west-virginia-doctor-says-patients-suicide/.

92 "West Virginia doctor claims patients on VA waiting list committed suicide," Fox News, May 19, 2014; http://www.foxnews.com/politics/2014/05/19/west-virginia-doctor-says-patients-suicide/.

93 "West Virginia doctor claims patients on VA waiting list committed suicide," Fox News, May 19, 2014; http://www.foxnews.com/politics/2014/05/19/west-virginia-doctor-says-patients-suicide/.

94 "West Virginia doctor claims patients on VA waiting list committed suicide," Fox News, May 19, 2014; http://www.foxnews.com/politics/2014/05/19/west-virginia-doctor-says-patients-suicide/.

95 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http://www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

96 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http://www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

97 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http://www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

98 Statement of John D. Daigh, Jr., M.D., Assistant Inspector General for Healthcare Inspections Office of Inspector General Department of Veterans Affairs before United States House of Representatives Committee on Veterans' Affairs hearing, "A Continued Assessment of Delays in VA Medical Care and Preventable Veterans Deaths," April 9, 2014; http://www.va.gov/oig/pubs/statements/VAOIG-statement-20140409-daigh.pdf.

99 "Department of Veterans Affairs Disclosures of Quality of Medical Care and Scheduling Issues," U.S. Office of Special Counsel, May 14, 2014.

Endnotes

100 "Department of Veterans Affairs Disclosures of Quality of Medical Care and Scheduling Issues," U.S. Office of Special Counsel, May 14, 2014.

101 Department of Veterans Affairs Office of the Inspector General "Semiannual Report to Congress, issue 63, page 19, October 1, 2009 – March 31, 2010;" http://www.va.gov/oig/pubs/sars/vaoig-sar-2010-1.pdf.

102 Abby Goodnough, "Many Veterans Praise Care, but All Hate the Wait," The New York Times, May 31, 2014; http://www.nytimes.com/2014/06/01/us/many-veterans-praise-health-care-but-all-hate-the-wait.html?_r=1.

103 Abby Goodnough, "Many Veterans Praise Care, but All Hate the Wait," The New York Times, May 31, 2014; http://www.nytimes.com/2014/06/01/us/many-veterans-praise-health-care-but-all-hate-the-wait.html?_r=1.

104 David Zucchino, Cindy Carcamo, and Alan Zarembo, "Growing evidence points to systemic troubles in VA healthcare system," LA Times, May 18, 2014; http://www.latimes.com/nation/la-na-va-delays-20140518-story.html#page=1.

105 "Semiannual Report to Congress," Issue 69, Department of Veterans Affairs Office of Inspector General, October 1, 2012 – March 31, 2013; http://www.va.gov/oig/pubs/sars/vaoig-sar-2013-1.pdf.

106 "Semiannual Report to Congress," Issue 69, Department of Veterans Affairs Office of Inspector General, October 1, 2012 – March 31, 2013; http://www.va.gov/oig/pubs/sars/vaoig-sar-2013-1.pdf.

107 "Semiannual Report to Congress," Issue 69, Department of Veterans Affairs Office of Inspector General, October 1, 2012 – March 31, 2013; http://www.va.gov/oig/pubs/sars/vaoig-sar-2013-1.pdf.

108 "Semiannual Report to Congress," Issue 69, Department of Veterans Affairs Office of Inspector General, October 1, 2012 – March 31, 2013; http://www.va.gov/oig/pubs/sars/vaoig-sar-2013-1.pdf.

109 Abby Goodnough, "Many Veterans Praise Care, but All Hate the Wait," The New York Times, May 31, 2014; http://www.nytimes.com/2014/06/01/us/many-veterans-praise-health-care-but-all-hate-the-wait.html?_r=1.

110 Abby Goodnough, "Many Veterans Praise Care, but All Hate the Wait," The New York Times, May 31, 2014; http://www.nytimes.com/2014/06/01/us/many-veterans-praise-health-care-but-all-hate-the-wait.html?_r=1.

111 Abby Goodnough, "Many Veterans Praise Care, but All Hate the Wait," The New York Times, May 31, 2014; http://www.nytimes.com/2014/06/01/us/many-veterans-praise-health-care-but-all-hate-the-wait.html?_r=1.

112 Abby Goodnough, "Many Veterans Praise Care, but All Hate the Wait," The New York Times, May 31, 2014; http://www.nytimes.com/2014/06/01/us/many-veterans-praise-health-care-but-all-hate-the-wait.html?_r=1.

113 Abby Goodnough, "Many Veterans Praise Care, but All Hate the Wait," The New York Times, May 31, 2014; http://www.nytimes.com/2014/06/01/us/many-veterans-praise-health-care-but-all-hate-the-wait.html?_r=1.

114 Associated Press, "Vets around the country describe VA experiences," AZ Family, June 1, 2014; http://www.az mfamily.com/news/Vets-around-the-country-describe-VA-experiences-261454301.html.

115 Associated Press, "Vets around the country describe VA experiences," AZ Family, June 1, 2014; http://www.azfamily.com/news/Vets-around-the-country-describe-VA-experiences-261454301.html.

116 Associated Press, "Vets around the country describe VA experiences," AZ Family, June 1, 2014; http://www.azfamily.com/news/Vets-around-the-country-describe-VA-experiences-261454301.html.

117 Associated Press, "Vets around the country describe VA experiences," AZ Family, June 1, 2014; http://www.azfamily.com/news/Vets-around-the-country-describe-VA-experiences-261454301.html.

118 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014; http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (p. i).

119 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014; http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (p. 1).

120 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014; http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (p. 1).

121 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014; http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (p. 1).

122 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014, http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (p. iii).

123 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014, http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (p. iii).

124 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014, http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (p. iv).

125 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014, http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (p. iv).

126 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014, http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (p. iii).

127 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014, http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (p. 12).

128 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014, http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (pp. iii-iv).

129 Dennis Wagner, "Acting VA secretary: 18 vets on Phoenix wait list died," USA Today, June 6, 2014; http://www.usatoday.com/story/news/nation/2014/06/05/va-scandal-sloan-gibson-phoenix/10033543/.

130 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014, http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (pp. iii-iv).

131 Department of Veterans Affairs Access Audit: System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014, June 9, 2014; http://www.va.gov/health/docs/VAAccessAuditFindingsReport.pdf.

132 Patricia Kane, "Audit: Many VA facilities altered appointment dates," Military Times, May 30, 2014; http://www.militarytimes.com/article/20140530/BENEFITS/305300047.

Endnotes

133 Access Audit Results Summary: Phase One Access Audit from 12 May 2014 – 16 May 2014, U.S. Department of Veterans Affairs, May 30, 2014; https://s3.amazonaws.com/s3.documentcloud.org/documents/1175580/veterans-health-administration-access-audit.pdf.

134 Gregg Jaffe and Josh Hicks, "VA audit: 57,000 veterans waiting more than 90 days for appointment at medical facilities," The Washington Post, June 9, 2014; http://www.washingtonpost.com/politics/va-audit-57000-veterans-waiting-more-than-90-days-for-appointment-at-medical-facilities/2014/06/09/599d26ee-f014-11e3-9ebc-2ee6f81ed217_story.html.

135 Department of Veterans Affairs Access Audit: System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014, June 9, 2014; http://www.va.gov/health/docs/VAAccessAuditFindingsReport.pdf.

136 Department of Veterans Affairs Access Audit: System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014, June 9, 2014; http://www.va.gov/health/docs/VAAccessAuditFindingsReport.pdf.

137 Department of Veterans Affairs Access Audit: System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014, June 9, 2014; http://www.va.gov/health/docs/VAAccessAuditFindingsReport.pdf.

138 Department of Veterans Affairs Access Audit: System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014, June 9, 2014; http://www.va.gov/health/docs/VAAccessAuditFindingsReport.pdf.

139 Department of Veterans Affairs Access Audit: System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014, June 9, 2014; http://www.va.gov/health/docs/VAAccessAuditFindingsReport.pdf.

140 Department of Veterans Affairs Access Audit: System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014, June 9, 2014; http://www.va.gov/health/docs/VAAccessAuditFindingsReport.pdf.

141 Department of Veterans Affairs Access Audit: System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014, June 9, 2014; http://www.va.gov/health/docs/VAAccessAuditFindingsReport.pdf.

142 Department of Veterans Affairs Access Audit: System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014, June 9, 2014; http://www.va.gov/health/docs/VAAccessAuditFindingsReport.pdf.

143 "Veterans Benefits Administration Reports, 2014 Monday Morning Workload Reports First Quarter," Department of Veterans Affairs, March 17, 2014 report; http://www.vba.va.gov/REPORTS/mmwr/index.asp.

144 "Veterans Benefits Administration Reports, 2014 Monday Morning Workload Reports First Quarter," Department of Veterans Affairs, March 17, 2014 report; http://www.vba.va.gov/REPORTS/mmwr/index.asp.

145 "Veterans Benefits Administration Reports, 2014 Monday Morning Workload Reports First Quarter," Department of Veterans Affairs, accessed March 24, 2014; http://www.vba.va.gov/REPORTS/mmwr/index.asp.

146 Aaron Glantz and Lauren Rabaino, "Veterans waiting longer," Bay Citizen, March 12, 2013; https://www.baycitizen.org/news/veterans/infographic-vets-wait-longer/.

147 "Veterans Benefits Administration Reports, 2014 Monday Morning Workload Reports First Quarter," Department of Veterans Affairs website, March 17, 2014 report; http://www.vba.va.gov/REPORTS/mmwr/index.asp.

148 Reid Wilson, "Veterans in 9 cities have to wait more than a year for claims to be addressed," Washington Post, December 16, 2013; http://www.washingtonpost.com/blogs/govbeat/wp/2013/12/16/veterans-in-9-cities-have-to-wait-more-than-a-year-for-claims-to-be-addressed/.

149 Keith Rogers, "Heller: Nevada veterans have longest wait for VA benefits," Las Vegas Review-Journal, December 11, 2013; http://www.reviewjournal.com/news/heller-nevada-veterans-have-longest-wait-va-benefits.

150 Reid Wilson, "Veterans in 9 cities have to wait more than a year for claims to be addressed," Washington Post, December 16, 2013; http://www.washingtonpost.com/blogs/govbeat/wp/2013/12/16/veterans-in-9-cities-have-to-wait-more-than-a-year-for-claims-to-be-addressed/.

151 Reid Wilson, "Veterans in 9 cities have to wait more than a year for claims to be addressed," Washington Post, December 16, 2013; http://www.washingtonpost.com/blogs/govbeat/wp/2013/12/16/veterans-in-9-cities-have-to-wait-more-than-a-year-for-claims-to-be-addressed/.

152 Mark Thompson, "Guess the VA Does Have a Paperwork Problem…," Time.com, August 10, 2012, http://nation.time.com/2012/08/10/guess-the-va-does-have-a-paperwork-problem/.

153 "Veterans Benefits Administration Claims Folder Storage at the VA Regional Office, Winston-Salem, North Carolina," Department of Veterans Affairs Office of Inspector General, August 9, 2012; http://www.va.gov/oig/pubs/VAOIG-12-00244-276.pdf.

154 Reid Wilson, "Veterans in 9 cities have to wait more than a year for claims to be addressed," The Washington Post, December 16, 2013; http://www.washingtonpost.com/blogs/govbeat/wp/2013/12/16/veterans-in-9-cities-have-to-wait-more-than-a-year-for-claims-to-be-addressed/.

155 Mike Baker, "Agent Orange cases may cost billions more," Washington Post, September 1, 2010; http://www.washingtonpost.com/wp-dyn/content/article/2010/08/31/AR2010083106819.html.

156 Reid Wilson, "Veterans in 9 cities have to wait more than a year for claims to be addressed," The Washington Post, December 16, 2013; http://www.washingtonpost.com/blogs/govbeat/wp/2013/12/16/veterans-in-9-cities-have-to-wait-more-than-a-year-for-claims-to-be-addressed/.

157 Reid Wilson, "Veterans in 9 cities have to wait more than a year for claims to be addressed," The Washington Post, December 16, 2013; http://www.washingtonpost.com/blogs/govbeat/wp/2013/12/16/veterans-in-9-cities-have-to-wait-more-than-a-year-for-claims-to-be-addressed/.

158 "Veterans Benefits Administration Claims Folder Storage at the VA Regional Office, Winston-Salem, North Carolina," Department of Veterans Affairs Office of Inspector General, August 9, 2012, http://www.va.gov/oig/pubs/VAOIG-12-00244-276.pdf.

159 "Baltimore Urged As Hospital Site: Delegation From Maryland Before Veterans' Administration Board, Big Waiting List Cited, Pleas Made By Senator Goldsborough, Representatives Linthicum and Cole," Baltimore Sun, June 25, 1932; (p. 12).

160 "Baltimore Urged As Hospital Site: Delegation From Maryland Before Veterans' Administration Board, Big Waiting List Cited, Pleas Made By Senator Goldsborough, Representatives Linthicum and Cole," Baltimore Sun, June 25, 1932; (p. 12).

161 "Gen. Bradley's Reply to Legion Charges: Changes Needed, General Says," New York Times, February 2, 1946; (p. 13).

162 "Gen. Bradley's Reply to Legion Charges: Changes Needed, General Says," New York Times, February 2, 1946; (p. 13).

163 "Gen. Bradley's Reply to Legion Charges: Changes Needed, General Says," New York Times, February 2, 1946; (p. 13).

164 "Veteran, A Waiting Hospital Bed, Dies: Letter From VA Found in Room With Man's Body," Baltimore Sun, July 5, 1952; (p. 22).

165 "Veteran, A Waiting Hospital Bed, Dies: Letter From VA Found in Room With Man's Body," Baltimore Sun, July 5, 1952; (p. 22).

166 "16,000 War Veterans Await Mental Illness Care," Hartford Courant, January 30, 1955; (p. 13).

167 "16,000 War Veterans Await Mental Illness Care," Hartford Courant, January 30, 1955; (p. 13).

168 "16,000 War Veterans Await Mental Illness Care," Hartford Courant, January 30, 1955; (p. 13).

Endnotes

169 Howard Norton, "82,000,000 Are Eligible: Numbers Given As Qualified for VA Health Care," Baltimore Sun, February 2, 1964;(p. 8).

170 "Sick veterans find waiting lists," Baltimore Sun, October, 4, 1971; (pg. A1).

171 "Sick veterans find waiting lists," Baltimore Sun, October, 4, 1971; (p. A1).

172 Susannah Rosenblatt, "VA Health Care System Failing, Survey Says; Veterans Have to Wait Up to Half a Year for Appointment," Los Angeles Times, July 15, 2003; (p. A.18).

173 Tom Cohen, "Audit: More than 120,000 veterans waiting or never got care," CNN, June 10, 2014; http://www.cnn.com/2014/06/09/politics/va-audit/index.html?iid=article_sidebar.

174 "Waiting for Care: Examining Patient Wait Times at VA," House Committee on Veterans Affairs Subcommittee on Oversight and Investigations hearing, March 14, 2013; http://veterans.house.gov/sites/republicans.veterans.house.gov/files/documents/113-11_0.pdf.

175 "Waiting for Care: Examining Patient Wait Times at VA," House Committee on Veterans Affairs Subcommittee on Oversight and Investigations hearing, March 14, 2013; http://veterans.house.gov/sites/republicans.veterans.house.gov/files/documents/113-11_0.pdf.

176 Alicia Parlapiano and Karen Yourish, "Major Reports and Testimony on V.A. Patient Wait Times," The New York Times, May 30, 2014; http://www.nytimes.com/interactive/2014/05/29/us/reports-on-va-patient-wait-periods.html?_r=0. See chart in Appendix.

177 "VETERANS' HEALTH CARE: VA Needs Better Data on Extent and Causes of Waiting Times," U.S. Government Accountability Office, May 2000; http://www.gao.gov/assets/240/230347.pdf.

178 "Audit of the Veterans Health Administration's Outpatient Scheduling Procedures," Department of Veterans Affairs Office of Inspector General, Report No. 04-02887-169, July 8, 2005; http://www.va.gov/oig/52/reports/2005/VAOIG-04-02887-169.pdf.

179 "Healthcare Inspection: Electronic Waiting List Management for Mental Health Clinics Atlanta VA Medical Center," Department of Veterans Affairs Office of Inspector General, Report No. 10-02986-215, July 12, 2011; http://www.va.gov/oig/54/reports/VAOIG-10-02986-215.pdf.

180 Mark Flatten, "Veterans Affairs officials purged 1.5 million unfinished medical orders," Washington Examiner, May 1, 2014; http://washingtonexaminer.com/veterans-affairs-officials-purged-1.5-million-unfinished-medical-orders/article/2547921.

181 Mark Flatten, "Veterans Affairs officials purged 1.5 million unfinished medical orders," Washington Examiner, May 1, 2014; http://washingtonexaminer.com/veterans-affairs-officials-purged-1.5-million-unfinished-medical-orders/article/2547921.

182 "Waiting for Care: Examining Patient Wait Times at VA," House Committee on Veterans Affairs Subcommittee on Oversight and Investigations hearing, March 14, 2013; http://veterans.house.gov/sites/republicans.veterans.house.gov/files/documents/113-11_0.pdf.

183 Patricia Kime, "VA wait times mean some die before getting care," Army Times, March 15, 2013; http://www.armytimes.com/article/20130315/BENEFITS04/303150016/VA-wait-times-mean-some-die-before-getting-care.

184 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/.

185 Interview with Staff, Office of Senator Tom Coburn.

186 Mark Flatten, "Veterans Affairs purged thousands of medical tests to 'game' its backlog stats," Washington Examiner, February 25, 2014; http://washingtonexaminer.com/veterans-affairs-purged-thousands-of-medical-tests-to-game-its-backlog-stats/article/2544580.

187 Mark Flatten, "Veterans Affairs purged thousands of medical tests to 'game' its backlog stats," Washington Examiner, February 25, 2014; http://washingtonexaminer.com/veterans-affairs-purged-thousands-of-medical-tests-to-game-its-backlog-stats/article/2544580.

188 Interview with Staff, Office of Senator Tom Coburn, February 26, 2014.

189 Interview with Staff, Office of Senator Tom Coburn, June 17, 2014.

190 Interview with Staff, Office of Senator Tom Coburn, February 26, 2014.

191 Interview with Staff, Office of Senator Tom Coburn, June 17, 2014.

192 Interview with Staff, Office of Senator Tom Coburn, June 17, 2014.

193 Josh Sweigart and Aaron Diamant, "Paying the Price – VA's malpractice tab: $845M in 10 years," WSB-TV and Cox Media Group; http://www.wsbtv.com/VA-lawsuits/.

194 Josh Sweigart and Aaron Diamant, "Paying the Price – VA's malpractice tab: $845M in 10 years," WSB-TV and Cox Media Group; http://www.wsbtv.com/VA-lawsuits/.

195 Scott Bronstein, Nelli Black, and Drew Griffin, "Hospital delays are killing America's war veterans," CNN, November 20, 2013; http://www.cnn.com/2013/11/19/health/veterans-dying-health-care-delays/index.html.

196 Scott Bronstein, Nelli Black, and Drew Griffin, "Hospital delays are killing America's war veterans," CNN, November 20, 2013; http://www.cnn.com/2013/11/19/health/veterans-dying-health-care-delays/index.html.

197 Josh Sweigart and Aaron Diamant, "Paying the Price – VA's malpractice tab: $845M in 10 years," WSB-TV and Cox Media Group; http://www.wsbtv.com/VA-lawsuits/.

198 Rich Gardella and Talesha Reynolds, "Memos Show VA Staffers Have Been 'Gaming System' for Six Years," NBC News, May 14, 2014; http://www.nbcnews.com/storyline/va-hospital-scandal/memos-show-va-staffers-have-been-gaming-system-six-years-n104621.

199 Rich Gardella and Talesha Reynolds, "Memos Show VA Staffers Have Been 'Gaming System' for Six Years," NBC News, May 14, 2014; http://www.nbcnews.com/storyline/va-hospital-scandal/memos-show-va-staffers-have-been-gaming-system-six-years-n104621.

200 Alicia Parlapiano and Karen Yourish, "Major Reports and Testimony on V.A. Patient Wait Times," The New York Times, May 30, 2014; http://www.nytimes.com/interactive/2014/05/29/us/reports-on-va-patient-wait-periods.html?_r=0. See chart in Appendix.

201 Memorandum from Department of Veterans Affairs Deputy Under Secretary for Health Operations and Management William Schoenhard to network directors regarding inappropriate scheduling practices, April 26, 2010.

202 Memorandum from Department of Veterans Affairs Deputy Under Secretary for Health Operations and Management William Schoenhard to network directors regarding inappropriate scheduling practices, April 26, 2010.

203 Memorandum from Department of Veterans Affairs Deputy Under Secretary for Health Operations and Management William Schoenhard to network directors regarding inappropriate scheduling practices, April 26, 2010.

204 "Department of Veterans Affairs Disclosures of Quality of Medical Care and Scheduling Issues," U.S. Office of Special Counsel, May 14, 2014.

205 Jeremy Schwartz, "VA employee: Wait list data was manipulated in Austin, San Antonio," American-Statesman, May 6, 2014; http://www.statesman.com/news/news/local-military/va-employee-wait-list-data-was-manipulated-in-aust/nfqfh/.

206 Jeremy Schwartz, "VA employee: Wait list data was manipulated in Austin, San Antonio," American-Statesman, May 6, 2014; http://www.statesman.com/news/

news/local-military/va-employee-wait-list-data-was-manipulated-in-aust/nfqfh/.

207 Dennis Wagner, "Acting VA secretary: 18 vets on Phoenix wait list died," USA Today, June 6, 2014; http://www.usatoday.com/story/news/nation/2014/06/05/va-scandal-sloan-gibson-phoenix/10033543/.

208 Scott Bronstein and Drew Griffin, "A fatal wait: Veterans languish and die on a VA hospital's secret list," CNN, April 24, 2014; http://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/.

209 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014; http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (p. 1).

210 Scott Bronstein and Drew Griffin, "A fatal wait: Veterans languish and die on a VA hospital's secret list," CNN, April 24, 2014; http://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/.

211 Scott Bronstein and Drew Griffin, "A fatal wait: Veterans languish and die on a VA hospital's secret list," CNN, April 24, 2014; http://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/.

212 "Electronic Wait List (EWL) for Scheduling and Primary Care Management Module (PCMM) User Manual," Department Of Veterans Affairs Office of Enterprise Development Management, Enrollment, Financial Systems, November 2002; http://www.va.gov/vdl/documents/Clinical/Electronic_Wait_List/ewl_um.pdf.

213 Mac Watson and Larry Gaydos, "Doctor: Phoenix VA problems started in 2010, spiraled from there," KTAR, April 25, 2014; http://ktar.com/22/1726708/Doctor-Phoenix-VA-problems-started-in-2010-spiraled-from-there.

214 Mac Watson and Larry Gaydos, "Doctor: Phoenix VA problems started in 2010, spiraled from there," KTAR, April 25, 2014; http://ktar.com/22/1726708/Doctor-Phoenix-VA-problems-started-in-2010-spiraled-from-there.

215 Mac Watson and Larry Gaydos, "Doctor: Phoenix VA problems started in 2010, spiraled from there," KTAR, April 25, 2014; http://ktar.com/22/1726708/Doctor-Phoenix-VA-problems-started-in-2010-spiraled-from-there.

216 Open the Books Investigation: Phoenix Veterans Affairs Health Care System, May 15, 2014; http://www.openthebooks.com/breaking_phoenix_veterans_affairs-_we_investigate/.

217 Open the Books Investigation: Phoenix Veterans Affairs Health Care System, May 15, 2014; http://www.openthebooks.com/breaking_phoenix_veterans_affairs-_we_investigate/.

218 Open the Books Investigation: Phoenix Veterans Affairs Health Care System, May 15, 2014; http://www.openthebooks.com/breaking_phoenix_veterans_affairs-_we_investigate/.

219 Open the Books Investigation: Phoenix Veterans Affairs Health Care System, May 15, 2014; http://www.openthebooks.com/breaking_phoenix_veterans_affairs-_we_investigate/.

220 Open the Books Investigation: Phoenix Veterans Affairs Health Care System, May 15, 2014; http://www.openthebooks.com/breaking_phoenix_veterans_affairs-_we_investigate/.

221 Emily Boyd Walker, "Staff at embattled Phoenix VA pocketed bonuses, hefty salaries," Fox News, May 15, 2014; http://www.foxnews.com/politics/2014/05/15/phoenix-va-workers-pocketed-bonuses-hefty-salaries-despite-allegations/.

222 Gregg Zoroya, "VA treatment records falsified, probe finds," USA Today, May 4, 2014; http://www.usatoday.com/story/news/nation/2014/05/04/va-healthcare-delays-treatment-phoenix-cheyenne-deaths/8602117/.

223 "Department of Veterans Affairs Disclosures of Quality of Medical Care and Scheduling Issues," U.S. Office of Special Counsel, May 14, 2014.

224 Gregg Zoroya, "VA treatment records falsified, probe finds," USA Today, May 4, 2014; http://www.usatoday.com/story/news/nation/2014/05/04/va-healthcare-delays-treatment-phoenix-cheyenne-deaths/8602117/.

225 Jennifer Janisch, "Email reveals deliberate effort by VA hospital to hide long patient waits," CBS News, May 9, 2014; http://www.cbsnews.com/news/email-reveals-effort-by-va-hospital-to-hide-long-patient-waits/.

226 Email from David G. Newman, Telehealth Coordinator at the VA Medical Center in Cheyenne, Wyoming, posted on CBS News, June 19, 2013; http://www.cbsnews.com/htdocs/pdf/Cheyenne_Email_Redacted.pdf.

227 Email from David G. Newman, Telehealth Coordinator at the VA Medical Center in Cheyenne, Wyoming, posted on CBS News, June 19, 2013; http://www.cbsnews.com/htdocs/pdf/Cheyenne_Email_Redacted.pdf.

228 Email from David G. Newman, Telehealth Coordinator at the VA Medical Center in Cheyenne, Wyoming, posted on CBS News, June 19, 2013; http://www.cbsnews.com/htdocs/pdf/Cheyenne_Email_Redacted.pdf.

229 Jennifer Janisch, "Email reveals deliberate effort by VA hospital to hide long patient waits," CBS News, May 9, 2014; http://www.cbsnews.com/news/email-reveals-effort-by-va-hospital-to-hide-long-patient-waits/.

230 Al Pefley, "South Florida Veteran Waiting Over 10 Years For Transplant," CBS 12 News, May 31, 2014; http://www.cbs12.com/news/top-stories/stories/vid_16376.shtml.

231 Al Pefley, "South Florida Veteran Waiting Over 10 Years For Transplant," CBS 12 News, May 31, 2014; http://www.cbs12.com/news/top-stories/stories/vid_16376.shtml.

232 Al Pefley, "South Florida Veteran Waiting Over 10 Years For Transplant," CBS 12 News, May 31, 2014; http://www.cbs12.com/news/top-stories/stories/vid_16376.shtml.

233 Al Pefley, "South Florida Veteran Waiting Over 10 Years For Transplant," CBS 12 News, May 31, 2014; http://www.cbs12.com/news/top-stories/stories/vid_16376.shtml.

234 Patrick Howley, "New evidence that the Department of Veterans Affairs deleted necessary medical requests from veterans," The Daily Caller, February 28, 2014; http://dailycaller.com/2014/02/28/new-evidence-that-the-department-of-veterans-affairs-deleted-neccessary-medical-requests-from-veterans/#ixzz2wWEfeGbu.

235 Patrick Howley, "New evidence that the Department of Veterans Affairs deleted necessary medical requests from veterans," The Daily Caller, February 28, 2014; http://dailycaller.com/2014/02/28/new-evidence-that-the-department-of-veterans-affairs-deleted-neccessary-medical-requests-from-veterans/#ixzz2wWEfeGbu.

236 Mark Flatten, "Veterans Affairs purged thousands of medical tests to 'game' its backlog stats," Washington Examiner, February 25, 2014; http://washingtonexaminer.com/veterans-affairs-purged-thousands-of-medical-tests-to-game-its-backlog-stats/article/2544580.

237 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/.

238 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/.

239 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/.

240 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/.

241 Scott Bronstein and Drew Griffin, "A fatal wait: Veterans languish and die on a VA hospital's secret list," CNN, April 24, 2014; http://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/.

242 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http://www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

243 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http://www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

244 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http://www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

245 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http://www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

246 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http://www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

247 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http://www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

248 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http://www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

249 David A. Fahrenthold, "How the VA developed its culture of coverups: Once a bureaucratic success story, the agency began to hide its problems from those in Washington," The Washington Post, May 30, 2014; http://www.washingtonpost.com/sf/national/2014/05/30/how-the-va-developed-its-culture-of-coverups/.

250 David A. Fahrenthold, "How the VA developed its culture of coverups: Once a bureaucratic success story, the agency began to hide its problems from those in Washington," The Washington Post, May 30, 2014; http://www.washingtonpost.com/sf/national/2014/05/30/how-the-va-developed-its-culture-of-coverups/.

251 David A. Fahrenthold, "How the VA developed its culture of coverups: Once a bureaucratic success story, the agency began to hide its problems from those in Washington," The Washington Post, May 30, 2014; http://www.washingtonpost.com/sf/national/2014/05/30/how-the-va-developed-its-culture-of-coverups/.

252 David A. Fahrenthold, "How the VA developed its culture of coverups: Once a bureaucratic success story, the agency began to hide its problems from those in Washington," The Washington Post, May 30, 2014; http://www.washingtonpost.com/sf/national/2014/05/30/how-the-va-developed-its-culture-of-coverups/.

253 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http://www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

254 Patricia Kime, "VA wait times mean some die before getting care," Army Times, March 15, 2013; http://www.armytimes.com/article/20130315/BENEFITS04/303150016/VA-wait-times-mean-some-die-before-getting-care.

255 Patricia Kime, "VA wait times mean some die before getting care," Army Times, March 15, 2013; http://www.armytimes.com/article/20130315/BENEFITS04/303150016/VA-wait-times-mean-some-die-before-getting-care.

256 Scott Bronstein, Nelli Black and Drew Griffin, "Hospital delays are killing America's war veterans," CNN, November 20, 2013; http://www.cnn.com/2013/11/19/health/veterans-dying-health-care-delays/.

257 Scott Bronstein and Drew Griffin, "A fatal wait: Veterans languish and die on a VA hospital's secret list," CNN, April 24, 2014; http://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/.

258 Department of Veterans Affairs 2013 Performance and Accountability Report, Part II – Performance Results, December 16,2013; http://www.va.gov/budget/docs/report/2013-VAPAR_Part_II.pdf.

259 Department of Veterans Affairs 2013 Performance and Accountability Report, December 16, 2013; http://www.va.gov/budget/report/.

260 "Audit of VA's Hearing Aid Services," Department of Veterans Affairs Office of Inspector General, Office of Audits and Evaluations, February 20, 2014; http://www.va.gov/oig/pubs/VAOIG-12-02910-80.pdf.

261 "Audit of VA's Hearing Aid Services," Department of Veterans Affairs Office of Inspector General, Office of Audits and Evaluations, February 20, 2014; http://www.va.gov/oig/pubs/VAOIG-12-02910-80.pdf.

262 "Audit of VA's Hearing Aid Services," Department of Veterans Affairs Office of Inspector General, Office of Audits and Evaluations, February 20, 2014; http://www.va.gov/oig/pubs/VAOIG-12-02910-80.pdf.

263 "Audit of VA's Hearing Aid Services," Department of Veterans Affairs Office of Inspector General, Office of Audits and Evaluations, February 20, 2014; http://www.va.gov/oig/pubs/VAOIG-12-02910-80.pdf.

264 "Audit of VA's Hearing Aid Services," Department of Veterans Affairs Office of Inspector General, Office of Audits and Evaluations, February 20, 2014; http://www.va.gov/oig/pubs/VAOIG-12-02910-80.pdf.

265 "Audit of VA's Hearing Aid Services," Department of Veterans Affairs Office of Inspector General, Office of Audits and Evaluations, February 20, 2014; http://www.va.gov/oig/pubs/VAOIG-12-02910-80.pdf.

266 "Semiannual Report to Congress," Issue 70, Department of Veterans Affairs Office of the Inspector General, April 1- September 30, 2013; http://www.va.gov/oig/pubs/sars/VAOIG-SAR-2013-2.pdf.

267 "Semiannual Report to Congress," Issue 70, Department of Veterans Affairs Office of the Inspector General, April 1- September 30, 2013; http://www.va.gov/oig/pubs/sars/VAOIG-SAR-2013-2.pdf.

268 "Semiannual Report to Congress," Issue 70, Department of Veterans Affairs Office of the Inspector General, April 1- September 30, 2013; http://www.va.gov/oig/pubs/sars/VAOIG-SAR-2013-2.pdf.

269 "Semiannual Report to Congress," Issue 70, Department of Veterans Affairs Office of the Inspector General, April 1- September 30, 2013; http://www.va.gov/oig/pubs/sars/VAOIG-SAR-2013-2.pdf.

270 David Zucchino, Cindy Carcamo, and Alan Zarembo, "Growing evidence points to systemic troubles in VA healthcare system," LA Times, May 18, 2014; http://www.latimes.com/nation/la-na-va-delays-20140518-story.html#page=1.

271 David Zucchino, Cindy Carcamo, and Alan Zarembo, "Growing evidence points to systemic troubles in VA healthcare system," LA Times, May 18, 2014; http://www.latimes.com/nation/la-na-va-delays-20140518-story.html#page=1.

272 David Zucchino, Cindy Carcamo, and Alan Zarembo, "Growing evidence points to systemic troubles in VA healthcare system," LA Times, May 18, 2014; http://

www.latimes.com/nation/la-na-va-delays-20140518-story.html#page=1.

273 David Zucchino, Cindy Carcamo, and Alan Zarembo, "Growing evidence points to systemic troubles in VA healthcare system," LA Times, May 18, 2014; http://www.latimes.com/nation/la-na-va-delays-20140518-story.html#page=1.

274 David Zucchino, Cindy Carcamo, and Alan Zarembo, "Growing evidence points to systemic troubles in VA healthcare system," LA Times, May 18, 2014; http://www.latimes.com/nation/la-na-va-delays-20140518-story.html#page=1.

275 David Zucchino, Cindy Carcamo, and Alan Zarembo, "Growing evidence points to systemic troubles in VA healthcare system," LA Times, May 18, 2014; http://www.latimes.com/nation/la-na-va-delays-20140518-story.html#page=1.

276 David Zucchino, Cindy Carcamo, and Alan Zarembo, "Growing evidence points to systemic troubles in VA healthcare system," LA Times, May 18, 2014; http://www.latimes.com/nation/la-na-va-delays-20140518-story.html#page=1.

277 Amy Lipman, "Local VA patients bring complaints to surface," NBC 11 News, May 29, 2014; http://www.nbc11news.com/home/headlines/Local-VA-patients-bring-complaints-to-surface-261182401.html.

278 Amy Lipman, "Local VA patients bring complaints to surface," NBC 11 News, May 29, 2014; http://www.nbc11news.com/home/headlines/Local-VA-patients-bring-complaints-to-surface-261182401.html.

279 Amy Lipman, "Local VA patients bring complaints to surface," NBC 11 News, May 29, 2014; http://www.nbc11news.com/home/headlines/Local-VA-patients-bring-complaints-to-surface-261182401.html.

280 Steve Tetreault, "Inspectors: Long waits at North Las Vegas VA hospital not unusual," Las Vegas Review-Journal, April 30, 2014; http://www.reviewjournal.com/news/military/inspectors-long-waits-north-las-vegas-va-hospital-not-unusual.

281 Steve Tetreault, "Inspectors: Long waits at North Las Vegas VA hospital not unusual," Las Vegas Review-Journal, April 30, 2014; http://www.reviewjournal.com/news/military/inspectors-long-waits-north-las-vegas-va-hospital-not-unusual.

282 Steve Tetreault, "Inspectors: Long waits at North Las Vegas VA hospital not unusual," Las Vegas Review-Journal, April 30, 2014; http://www.reviewjournal.com/news/military/inspectors-long-waits-north-las-vegas-va-hospital-not-unusual.

283 Department of Veterans Affairs Office of Inspector General, "Healthcare Inspection: Alleged Excessive Wait for Emergency Care and Staff Disrespect VA Southern Nevada Healthcare," Report No. 14-01104-134, April 30, 2014; http://www.va.gov/oig/pubs/VAOIG-14-01104-134.pdf (p. 13).

284 Department of Veterans Affairs Office of Inspector General, "Healthcare Inspection: Alleged Excessive Wait for Emergency Care and Staff Disrespect VA Southern Nevada Healthcare," Report No. 14-01104-134, April 30, 2014; http://www.va.gov/oig/pubs/VAOIG-14-01104-134.pdf (p. 13).

285 Department of Veterans Affairs Office of Inspector General, "Healthcare Inspection: Alleged Excessive Wait for Emergency Care and Staff Disrespect VA Southern Nevada Healthcare," Report No. 14-01104-134, April 30, 2014; http://www.va.gov/oig/pubs/VAOIG-14-01104-134.pdf (p. 13).

286 Steve Tetreault, "Inspectors: Long waits at North Las Vegas VA hospital not unusual," Las Vegas Review-Journal, April 30, 2014; http://www.reviewjournal.com/news/military/inspectors-long-waits-north-las-vegas-va-hospital-not-unusual.

287 One widely cited study is Trivedi et al. (2011) "Systematic Review: Comparison of the Quality of Medical Care in Veterans Affairs and Non-Veterans Affairs Settings," Medical Care, 49(1): 76-88.

288 Kenneth Kizer and Ashish Jha, "Restoring Trust in VA Health Care," New England Journal of Medicine, June 4, 2014; http://www.nejm.org/doi/full/10.1056/NEJMp1406852.

289 Thomas Burton and Damian Paletta, "Veterans Affairs Hospitals Vary Widely in Patient Care," Wall Street Journal, June 3, 2014; http://online.wsj.com/articles/veterans-affairs-hospitals-vary-widely-in-patient-care-1401753437.

290 Thomas Burton, "VA Halted Visits to Troubled Hospitals," Wall Street Journal, June 9, 2014; http://online.wsj.com/articles/visits-to-troubled-hospitals-1402357126.

291 Thomas Burton and Damian Paletta, "Veterans Affairs Hospitals Vary Widely in Patient Care," Wall Street Journal, June 3, 2014; http://online.wsj.com/articles/veterans-affairs-hospitals-vary-widely-in-patient-care-1401753437.

292 ASPIRE Dashboard for VISN 18, http://www.hospitalcompare.va.gov/reports/Aspire_Report18.pdf, accessed June 6, 2014.

293 "Embattled Phoenix VA's health-care quality measured," AZCentral, June 4, 2014; http://www.azcentral.com/story/news/politics/2014/06/04/embattled-phoenix-vas-health-care-quality-measured/9944269/.

294 "Embattled Phoenix VA's health-care quality measured," AZCentral, June 4, 2014; http://www.azcentral.com/story/news/politics/2014/06/04/embattled-phoenix-vas-health-care-quality-measured/9944269/.

295 Thomas Burton and Damian Paletta, "Veterans Affairs Hospitals Vary Widely in Patient Care," Wall Street Journal, June 3, 2014; http://online.wsj.com/articles/veterans-affairs-hospitals-vary-widely-in-patient-care-1401753437.

296 Strategic Analytics for Improvement and Learning reports for VISN 20, FY2012Q1-FY2013Q2, posted at http://s3.documentcloud.org/documents/784605/sail-data.pdf, accessed June 6, 2014.

297 Strategic Analytics for Improvement and Learning reports for VISN 20, FY2012Q1-FY2013Q2, posted at http://s3.documentcloud.org/documents/784605/sail-data.pdf, accessed June 6, 2014.

298 Thomas Burton, "VA Halted Visits to Troubled Hospitals," Wall Street Journal, June 9, 2014; http://online.wsj.com/articles/visits-to-troubled-hospitals-1402357126.

299 See the Hospital Profile for the Augusta VA Medical Center on the Hospital Compare website, http://www.medicare.gov/hospitalcompare/profile.html#profTab=3&ID=11030F&loc=AUGUSTA%2C%20GA&lat=33.4734978&lng=-82.0105148, accessed June 10, 2014.

300 Thomas Burton and Damian Paletta, "Veterans Affairs Hospitals Vary Widely in Patient Care," Wall Street Journal, June 3, 2014; http://online.wsj.com/articles/veterans-affairs-hospitals-vary-widely-in-patient-care-1401753437.

301 Thomas Burton and Damian Paletta, "Veterans Affairs Hospitals Vary Widely in Patient Care," Wall Street Journal, June 3, 2014; http://online.wsj.com/articles/veterans-affairs-hospitals-vary-widely-in-patient-care-1401753437.

302 Thomas Burton and Damian Paletta, "Veterans Affairs Hospitals Vary Widely in Patient Care," Wall Street Journal, June 3, 2014; http://online.wsj.com/articles/veterans-affairs-hospitals-vary-widely-in-patient-care-1401753437.

303 Thomas Burton and Damian Paletta, "Veterans Affairs Hospitals Vary Widely in Patient Care," Wall Street Journal, June 3, 2014; http://online.wsj.com/articles/veterans-affairs-hospitals-vary-widely-in-patient-care-1401753437.

304 The VA publicly released information from its SAIL database on June 9, 2014.

305 Thomas Burton, "VA Halted Visits to Troubled Hospitals," Wall Street Journal, June 9, 2014; http://online.wsj.com/articles/visits-to-troubled-hospitals-1402357126.

306 Thomas Burton, "VA Halted Visits to Troubled Hospitals," Wall Street Journal, June 9, 2014; http://online.wsj.com/articles/visits-to-troubled-hospitals-1402357126.

307 Thomas Burton, "VA Halted Visits to Troubled Hospitals," Wall Street Journal, June 9, 2014; http://online.wsj.com/articles/visits-to-troubled-hospitals-1402357126.

308 Strategic Analytics for Improvement and Learning reports for VISN 20, FY2012Q1-FY2013Q2, posted at http://s3.documentcloud.org/documents/784605/sail-data.

pdf, accessed June 6, 2014.

309 "Veterans Benefits Administration Reports – Aspire Dashboard," U.S. Department of Veterans Affairs, http://www.benefits.va.gov/REPORTS/aspire_dashboard. asp, accessed June 10, 2014.

310 "VISN 17 FY2014 through Q1 Safety Measures," LinKS database, http://www.hospitalcompare.va.gov/reports/VISN7_LinKS.pdf, accessed June 6, 2014. Facilities receive a checkmark if they are within 2 standard deviations of the mean – which encompasses 95 percent of all facilities.

311 Joel Zinberg, "The Worst Available Care," City Journal, June 6, 2014; http://www.city-journal.org/2014/eon0606jz.html.

312 "Healthcare Inspection: Quality of Care Issues in the Dialysis Unit," VA Office of Inspector General, Report No. 05-02589-47, December 27, 2005; http://www. va.gov/oig/54/reports/VAOIG-05-02589-47.pdf.

313 "Semiannual Report to Congress: Issue 68 | April 1-September 30, 2012," VA Office of Inspector General, http://www.va.gov/oig/pubs/sars/VAOIG-SAR-2012-2.pdf.

314 "VISN 18 FY2014 through Q1 Safety Measures," LinKS database, http://www.hospitalcompare.va.gov/reports/VISN18_LinKS.pdf, accessed June 6, 2014.

315 "VISN 17 FY2014 through Q1 Safety Measures," LinKS database, http://www.hospitalcompare.va.gov/reports/VISN7_LinKS.pdf, accessed June 6, 2014.

316 "VISN 1 FY2014 through Q1 Safety Measures," LinKS database, http://www.hospitalcompare.va.gov/reports/VISN1_LinKS.pdf, accessed June 6, 2014.

317 "VISN 5 FY2014 through Q1 Safety Measures," LinKS database, http://www.hospitalcompare.va.gov/reports/VISN5_LinKS.pdf, accessed June 6, 2014.

318 Kenneth Kizer and Ashish Jha, "Restoring Trust in VA Health Care," New England Journal of Medicine, June 4, 2014; http://www.nejm.org/doi/full/10.1056/ NEJMp1406852.

319 Thomas Burton, "VA Halted Visits to Troubled Hospitals," Wall Street Journal, June 9, 2014; http://online.wsj.com/articles/visits-to-troubled-hospitals-1402357126.

320 Altschuler, Justin, David Margolius, Thomas Bodenheimer, and Kevin Grumach. (2012) "Estimating a Reasonable Patient Panel Size for Primary Care Physicians With Team-Based Task Delegation," Annals of Family Medicine, 10(5):396-400.

321 Altschuler, Justin, David Margolius, Thomas Bodenheimer, and Kevin Grumach. (2012) "Estimating a Reasonable Patient Panel Size for Primary Care Physicians With Team-Based Task Delegation," Annals of Family Medicine, 10(5):396-400.

322 Zinberg, Joel. "The Worst Available Care," City Journal, June 6, 2014.

323 Zinberg, Joel. "The Worst Available Care," City Journal, June 6, 2014.

324 Scherz, Hal. "Doctors' War Stories From VA Hospitals," Wall Street Journal, May 27, 2014.

325 Zinberg, Joel. "The Worst Available Care," City Journal, June 6, 2014.

326 Zinberg, Joel. "The Worst Available Care," City Journal, June 6, 2014.

327 "Veterans Health Administration: Audit of Physician Staffing Levels for Specialty Care Services," VA Office of Inspector General, December 27, 2012, Report No. 11-01827-36.

328 "Veterans Health Administration: Audit of Physician Staffing Levels for Specialty Care Services," VA Office of Inspector General, December 27, 2012, Report No. 11-01827-36.

329 "Veterans Health Administration: Audit of Physician Staffing Levels for Specialty Care Services," VA Office of Inspector General, December 27, 2012, Report No. 11-01827-36.

330 "Veterans Health Administration: Audit of Physician Staffing Levels for Specialty Care Services," VA Office of Inspector General, December 27, 2012, Report No. 11-01827-36.

331 "Veterans Health Administration: Audit of Physician Staffing Levels for Specialty Care Services," VA Office of Inspector General, December 27, 2012, Report No. 11-01827-36.

332 "Veterans Health Administration: Audit of Physician Staffing Levels for Specialty Care Services," VA Office of Inspector General, December 27, 2012, Report No. 11-01827-36.

333 B. Christopher Agee, "Shocking Report: Phoenix VA Salaries Eclipse All Other Gov't Agencies," Western Journalism, May 30, 2014; http://www.westernjournalism. com/shocking-report-phoenix-va-salaries-eclipse-govt-agencies/.

334 Adam Smeltz and Mike Wereschagin, "Veterans Affairs execs who quit can avoid discipline, agency leader tells Congress," The Pittsburgh Tribune, February 26, 2014; http://triblive.com/news/allegheny/5666924-74/outbreak-veterans-died#axzz30O7C99c0.

335 Department of Veterans Affairs Office of Inspector General, Semiannual Report to Congress, Issue 67, October 1, 2011—March 31, 2012; http://www.va.gov/oig/ pubs/sars/vaoig-sar-2012-1.pdf (p. 21).

336 U.S. Office of Personnel Management, "Pay & Leave – Recruitment, Relocation, and Retention Incentives," Office of Personnel Management; http://www.opm.gov/ policy-data-oversight/pay-leave/recruitment-relocation-retention-incentives/.

337 Department of Veterans Affairs Office of Inspector General, Semiannual Report to Congress, Issue 67, October 1, 2011—March 31, 2012; http://www.va.gov/oig/ pubs/sars/vaoig-sar-2012-1.pdf (p. 21).

338 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http:// www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

339 "VA Health Care: Actions Needed to Improve Administration of the Provider Performance Pay and Award Systems," U.S. Government Accountability Office, GAO-13-536, July 2013; http://www.gao.gov/assets/660/656185.pdf.

340 "VA Health Care: Actions Needed to Improve Administration of the Provider Performance Pay and Award Systems," U.S. Government Accountability Office, GAO-13-536, July 2013; http://www.gao.gov/assets/660/656185.pdf.

341 "VA Health Care: Actions Needed to Improve Administration of the Provider Performance Pay and Award Systems," U.S. Government Accountability Office, GAO-13-536, July 2013; http://www.gao.gov/assets/660/656185.pdf.

342 Craig Harris and Rob O'Dell, "Phoenix VA gave out $10 mill in bonuses in last 3 years," AZ Central, June 16, 2014; http://www.azcentral.com/story/news/arizona/ investigations/2014/06/17/phoenix-va-gave-mil-bonuses-last-years/10653263/.

343 Open the Books Investigation: Phoenix Veterans Affairs Health Care System, May 15, 2014; http://www.openthebooks.com/breaking_phoenix_veterans_affairs-_ we_investigate/; CJ Ciaramella, "VA Director at Phoenix Hospital Got $9K Bonus," The Washington Free Beacon, April 14, 201; http://freebeacon.com/issues/va-director-at-phoenix-hospital-got-9k-bonus/.

344 Craig Harris and Rob O'Dell, "Phoenix VA gave out $10 mill in bonuses in last 3 years," AZ Central, June 16, 2014; http://www.azcentral.com/story/news/arizona/ investigations/2014/06/17/phoenix-va-gave-mil-bonuses-last-years/10653263/.

345 Sheila Hagar, "Suspended VA director drew ire in Walla Walla," Yakima Herald, May 11, 2014; http://www.yakimaherald.com/news/latestnews/2168806-8/ suspended-va-director-drew-ire-in-walla-walla.

346 Sheila Hagar, "Suspended VA director drew ire in Walla Walla," Yakima Herald, May 11, 2014; http://www.yakimaherald.com/news/latestnews/2168806-8/

suspended-va-director-drew-ire-in-walla-walla.

347 Cristina Corbin, "Arizona VA boss accused of covering up veterans' deaths linked to previous scandal," Fox News, April 24, 2014; http://www.foxnews.com/politics/2014/04/24/arizona-va-boss-accused-covering-up-veterans-deaths-linked-to-previous-scandal/.

348 Brian Skoloff, "3 at Phoenix VA hospital on leave over allegations," Washington Post, May 1, 2014; http://www.washingtonpost.com/politics/3-at-phoenix-va-hospital-on-leave-over-allegations/2014/05/01/31b500ec-d19d-11e3-9e25-188ebe1fa93b_story.html.

349 Brian Skoloff, "3 at Phoenix VA hospital on leave over allegations," Washington Post, May 1, 2014; http://www.washingtonpost.com/politics/3-at-phoenix-va-hospital-on-leave-over-allegations/2014/05/01/31b500ec-d19d-11e3-9e25-188ebe1fa93b_story.html.

350 Feds Data Center, http://fedsdatacenter.com/ (accessed June 6, 2014).

351 Feds Data Center, http://fedsdatacenter.com/ (accessed June 5, 2014).

352 "VA Study - $136 billion in Salaries, $282 Million in Bonuses (2007-2013)," Open the Books, June 3, 2014; http://www.openthebooks.com/va_study-_136_billion_in_salaries_282_million_in_bonuses_2007-2013/?PensionCode=840&F_fiscalyear=2013&F_Station=Phoenix&F_Name=&perpage=100.

353 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014, http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (p. 1).

354 VA Office of the Inspector General, Veterans Health Administration – Interim Report, "Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," 14-02603-178, May 28, 2014, http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf (p. iii); B. Christopher Agee, "Shocking Report: Phoenix VA Salaries Eclipse All Other Gov't Agencies," Western Journalism, May 30, 2014; http://www.westernjournalism.com/shocking-report-phoenix-va-salaries-eclipse-govt-agencies/.

355 "Feds Data Center, http://fedsdatacenter.com/ (accessed June 6, 2014).

356 Bob Unruh, "Report: Top VA Execs Took Home Millions," WND, May 28, 2014; http://www.wnd.com/2014/05/report-top-va-execs-took-home-millions/.

357 Scott Bronstein, Nelli Black, and Drew Griffin, "Veterans dying because of health delays," CNN, January 30, 2014; http://www.cnn.com/2014/01/30/health/veterans-dying-health-care-delays/index.html?hpt=hp_t2.

358 "VA Health Care: Actions Needed to Improve Administration of the Provider Performance Pay and Award Systems," U.S. Government Accountability Office, GAO-13-536, Appendix I, p. 27, July 2013; http://www.gao.gov/assets/660/656185.pdf.

359 Wesley Brown, "Augusta VA chief of staff remains on payroll after resignation," The Augusta Chronicle, March 11, 2014; http://chronicle.augusta.com/news/health/2014-03-11/augusta-va-chief-staff-remains-payroll-after-resignation.

360 Wesley Brown, "Augusta VA chief of staff remains on payroll after resignation," The Augusta Chronicle, March 11, 2014; http://chronicle.augusta.com/news/health/2014-03-11/augusta-va-chief-staff-remains-payroll-after-resignation.

361 Wesley Brown, "Augusta VA chief of staff remains on payroll after resignation," The Augusta Chronicle, March 11, 2014; http://chronicle.augusta.com/news/health/2014-03-11/augusta-va-chief-staff-remains-payroll-after-resignation.

362 Wesley Brown, "Augusta VA chief of staff remains on payroll after resignation," The Augusta Chronicle, March 11, 2014; http://chronicle.augusta.com/news/health/2014-03-11/augusta-va-chief-staff-remains-payroll-after-resignation.

363 Wesley Brown, "Augusta VA chief of staff remains on payroll after resignation," The Augusta Chronicle, March 11, 2014; http://chronicle.augusta.com/news/health/2014-03-11/augusta-va-chief-staff-remains-payroll-after-resignation.

364 Jennifer Janissch, "VA hospital knew human error caused Legionnaires' outbreak," CBS News, March 13, 2014; http://www.cbsnews.com/news/va-hospital-knew-human-error-caused-legionnaires-outbreak/.

365 Mike Wereschagin and Adam Smeltz, "Second report critical of VA Pittsburgh," TribeLive News, May 4, 2013; http://triblive.com/news/allegheny/3959616-74/moreland-pittsburgh-report#axzz2vrcNTlNT.

366 Jennifer Janissch, "VA hospital knew human error caused Legionnaires' outbreak," CBS News, March 13; 2014, http://www.cbsnews.com/news/va-hospital-knew-human-error-caused-legionnaires-outbreak/.

367 Mike Wereschagin and Adam Smeltz, "Second report critical of VA Pittsburgh," TribLive News, May 4, 2013; http://triblive.com/news/allegheny/3959616-74/moreland-pittsburgh-report#axzz2vrcNTlNT.

368 Mike Wereschagin and Adam Smeltz, "Second report critical of VA Pittsburgh," TribLive News, May 4, 2013; http://triblive.com/news/allegheny/3959616-74/moreland-pittsburgh-report#axzz2vrcNTlNT.

369 Department of Veterans Affairs Office of Inspector General, "Healthcare Inspection: Legionnaires' Disease at the VA Pittsburgh Healthcare System," Report No. 13-00994-180, April 23, 2013; http://www.va.gov/oig/pubs/VAOIG-13-00994-180.pdf. The OIG cited "lack of documentation of system monitoring . . . and inconsistent communication and coordination between the Infection Prevention Team and Facility Management Service staff."

370 Sean D. Hamill, "Veterans Affairs leader Michael Moreland's exit worries families," Pittsburg Post-Gazette, October 5, 2013; http://www.post-gazette.com/news/nation/2013/10/05/Veterans-Affairs-leader-Michael-Moreland-s-exit-worries-families/stories/201310050046.

371 "Presidential Distinguished Rank Award Banquet," Senior Executives Organization; https://seniorexecs.org/professional-development-league/rank-awards.

372 Aaron Glantz, "VA Rewarded Top Officials with Bonuses, Despite Growing Claims Backlog," KQED News, April 29, 2013; http://blogs.kqed.org/newsfix/2013/04/29/va-rewarded-top-officials-with-bonuses-despite-growing-claims-backlog/.

373 Aaron Glantz, "VA Rewarded Top Officials with Bonuses, Despite Growing Claims Backlog," KQED News, Blogs.kqued.org, April 29, 2013, http://blogs.kqed.org/newsfix/2013/04/29/va-rewarded-top-officials-with-bonuses-despite-growing-claims-backlog/.

374 Mark Flatten, "Examiner Exclusive: Failing VA officials collected massive bonuses for years," Washington Examiner, May 8, 2013; http://washingtonexaminer.com/failing-va-officials-collected-huge-bonuses-for-years/article/2529219.

375 Mark Flatten, "Examiner Exclusive: Failing VA officials collected massive bonuses for years," Washington Examiner, May 8, 2013; http://washingtonexaminer.com/failing-va-officials-collected-huge-bonuses-for-years/article/2529219.

376 Joe Schoffstall, "Over $550,000 in bonuses given to Veteran Affairs managers despite preventable deaths, disease outbreaks, and delays," Capitol City Project, November 1, 2013; http://capitolcityproject.com/nearly-500000-in-bonuses-given-to-veteran-affairs-employees-despite-preventable-deaths-disease-outbreaks-and-delays/.

377 Patrick Howley, "Veterans Affairs ran up more than $1.5 billion in construction cost overruns, sued for failing to pay contractors," The Daily Caller, April 21, 2014; http://dailycaller.com/2014/04/21/department-of-veterans-affairs-ran-up-more-than-1-5-billion-in-construction-cost-overruns-sued-for-failing-to-pay-contractors/.

378 VIDEO: House Committee on Veterans' Affairs, "VA Exec Can't Explain Why He Collected $54,792 in Bonuses," YouTube, May 7, 2013; https://www.youtube.com/watch?v=oA8zZ9BJNmc.

379 VIDEO: House Committee on Veterans' Affairs, "VA Exec Can't Explain Why He Collected $54,792 in Bonuses," YouTube, May 7, 2013; https://www.youtube.com/

watch?v=oA8zZ9BJNmc.

380 U.S. Department of Veterans Affairs, Office of Public and Intergovernmental Affairs – Executive Biographies, Glenn D. Haggstrom; http://www.va.gov/opa/bios/bio_haggstrom.asp.

381 House Committee on Veterans' Affairs, "VA Accountability Watch," http://veterans.house.gov/accountability; Associated Press, "St. Louis VA dental technician says she warned supervisors of sterilization issues months ago,"
Fox News, July 13, 2010; http://www.foxnews.com/us/2010/07/13/st-louis-va-dental-technician-says-warned-supervisors-sterilization-issues/; Mark Flatten, "Nothing stopped VA's fat bonuses, not even dead vets, dirty hospitals," Washington Examiner, August 27, 2013; http://washingtonexaminer.com/nothing-stopped-vas-fat-bonuses-not-even-dead-vets-dirty-hospitals/article/2534733.

382 House Committee on Veterans' Affairs, "VA Accountability Watch," http://veterans.house.gov/accountability; Associated Press, "St. Louis VA dental technician says she warned supervisors of sterilization issues months ago," Fox News, July 13, 2010; http://www.foxnews.com/us/2010/07/13/st-louis-va-dental-technician-says-warned-supervisors-sterilization-issues/; Mark Flatten, "Nothing stopped VA's fat bonuses, not even dead vets, dirty hospitals," Washington Examiner, August 27, 2013; http://washingtonexaminer.com/nothing-stopped-vas-fat-bonuses-not-even-dead-vets-dirty-hospitals/article/2534733.

383 Department of Veterans Affairs Office of Inspector General, "Healthcare Inspection: Reprocessing of Dental Instruments John Cochran Division of the St. Louis VA Medical Center, St. Louis, Missouri," Report No. 10-03346-112, March 7, 2011; http://www.va.gov/oig/54/reports/VAOIG-10-03346-112.pdf (p. 6). Following OIG's report and recommendations, the St. Louis dental center corrected most leadership and compliance deficiencies. Noting some aspects of the VA facility could still be bettered, OIG found that the center made vast improvements in its dental instrument cleaning policies. http://www.va.gov/oig/pubs/sars/vaoig-sar-2012-2.pdf (p. 15).

384 Ben Sutherly, "Despite probe, Dayton VA chief received bonuses," Dayton Daily News, March 8, 2011; http://www.daytondailynews.com/news/news/local/despite-probe-dayton-va-chief-received-bonuses/nMprf/.

385 Ben Sutherly, "Despite probe, Dayton VA chief received bonuses," Dayton Daily News, March 8, 2011; http://www.daytondailynews.com/news/news/local/despite-probe-dayton-va-chief-received-bonuses/nMprf/.

386 House Committee on Veterans' Affairs, "VA Accountability Watch," http://veterans.house.gov/accountability; Michael Wooten, "Higgins, Schumer Call For Investigation of Buffalo VA," WRGRZ News and NBC News, January 16, 2013; http://www.wgrz.com/news/article/196069/37/Local-Veterans-May-Have-Ben-Exposed-to-HIV-Hepatitis-at-VA-Hospital.

387 Jacob Siegel, "Exclusive: Texas VA Run Like a 'Crime Syndicate,' Whistleblower Says," The Daily Beast, May 27, 2014; http://www.thedailybeast.com/articles/2014/05/27/exclusive-texas-va-run-like-a-crime-syndicate-whistleblower-says.html.

388 Jacob Siegel, "Exclusive: Texas VA Run Like a 'Crime Syndicate,' Whistleblower Says," The Daily Beast, May 27, 2014; http://www.thedailybeast.com/articles/2014/05/27/exclusive-texas-va-run-like-a-crime-syndicate-whistleblower-says.html.

389 Jacob Siegel, "Exclusive: Texas VA Run Like a 'Crime Syndicate,' Whistleblower Says," The Daily Beast, May 27, 2014; http://www.thedailybeast.com/articles/2014/05/27/exclusive-texas-va-run-like-a-crime-syndicate-whistleblower-says.html.

390 Jacob Siegel, "Exclusive: Texas VA Run Like a 'Crime Syndicate,' Whistleblower Says," The Daily Beast, May 27, 2014; http://www.thedailybeast.com/articles/2014/05/27/exclusive-texas-va-run-like-a-crime-syndicate-whistleblower-says.html.

391 Nick Coltrain, "VA chief signed "misunderstood" scheduling policy," Coloradoan, May 13, 2014; http://www.coloradoan.com/story/news/local/2014/05/13/va-chief-signed-misunderstood-scheduling-policy/9047005/.

392 Nick Coltrain, "VA chief signed "misunderstood" scheduling policy," Coloradoan, May 13, 2014; http://www.coloradoan.com/story/news/local/2014/05/13/va-chief-signed-misunderstood-scheduling-policy/9047005/.

393 Nick Coltrain, "VA chief signed "misunderstood" scheduling policy," Coloradoan, May 13, 2014; http://www.coloradoan.com/story/news/local/2014/05/13/va-chief-signed-misunderstood-scheduling-policy/9047005/.

394 Nick Coltrain, "VA chief signed "misunderstood" scheduling policy," Coloradoan, May 13, 2014; http://www.coloradoan.com/story/news/local/2014/05/13/va-chief-signed-misunderstood-scheduling-policy/9047005/.

395 Nick Coltrain, "VA chief signed "misunderstood" scheduling policy," Coloradoan, May 13, 2014; http://www.coloradoan.com/story/news/local/2014/05/13/va-chief-signed-misunderstood-scheduling-policy/9047005/.

396 Nick Coltrain, "VA chief signed "misunderstood" scheduling policy," Coloradoan, May 13, 2014; http://www.coloradoan.com/story/news/local/2014/05/13/va-chief-signed-misunderstood-scheduling-policy/9047005/.

397 Jim McElhatton, "Resume-padding VA employee got big bonus," Washington Times, June 16, 2014; http://www.washingtontimes.com/news/2014/jun/16/resume-padding-va-employee-got-big-bonuses/.

398 Jim McElhatton, "Resume-padding VA employee got big bonus," Washington Times, June 16, 2014; http://www.washingtontimes.com/news/2014/jun/16/resume-padding-va-employee-got-big-bonuses/.

399 Jim McElhatton, "Resume-padding VA employee got big bonus," Washington Times, June 16, 2014; http://www.washingtontimes.com/news/2014/jun/16/resume-padding-va-employee-got-big-bonuses/.

400 Jim McElhatton, "Resume-padding VA employee got big bonus," Washington Times, June 16, 2014; http://www.washingtontimes.com/news/2014/jun/16/resume-padding-va-employee-got-big-bonuses/.

401 Jim McElhatton, "Resume-padding VA employee got big bonus," Washington Times, June 16, 2014; http://www.washingtontimes.com/news/2014/jun/16/resume-padding-va-employee-got-big-bonuses/.

402 Phil Anderson, "ER services suspended at Colmery-O'Neil VA Medical Center," The Topeka Capital-Journal, January 31, 2014; http://cjonline.com/news/2014-01-31/er-services-suspended-colmery-oneil-va-medical-center.

403 Phil Anderson, "ER services suspended at Colmery-O'Neil VA Medical Center," The Topeka Capital-Journal, January 31, 2014; http://cjonline.com/news/2014-01-31/er-services-suspended-colmery-oneil-va-medical-center.

404 Phil Anderson, "ER services suspended at Colmery-O'Neil VA Medical Center," The Topeka Capital-Journal, January 31, 2014; http://cjonline.com/news/2014-01-31/er-services-suspended-colmery-oneil-va-medical-center.

405 Phil Anderson, "ER services suspended at Colmery-O'Neil VA Medical Center," The Topeka Capital-Journal, January 31, 2014; http://cjonline.com/news/2014-01-31/er-services-suspended-colmery-oneil-va-medical-center.

406 Phil Anderson, "ER services suspended at Colmery-O'Neil VA Medical Center," The Topeka Capital-Journal, January 31, 2014; http://cjonline.com/news/2014-01-31/er-services-suspended-colmery-oneil-va-medical-center.

407 Phil Anderson, "ER services suspended at Colmery-O'Neil VA Medical Center," The Topeka Capital-Journal, January 31, 2014; http://cjonline.com/news/2014-01-31/er-services-suspended-colmery-oneil-va-medical-center.

408 Richard A. Oppel, Jr. and Abby Goodnough, "Why So Many V.A. Delays? Too Few Doctors for Starters," The New York Times, May 29, 2014; http://www.nytimes.com/2014/05/30/us/doctor-shortages-cited-in-va-hospital-waits.html?_r=0.n

409 Conor Shine, "Shiny, new VA hospital suffers from longtime Nevada malady: doctor shortages," Las Vegas Sun, September 6, 2012; http://www.lasvegassun.com/news/2012/sep/09/shiny-new-va-hospital-suffers-longtime-nevada-mala/.

410 Richard A. Oppel, Jr. and Abby Goodnough, "Why So Many V.A. Delays? Too Few Doctors for Starters," The New York Times, May 29, 2014; http://www.nytimes.com/2014/05/30/us/doctor-shortages-cited-in-va-hospital-waits.html?_r=0.n

411 Richard A. Oppel, Jr. and Abby Goodnough, "Why So Many V.A. Delays? Too Few Doctors for Starters," The New York Times, May 29, 2014; http://www.nytimes.com/2014/05/30/us/doctor-shortages-cited-in-va-hospital-waits.html?_r=0.n

412 Richard A. Oppel, Jr. and Abby Goodnough, "Why So Many V.A. Delays? Too Few Doctors for Starters," The New York Times, May 29, 2014; http://www.nytimes.com/2014/05/30/us/doctor-shortages-cited-in-va-hospital-waits.html?_r=0.

413 House Committee on Veterans' Affairs, Witness Testimony of Mr. Randall Williamson, Director, Health Care, Government Accountability Office, January 15, 2014, http://veterans.house.gov/witness-testimony/mr-randall-williamson-1.

414 Government Accountability Office, "VA Surgical Implants: Purchase Requirements Were Not Always Followed at Selected Medical Centers and Oversight Needs Improvement," GAO-14-146, January 13, 2014; http://www.gao.gov/assets/670/660108.txt.

415 Government Accountability Office, "VA Surgical Implants: Purchase Requirements Were Not Always Followed at Selected Medical Centers and Oversight Needs Improvement," GAO-14-146, January 13, 2014; http://www.gao.gov/assets/670/660108.txt.

416 Sandra Basu, "Lawmakers 'Shocked' by Surgical Implant Vendor Role in Patient Care," US Medicine, February 2014; http://www.usmedicine.com/agencies/department-of-veterans-affairs/lawmakers-shocked-by-surgical-implant-vendor-role-in-patient-care/.

417 Government Accountability Office, "VA Surgical Implants: Purchase Requirements Were Not Always Followed at Selected Medical Centers and Oversight Needs Improvement," GAO-14-146, January 13, 2014; http://www.gao.gov/assets/670/660108.txt.

418 Kathleen Miller, "FDA Warnings to Body-Parts Vendors Overlooked by VA," Bloomberg News, April 2, 2014; http://www.bloomberg.com/news/2014-04-02/fda-warnings-to-body-parts-vendors-overlooked-by-va.html.

419 Kathleen Miller, "FDA Warnings to Body-Parts Vendors Overlooked by VA," Bloomberg News, April 2, 2014; http://www.bloomberg.com/news/2014-04-02/fda-warnings-to-body-parts-vendors-overlooked-by-va.html.

420 Kathleen Miller, "FDA Warnings to Body-Parts Vendors Overlooked by VA," Bloomberg News, April 2, 2014; http://www.bloomberg.com/news/2014-04-02/fda-warnings-to-body-parts-vendors-overlooked-by-va.html.

421 Kathleen Miller, "FDA Warnings to Body-Parts Vendors Overlooked by VA," Bloomberg News, April 2, 2014; http://www.bloomberg.com/news/2014-04-02/fda-warnings-to-body-parts-vendors-overlooked-by-va.html.

422 Kathleen Miller, "FDA Warnings to Body-Parts Vendors Overlooked by VA," Bloomberg News, April 2, 2014; http://www.bloomberg.com/news/2014-04-02/fda-warnings-to-body-parts-vendors-overlooked-by-va.html.

423 House Committee on Veterans' Affairs, Opening Statement of the Honorable Mike Coffman, Chairman, Oversight and Investigations, "Vendors in the OR – VA's Failed Oversight of Surgical Implants," January 15, 2014; http://veterans.house.gov/opening-statement/hon-mike-coffman-1.

424 Bryant Jordan, "Congress Questions VA on Tissue Used in Surgeries," Military News, April 2, 2014; http://www.military.com/daily-news/2014/04/02/congress-questions-va-on-tissue-used-in-surgeries.html?comp=700001075741&rank=1.

425 Bryant Jordan, "Congress Questions VA on Tissue Used in Surgeries," Military News, April 2, 2014; http://www.military.com/daily-news/2014/04/02/congress-questions-va-on-tissue-used-in-surgeries.html?comp=700001075741&rank=1.

426 "Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan," Institute of Medicine of the National Academy of Sciences, October 31, 2011; http://www.iom.edu/Reports/2011/Long-Term-Health-Consequences-of-Exposure-to-Burn-Pits-in-Iraq-and-Afghanistan.aspx.

427 Sean Dobbin, "Research stalls on dangers of military burn pits," Rochester Democrat and Chronicle, October 20, 2013; http://rocdocs.democratandchronicle.com/investigativereport/research-stalls-dangers-military-burn-pits.

428 Sean Dobbin, "Research stalls on dangers of military burn pits," Rochester Democrat and Chronicle, October 20, 2013; http://rocdocs.democratandchronicle.com/investigativereport/research-stalls-dangers-military-burn-pits.

429 Text of Public Law 112-260 (S. 3202, the "Dignified Burial and Other Veterans' Benefits Improvement Act of 2012").

430 Text of Public Law 112-260 (S. 3202, the "Dignified Burial and Other Veterans' Benefits Improvement Act of 2012").

431 "Public Health: VA's Action Plan: Burn Pits and Airborne Hazards; Registry for Veterans who may have been exposed," U.S. Department of Veterans Affairs website, accessed March 27, 2014; http://www.publichealth.va.gov/exposures/burnpits/action-plan.asp.

432 Correspondence from U.S. Senator Bob Corker (R-Tennessee) and Senator Tom Udall (D-New Mexico) to U.S. Department of Veteran Affairs Secretary Eric K. Shinseki, March 18, 2014; http://www.corker.senate.gov/public/index.cfm/news?ContentRecord_id=1a830070-7f00-480a-9f57-394ce242c1d9.

433 "Public Health: VA's Action Plan: Burn Pits and Airborne Hazards; Registry for Veterans who may have been exposed," U.S. Department of Veterans Affairs website, accessed March 27, 2014; http://www.publichealth.va.gov/exposures/burnpits/action-plan.asp.

434 Michael J. Ybarra, "VA Hospitals Often Lax in Checking Doctors' Backgrounds, Report Says." LA Times, August 31, 1989.

435 Michael J. Ybarra, "VA Hospitals Often Lax in Checking Doctors' Backgrounds, Report Says." LA Times, August 31, 1989.

436 Michael J. Ybarra, "VA Hospitals Often Lax in Checking Doctors' Backgrounds, Report Says." LA Times, August 31, 1989.

437 Michael J. Ybarra, "VA Hospitals Often Lax in Checking Doctors' Backgrounds, Report Says." LA Times, August 31, 1989.

438 Michael J. Ybarra, "VA Hospitals Often Lax in Checking Doctors' Backgrounds, Report Says." LA Times, August 31, 1989.

439 Associated Press, "Top Miami VA doctor lost medical license in NY," The Miami Herald, June 7, 2014; http://www.miamiherald.com/2014/06/07/4164358/top-miami-va-exec-accused-of-botching.html.

440 Associated Press, "Top Miami VA doctor lost medical license in NY," The Miami Herald, June 7, 2014; http://www.miamiherald.com/2014/06/07/4164358/top-miami-va-exec-accused-of-botching.html.

441 Associated Press, "Top Miami VA doctor lost medical license in NY," The Miami Herald, June 7, 2014; http://www.miamiherald.com/2014/06/07/4164358/top-miami-va-exec-accused-of-botching.html.

442 Associated Press, "Top Miami VA doctor lost medical license in NY," The Miami Herald, June 7, 2014; http://www.miamiherald.com/2014/06/07/4164358/top-miami-va-exec-accused-of-botching.html.

443 Associated Press, "Top Miami VA doctor lost medical license in NY," The Miami Herald, June 7, 2014; http://www.miamiherald.com/2014/06/07/4164358/top-miami-va-exec-accused-of-botching.html.

Endnotes

444 Associated Press, "Top Miami VA doctor lost medical license in NY," The Miami Herald, June 7, 2014; http://www.miamiherald.com/2014/06/07/4164358/top-miami-va-exec-accused-of-botching.html.

445 Associated Press, "Top Miami VA doctor lost medical license in NY," The Miami Herald, June 7, 2014; http://www.miamiherald.com/2014/06/07/4164358/top-miami-va-exec-accused-of-botching.html.

446 Joshua Rhett Miller, "Price of coming forward: 37 VA whistle-blowers claim retaliation," Fox News, June 6, 2014; http://www.foxnews.com/us/2014/06/06/price-coming-forward-37-va-whistle-blowers-charge-retaliation/.

447 Joshua Rhett Miller, "Price of coming forward: 37 VA whistle-blowers claim retaliation," Fox News, June 6, 2014; http://www.foxnews.com/us/2014/06/06/price-coming-forward-37-va-whistle-blowers-charge-retaliation/.

448 Joshua Rhett Miller, "Price of coming forward: 37 VA whistle-blowers claim retaliation," Fox News, June 6, 2014; http://www.foxnews.com/us/2014/06/06/price-coming-forward-37-va-whistle-blowers-charge-retaliation/.

449 Joshua Rhett Miller, "Price of coming forward: 37 VA whistle-blowers claim retaliation," Fox News, June 6, 2014; http://www.foxnews.com/us/2014/06/06/price-coming-forward-37-va-whistle-blowers-charge-retaliation/.

450 Joshua Rhett Miller, "Price of coming forward: 37 VA whistle-blowers claim retaliation," Fox News, June 6, 2014; http://www.foxnews.com/us/2014/06/06/price-coming-forward-37-va-whistle-blowers-charge-retaliation/.

451 Joshua Rhett Miller, "Price of coming forward: 37 VA whistle-blowers claim retaliation," Fox News, June 6, 2014; http://www.foxnews.com/us/2014/06/06/price-coming-forward-37-va-whistle-blowers-charge-retaliation/.

452 Eric Lichtblau, "V.A. Punished Critics on Staff, Doctors Assert," New York Times, June 15, 2014; http://www.nytimes.com/2014/06/16/us/va-punished-critics-on-staff-doctors-assert.html?_r=0.

453 Eric Lichtblau, "V.A. Punished Critics on Staff, Doctors Assert," New York Times, June 15, 2014; http://www.nytimes.com/2014/06/16/us/va-punished-critics-on-staff-doctors-assert.html?_r=0.

454 Eric Lichtblau, "V.A. Punished Critics on Staff, Doctors Assert," New York Times, June 15, 2014; http://www.nytimes.com/2014/06/16/us/va-punished-critics-on-staff-doctors-assert.html?_r=0.

455 Eric Lichtblau, "V.A. Punished Critics on Staff, Doctors Assert," New York Times, June 15, 2014; http://www.nytimes.com/2014/06/16/us/va-punished-critics-on-staff-doctors-assert.html?_r=0.

456 Eric Lichtblau, "V.A. Punished Critics on Staff, Doctors Assert," New York Times, June 15, 2014; http://www.nytimes.com/2014/06/16/us/va-punished-critics-on-staff-doctors-assert.html?_r=0.

457 Eric Lichtblau, "V.A. Punished Critics on Staff, Doctors Assert," New York Times, June 15, 2014; http://www.nytimes.com/2014/06/16/us/va-punished-critics-on-staff-doctors-assert.html?_r=0.

458 Eric Lichtblau, "V.A. Punished Critics on Staff, Doctors Assert," New York Times, June 15, 2014; http://www.nytimes.com/2014/06/16/us/va-punished-critics-on-staff-doctors-assert.html?_r=0.

459 Eric Lichtblau, "VA Punished Critics on Staff, Doctors Assert," New York Times, June 15, 2014; http://www.nytimes.com/2014/06/16/us/va-punished-critics-on-staff-doctors-assert.html.

460 Eric Lichtblau, "VA Punished Critics on Staff, Doctors Assert," New York Times, June 15, 2014; http://www.nytimes.com/2014/06/16/us/va-punished-critics-on-staff-doctors-assert.html;

461 Eric Lichtblau, "VA Punished Critics on Staff, Doctors Assert," New York Times, June 15, 2014; http://www.nytimes.com/2014/06/16/us/va-punished-critics-on-staff-doctors-assert.html.

462 "Exclusive - Robert Gates Extended Interview," The Daily Show with Jon Stewart, January 15, 2014; http://www.thedailyshow.com/watch/wed-january-15-2014/exclusive---robert-gates-extended-interview-pt--2.

463 Correspondence from Gina S. Farrisee, Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, to Senator Tom A. Coburn, M.D. May 14, 2014.

464 Correspondence from Gina S. Farrisee, Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, to Senator Tom A. Coburn, M.D. May 14, 2014.

465 Correspondence from Gina S. Farrisee, Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, to Senator Tom A. Coburn, M.D. May 14, 2014. The 137 suspensions included 88 General Schedule (GS) employees; 5 GS-4 suspensions, 23 GS-5 suspensions, 20 GS-6 suspensions, 7 GS-7 suspensions, 3 G-S-8 suspensions, 7 GS-9 suspensions, 3 GS-10 suspensions, 13 GS-11 suspensions, 5 GS-12 suspensions, 1 GS-13 suspension, and 1 GS-14 suspension. The 49 remaining employees "fall into a variety of separate pay plans including trade workers, non-appropriated staff, and Veterans canteen workers."

466 Nick Coltrain, "Whistleblower: VA punished me for not falsifying records," The Coloradoan, May 19, 2014; http://www.coloradoan.com/story/news/2014/05/18/whistleblower-va-punished-cooking-books/9255921/.

467 Drew Griffin, Scott Bronstein, Nelli Black, and Ray Sanchez, "VA clinic employee on leave after e-mail about manipulating appointments," CNN, May 23, 2014; http://www.cnn.com/2014/05/09/us/va-scandal-cheyenne/index.html.

468 Nick Coltrain, "Whistleblower: VA punished me for not falsifying records," The Coloradoan, May 19, 2014; http://www.coloradoan.com/story/news/2014/05/18/whistleblower-va-punished-cooking-books/9255921/.

469 David Zucchino, Cindy Caramo, and Alan Zarembo, "Growing evidence points to systemic troubles in VA healthcare system," Los Angeles Times, May 18, 2014; http://www.latimes.com/nation/la-na-va-delays-20140518-story.html#page=1.

470 Nick Coltrain, "Whistleblower: VA punished me for not falsifying records," The Coloradoan, May 19, 2014; http://www.coloradoan.com/story/news/2014/05/18/whistleblower-va-punished-cooking-books/9255921/.

471 Nick Coltrain, "Whistleblower: VA punished me for not falsifying records," The Coloradoan, May 19, 2014; http://www.coloradoan.com/story/news/2014/05/18/whistleblower-va-punished-cooking-books/9255921/.

472 "Statement by VA Secretary Shinseki on Allegations Regarding the Phoenix VA Health Care System," Department of Veterans Affairs Office of Public and Intergovernmental Affairs, May 1, 2014; http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2541.

473 Gregg Zoroya, "VA worker put on leave over records foulup," USA Today, May 9, 2014; http://www.usatoday.com/story/news/nation/2014/05/09/va-shinseki-veterans-delays-medical/8907417/.

474 Gregg Zoroya, "VA worker put on leave over records foulup," USA Today, May 9, 2014; http://www.usatoday.com/story/news/nation/2014/05/09/va-shinseki-veterans-delays-medical/8907417/.

475 Gregg Zoroya, "VA worker put on leave over records foulup," USA Today, May 9, 2014; http://www.usatoday.com/story/news/nation/2014/05/09/va-shinseki-

veterans-delays-medical/8907417/.

476 Gregg Zoroya, "VA worker put on leave over records foulup," USA Today, May 9, 2014; http://www.usatoday.com/story/news/nation/2014/05/09/va-shinseki-veterans-delays-medical/8907417/.

477 "Veterans Affairs worker in Wyoming placed on leave in patient delay scandal – report," Reuters, May 9, 2014; http://www.reuters.com/article/2014/05/10/us-usa-veterans-wyoming-idUSKBN0DQ01I20140510.

478 Gregg Zoroya, "VA worker put on leave over records foulup," USA Today, May 9, 2014; http://www.usatoday.com/story/news/nation/2014/05/09/va-shinseki-veterans-delays-medical/8907417/.

479 "VA Statement on Durham VA Medical Center," Durham VA Medical Center Press Releases, May 13, 2014; http://www.durham.va.gov/pressreleases/VA_Statement_on_Durham_VA_Medical_Center.asp .

480 Morgan Watkins, "Gainesville VA director moves to reassure public," Gainesville Sun, May 16, 2014; http://www.gainesville.com/article/20140516/ARTICLES/140519709.

481 Statement of Claudia J. Bahorik, D.O. Primary Care Physician, before House of Representatives Committee on Veterans Affairs Subcommittee on Health, "Between Peril and Promise: Facing the Dangers of VA's Skyrocketing Use of Prescription Painkillers to Treat Veterans," October 10, 2013; http://veterans.house.gov/witness-testimony/claudia-j-bahorik-do.

482 Statement of Claudia J. Bahorik, D.O. Primary Care Physician, before House of Representatives Committee on Veterans Affairs Subcommittee on Health, "Between Peril and Promise: Facing the Dangers of VA's Skyrocketing Use of Prescription Painkillers to Treat Veterans," October 10, 2013; http://veterans.house.gov/witness-testimony/claudia-j-bahorik-do.

483 Statement of Claudia J. Bahorik, D.O. Primary Care Physician, before House of Representatives Committee on Veterans Affairs Subcommittee on Health, "Between Peril and Promise: Facing the Dangers of VA's Skyrocketing Use of Prescription Painkillers to Treat Veterans," October 10, 2013; http://veterans.house.gov/witness-testimony/claudia-j-bahorik-do.

484 Statement of Claudia J. Bahorik, D.O. Primary Care Physician, before House of Representatives Committee on Veterans Affairs Subcommittee on Health, "Between Peril and Promise: Facing the Dangers of VA's Skyrocketing Use of Prescription Painkillers to Treat Veterans," October 10, 2013; http://veterans.house.gov/witness-testimony/claudia-j-bahorik-do.

485 "Administrative Investigation: Failure to Properly Supervise, Misuse of Official Time and Resources, and Prohibited Personnel Practice VA Center for Innovation VA Central Office," Report No. 13-01488-86, Department of Veterans Affairs Office of Inspector General, February 24, 2014; http://www.va.gov/oig/pubs/VAOIG-13-01488-86r.pdf.

486 Leo Shane III, "IG: Managers let VA employee get away with cheating agency," Military Times, March 4, 2014; http://www.militarytimes.com/article/20140304/NEWS/303040012/IG-Managers-let-VA-employee-get-away-cheating-agency.

487 "Administrative Investigation: Failure to Properly Supervise, Misuse of Official Time and Resources, and Prohibited Personnel Practice VA Center for Innovation VA Central Office," Report No. 13-01488-86, Department of Veterans Affairs Office of Inspector General, February 24, 2014; http://www.va.gov/oig/pubs/VAOIG-13-01488-86r.pdf.

488 "Administrative Investigation: Failure to Properly Supervise, Misuse of Official Time and Resources, and Prohibited Personnel Practice VA Center for Innovation VA Central Office," Report No. 13-01488-86, Department of Veterans Affairs Office of Inspector General, February 24, 2014; http://www.va.gov/oig/pubs/VAOIG-13-01488-86r.pdf.

489 "Administrative Investigation: Failure to Properly Supervise, Misuse of Official Time and Resources, and Prohibited Personnel Practice VA Center for Innovation VA Central Office," Report No. 13-01488-86, Department of Veterans Affairs Office of Inspector General, February 24, 2014; http://www.va.gov/oig/pubs/VAOIG-13-01488-86r.pdf.

490 "Administrative Investigation: Failure to Properly Supervise, Misuse of Official Time and Resources, and Prohibited Personnel Practice VA Center for Innovation VA Central Office," Report No. 13-01488-86, Department of Veterans Affairs Office of Inspector General, February 24, 2014; http://www.va.gov/oig/pubs/VAOIG-13-01488-86r.pdf.

491 "Administrative Investigation: Failure to Properly Supervise, Misuse of Official Time and Resources, and Prohibited Personnel Practice VA Center for Innovation VA Central Office," Report No. 13-01488-86, Department of Veterans Affairs Office of Inspector General, February 24, 2014; http://www.va.gov/oig/pubs/VAOIG-13-01488-86r.pdf.

492 "Administrative Investigation: Failure to Properly Supervise, Misuse of Official Time and Resources, and Prohibited Personnel Practice VA Center for Innovation VA Central Office," Report No. 13-01488-86, Department of Veterans Affairs Office of Inspector General, February 24, 2014; http://www.va.gov/oig/pubs/VAOIG-13-01488-86r.pdf.

493 "Administrative Investigation: Failure to Properly Supervise, Misuse of Official Time and Resources, and Prohibited Personnel Practice VA Center for Innovation VA Central Office," Report No. 13-01488-86, Department of Veterans Affairs Office of Inspector General, February 24, 2014; http://www.va.gov/oig/pubs/VAOIG-13-01488-86r.pdf.

494 "Administrative Investigation: Failure to Properly Supervise, Misuse of Official Time and Resources, and Prohibited Personnel Practice VA Center for Innovation VA Central Office," Report No. 13-01488-86, Department of Veterans Affairs Office of Inspector General, February 24, 2014; http://www.va.gov/oig/pubs/VAOIG-13-01488-86r.pdf.

495 "Administrative Investigation: Failure to Properly Supervise, Misuse of Official Time and Resources, and Prohibited Personnel Practice VA Center for Innovation VA Central Office," Report No. 13-01488-86, Department of Veterans Affairs Office of Inspector General, February 24, 2014; http://www.va.gov/oig/pubs/VAOIG-13-01488-86r.pdf.

496 Bob Brewin, "What Happens After Sexting and Luxury Travel at VA? Paid Leave," Nextgov, March 13, 2014; http://www.nextgov.com/defense/whats-brewin/2014/03/sexting-and-traveling-luxury-va-go-paid-leave/80443/?oref=ng-relatedstories.

497 "Probe slams VA over $6M conference tab including parody video, official resigns," Fox News, October 1, 2012; http://www.foxnews.com/politics/2012/10/01/probe-slams-va-over-6m-orlando-conferences-official-resigns/.

498 "Administrative Investigation of the FY 2011 Human Resources Conferences in Orlando, Florida," Department of Veterans Affairs Office of Inspector General, September 30, 2012; http://www.va.gov/oig/pubs/VAOIG-12-02525-291R.pdf.

499 Corbin Hiar, "Bush appointee allows VA employee to be overpaid $41,000 and commute to D.C. from Ark.," The Center for Public Integrity, August 17, 2011; http://www.publicintegrity.org/2011/08/17/5805/bush-appointee-allows-va-employee-be-overpaid-41000-and-commute-dc-ark.

500 "Administrative Investigation Misuse of Position, Abuse of Authority, and Prohibited Personnel Practices, Office of Information & Technology, Washington, DC," Report No. 09-01123-195, Department of Veterans Affairs Office of Inspector General, August 18, 2009; http://www.va.gov/oig/pubs/VAOIG-09-01123-195.pdf.

501 Corbin Hiar, "Bush appointee allows VA employee to be overpaid $41,000 and commute to D.C. from Ark.," The Center for Public Integrity August 17, 2011; http://www.publicintegrity.org/2011/08/17/5805/bush-appointee-allows-va-employee-be-overpaid-41000-and-commute-dc-ark.

502 Corbin Hiar, "Bush appointee allows VA employee to be overpaid $41,000 and commute to D.C. from Ark.," The Center for Public Integrity August 17, 2011; http://www.publicintegrity.org/2011/08/17/5805/bush-appointee-allows-va-employee-be-overpaid-41000-and-commute-dc-ark.

503 David Perera," Spotlight: VA appeals Merit Board ruling on Adair Martinez," FierceGovernmentIT, May 12, 2011; http://www.fiercegovernmentit.com/story/spotlight-va-appeals-merit-board-ruling-adair-martinez/2011-05-12.

504 David Perera," Spotlight: VA appeals Merit Board ruling on Adair Martinez," FierceGovernmentIT, May 12, 2011; http://www.fiercegovernmentit.com/story/spotlight-va-appeals-merit-board-ruling-adair-martinez/2011-05-12.

505 Corbin Hiar, "Bush appointee allows VA employee to be overpaid $41,000 and commute to D.C. from Ark.," The Center for Public Integrity August 17, 2011; http://www.publicintegrity.org/2011/08/17/5805/bush-appointee-allows-va-employee-be-overpaid-41000-and-commute-dc-ark.

506 Andy Marso, "Sexual abuse and suspicious prescriptions at VA hospital," Topeka Capital-Journal, September 28, 2013; http://m.cjonline.com/news/2013-09-28/sexual-abuse-and-suspicious-prescriptions-va-hospital.

507 Andy Marso, "Sexual abuse and suspicious prescriptions at VA hospital; Congresswoman 'increasingly concerned' about short-staffed Colmery-O'Neil," The Topeka Capital-Journal, September 28, 2013; http://cjonline.com/news/2013-09-28/sexual-abuse-and-suspicious-prescriptions-va-hospital.

508 Andy Marso, "Sexual abuse and suspicious prescriptions at VA hospital," Topeka Capital-Journal, September 28, 2013; http://m.cjonline.com/news/2013-09-28/sexual-abuse-and-suspicious-prescriptions-va-hospital.

509 Andy Marso, "Sexual abuse and suspicious prescriptions at VA hospital," Topeka Capital-Journal, September 28, 2013; http://m.cjonline.com/news/2013-09-28/sexual-abuse-and-suspicious-prescriptions-va-hospital.

510 Andy Marso, "Sexual abuse and suspicious prescriptions at VA hospital," Topeka Capital-Journal, September 28, 2013; http://m.cjonline.com/news/2013-09-28/sexual-abuse-and-suspicious-prescriptions-va-hospital.

511 "VA counselor admits to sex with client," Associated Press, March 23, 2014; http://www.heraldandnews.com/news/article_8bd6aac6-b249-11e3-a914-001a4bcf887a.html.

512 "VA counselor admits to sex with client," Associated Press, March 23, 2014; http://www.heraldandnews.com/news/article_8bd6aac6-b249-11e3-a914-001a4bcf887a.html.

513 "VA counselor admits to sex with client," Associated Press, March 23, 2014; http://www.heraldandnews.com/news/article_8bd6aac6-b249-11e3-a914-001a4bcf887a.html.

514 "VA counselor admits to sex with client," Associated Press, March 23, 2014; http://www.heraldandnews.com/news/article_8bd6aac6-b249-11e3-a914-001a4bcf887a.html.

515 Jesse Bogan, "Cochran dental chief put on leave," St. Louis Post-Dispatch, July 2, 2010; http://www.stltoday.com/news/local/military/cochran-dental-chief-put-on-leave/article_7288d0c2-58ea-5ad6-be78-8b223a8f158d.html.

516 "St. Louis VA dental technician says she warned supervisors of sterilization issues months ago," Associated Press, July 13, 2010; http://www.foxnews.com/us/2010/07/13/st-louis-va-dental-technician-says-warned-supervisors-sterilization-issues/.

517 Jesse Bogan, "Cochran dental chief put on leave," St. Louis Post-Dispatch, July 2, 2010; http://www.stltoday.com/news/local/military/cochran-dental-chief-put-on-leave/article_7288d0c2-58ea-5ad6-be78-8b223a8f158d.html.

518 "Healthcare Inspection: Follow-Up Evaluation of Dental Instrument Reprocessing Deficiencies; St. Louis VA Medical Center; St. Louis, Missouri," Report No. 10-03346-152, Department of Veterans Affairs Office of Inspector General, April 5, 2012; http://www.va.gov/oig/pubs/VAOIG-10-03346-152.pdf.

519 Joris Evers, "Veterans Affairs faulted in data theft," CNET News, July 12, 2006; http://news.cnet.com/Veterans-Affairs-faulted-in-data-theft/2100-1029_3-6093551.html.

520 Reuters "U.S. Says Personal Data on Millions of Veterans Stolen," Washington Post, May 22, 2006; http://www.washingtonpost.com/wp-dyn/content/article/2006/05/22/AR2006052200690.html.

521 Reuters, "U.S. Says Personal Data on Millions of Veterans Stolen," Washington Post, May 22, 2006; http://www.washingtonpost.com/wp-dyn/content/article/2006/05/22/AR2006052200690.html.

522 Reuters, "U.S. Says Personal Data on Millions of Veterans Stolen," Washington Post, May 22, 2006; http://www.washingtonpost.com/wp-dyn/content/article/2006/05/22/AR2006052200690.html.

523 The hearing was held May 25, 2006.
Hope Yen, "VA Breach Discovered Through Office Gossip," The Associated Press and Washington Post, May 25, 2006; http://www.washingtonpost.com/wp-dyn/content/article/2006/05/25/AR2006052501469_pf.html.

524 The employee was fired May 30, 2006.
M. E. Kabay, PhD, CISSP-ISSMP, Program Director, MSIA & CTO – School of Graduate Studies, Norwich University, Vermont, "The VA Data Insecurity Saga," 2008; http://www.mekabay.com/infosecmgmt/vasaga.pdf .

525 Joris Evers, "Veterans Affairs faulted in data theft," CNET News, July 12, 2006, http://news.cnet.com/Veterans-Affairs-faulted-in-data-theft/2100-1029_3-6093551.html.

526 Sharon Gaudin, "Missing Hard Drive Holds Sensitive Data On 535K Vets, 1.3M Doctors," InformationWeek, February 2007; http://www.informationweek.com/missing-hard-drive-holds-sensitive-data-on-535k-vets-13m-doctors/d/d-id/1051953?print=yes.

527 U.S. Office of Personnel Management, Employee Relations – Reference Materials, "Addressing AWOL," http://www.opm.gov/policy-data-oversight/employee-relations/training/presentationaddressingawol.pdf.

528 U.S. Office of Personnel Management, Employee Relations – Reference Materials, "Addressing AWOL," http://www.opm.gov/policy-data-oversight/employee-relations/training/presentationaddressingawol.pdf.

529 Department of Veterans Affairs Office of Inspector General, "Administrative Investigation: Failure to Properly Supervise, Misuse of Official Time and Resources, and Prohibited Personnel Practice, VA Center for Innovation, VA Central Office," Report No. 13-01488-86, February 24, 2014, http://www.va.gov/oig/pubs/VAOIG-13-01488-86r.pdf (p. 19).

530 Department of Veterans Affairs Office of Inspector General, "Administrative Investigation: Failure to Properly Supervise, Misuse of Official Time and Resources, and Prohibited Personnel Practice, VA Center for Innovation, VA Central Office," Report No. 13-01488-86, February 24, 2014, http://www.va.gov/oig/pubs/VAOIG-13-01488-86r.pdf (p. 19).

531 Senator Tom Coburn, "Missing in Action: AWOL in the Federal Government," August 2008; http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_

Endnotes

id=8d706bec-eae6-49ba-9b42-c258f655e21e.

532 Letter from Gina S. Farrisse, Department of Veterans Affairs, to Senator Tom Coburn, May 14, 2014.

533 Letter from Gina S. Farrisse, Department of Veterans Affairs, to Senator Tom Coburn, May 14, 2014.

534 "Former VA Employee Sentenced To Prison For Theft of Veterans' Personal Information," United States Department of Justice, March 6, 2014; http://www.justice.gov/usao/flm/press/2014/Mar/20140306_Lewis.html.

535 "Former VA Employee Sentenced To Prison For Theft of Veterans' Personal Information," United States Department of Justice, March 6, 2014; http://www.justice.gov/usao/flm/press/2014/Mar/20140306_Lewis.html.

536 "Former VA Employee Sentenced To Prison For Theft of Veterans' Personal Information," United States Department of Justice, March 6, 2014; http://www.justice.gov/usao/flm/press/2014/Mar/20140306_Lewis.html.

537 "Former VA Employee Sentenced To Prison For Theft of Veterans' Personal Information," United States Department of Justice, March 6, 2014; http://www.justice.gov/usao/flm/press/2014/Mar/20140306_Lewis.html.

538 "Brandon man sentenced in fraud case involving VA records," TBO, May 16, 2014; http://tbo.com/news/crime/brandon-man-sentenced-in-fraud-case-involving-va-records-20140516/.

539 "Brandon man sentenced in fraud case involving VA records," TBO, May 16, 2014; http://tbo.com/news/crime/brandon-man-sentenced-in-fraud-case-involving-va-records-20140516/.

540 Department of Veterans Affairs Office of Inspector General, "Semi-Annual Report to Congress, Issue 66, April 1—September 30, 2011;" http://www.va.gov/oig/pubs/sars/vaoig-sar-2011-2.pdf (p. 25).

541 "Veterans Affairs Worker Arrested for Selling Cocaine to Veterans in Treatment," United States Department of Justice, May 17, 2011; http://www.justice.gov/usao/ma/news/2011/May/McNultyPatrickPR.html; Department of Veterans Affairs Office of Inspector General, "Semi-Annual Report to Congress, Issue 66, April 1—September 30, 2011;" http://www.va.gov/oig/pubs/sars/vaoig-sar-2011-2.pdf (p. 25).

542 "Veterans Affairs Worker Arrested for Selling Cocaine to Veterans in Treatment," United States Department of Justice, May 17, 2011; http://www.justice.gov/usao/ma/news/2011/May/McNultyPatrickPR.html.

543 "Former Veterans Affairs Worker Sentenced for Selling Cocaine to Vets in Treatment," U.S. Department of Justice, February 1, 2012; http://www.justice.gov/usao/ma/news/2012/February/McNultyPatrickSentencingPR.html.

544 "Former Veterans Affairs Worker Sentenced for Selling Cocaine to Vets in Treatment," U.S. Department of Justice, February 1, 2012; http://www.justice.gov/usao/ma/news/2012/February/McNultyPatrickSentencingPR.html.

545 Andrew Knittle, "Several veterans centers doctors have disciplinary records," The Oklahoman, March 16, 2014; http://newsok.com/several-veterans-centers-doctors-have-disciplinary-records/article/3943849.

546 Andrew Knittle, "Several veterans centers doctors have disciplinary records," The Oklahoman, March 16, 2014; http://newsok.com/several-veterans-centers-doctors-have-disciplinary-records/article/3943849.

547 Andrew Knittle, "Several veterans centers doctors have disciplinary records," The Oklahoman, March 16, 2014; http://newsok.com/several-veterans-centers-doctors-have-disciplinary-records/article/3943849.

548 Andrew Knittle, "Several veterans centers doctors have disciplinary records," The Oklahoman, March 16, 2014; http://newsok.com/several-veterans-centers-doctors-have-disciplinary-records/article/3943849.

549 Department of Veterans Affairs, Office of Inspector General, "Semiannual Report to Congress, Issue 70, April 1—September 30, 2013;" http://www.va.gov/oig/pubs/sars/VAOIG-SAR-2013-2.pdf (p. 53).

550 Department of Veterans Affairs, Office of Inspector General, "Semiannual Report to Congress, Issue 70, April 1—September 30, 2013;" http://www.va.gov/oig/pubs/sars/VAOIG-SAR-2013-2.pdf (p. 53).

551 Department of Veterans Affairs, Office of Inspector General, "Semiannual Report to Congress, Issue 70, April 1—September 30, 2013;" http://www.va.gov/oig/pubs/sars/VAOIG-SAR-2013-2.pdf (p. 53).

552 Robert Kahn, "Beaten to Death in VA Hospital, Widow Says," Courthouse News, May 25, 2014; http://www.courthousenews.com/2014/05/25/68182.htm.

553 Robert Kahn, "Beaten to Death in VA Hospital, Widow Says," Courthouse News, May 25, 2014; http://www.courthousenews.com/2014/05/25/68182.htm.

554 Robert Kahn, "Beaten to Death in VA Hospital, Widow Says," Courthouse News, May 25, 2014; http://www.courthousenews.com/2014/05/25/68182.htm.

555 Robert Kahn, "Beaten to Death in VA Hospital, Widow Says," Courthouse News, May 25, 2014; http://www.courthousenews.com/2014/05/25/68182.htm.

556 Robert Kahn, "Beaten to Death in VA Hospital, Widow Says," Courthouse News, May 25, 2014; http://www.courthousenews.com/2014/05/25/68182.htm.

557 Robert Kahn, "Beaten to Death in VA Hospital, Widow Says," Courthouse News, May 25, 2014; http://www.courthousenews.com/2014/05/25/68182.htm.

558 Robert Kahn, "Beaten to Death in VA Hospital, Widow Says," Courthouse News, May 25, 2014; http://www.courthousenews.com/2014/05/25/68182.htm.

559 Robert O'Harrow Jr., "Veterans Affairs called it a small-business contract, but a big firm got 90% of the money," The Washington Post, November 13, 2013; http://www.washingtonpost.com/investigations/va-called-it-a-small-business-contract-but-a-big-firm-got-90-percent-of-the-money/2013/11/13/d9a88018-b663-11e2-92f3-f291801936b8_story.html.

560 Robert O'Harrow Jr., "Veterans Affairs called it a small-business contract, but a big firm got 90% of the money," The Washington Post, November 13, 2013; http://www.washingtonpost.com/investigations/va-called-it-a-small-business-contract-but-a-big-firm-got-90-percent-of-the-money/2013/11/13/d9a88018-b663-11e2-92f3-f291801936b8_story.html.

561 Robert O'Harrow Jr., "Veterans Affairs called it a small-business contract, but a big firm got 90% of the money," The Washington Post, November 13, 2013; http://www.washingtonpost.com/investigations/va-called-it-a-small-business-contract-but-a-big-firm-got-90-percent-of-the-money/2013/11/13/d9a88018-b663-11e2-92f3-f291801936b8_story.html.

562 Robert O'Harrow Jr., "Veterans Affairs called it a small-business contract, but a big firm got 90% of the money," The Washington Post, November 13, 2013; http://www.washingtonpost.com/investigations/va-called-it-a-small-business-contract-but-a-big-firm-got-90-percent-of-the-money/2013/11/13/d9a88018-b663-11e2-92f3-f291801936b8_story.html.

563 Robert O'Harrow Jr., "Veterans Affairs called it a small-business contract, but a big firm got 90% of the money," The Washington Post, November 13, 2013; http://www.washingtonpost.com/investigations/va-called-it-a-small-business-contract-but-a-big-firm-got-90-percent-of-the-money/2013/11/13/d9a88018-b663-11e2-92f3-f291801936b8_story.html.

564 Robert O'Harrow Jr., "Veterans Affairs called it a small-business contract, but a big firm got 90% of the money," The Washington Post, November 13, 2013; http://www.washingtonpost.com/investigations/va-called-it-a-small-business-contract-but-a-big-firm-got-90-percent-of-the-money/2013/11/13/d9a88018-b663-11e2-92f3-f291801936b8_story.html.

Endnotes

565 Robert O'Harrow Jr., "Veterans Affairs called it a small-business contract, but a big firm got 90% of the money," The Washington Post, November 13, 2013; http://www.washingtonpost.com/investigations/va-called-it-a-small-business-contract-but-a-big-firm-got-90-percent-of-the-money/2013/11/13/d9a88018-b663-11e2-92f3-f291801936b8_story.html.

566 Robert O'Harrow Jr., "Veterans Affairs called it a small-business contract, but a big firm got 90% of the money," The Washington Post, November 13, 2013; http://www.washingtonpost.com/investigations/va-called-it-a-small-business-contract-but-a-big-firm-got-90-percent-of-the-money/2013/11/13/d9a88018-b663-11e2-92f3-f291801936b8_story.html.

567 Robert O'Harrow Jr., "Veterans Affairs called it a small-business contract, but a big firm got 90% of the money," The Washington Post, November 13, 2013; http://www.washingtonpost.com/investigations/va-called-it-a-small-business-contract-but-a-big-firm-got-90-percent-of-the-money/2013/11/13/d9a88018-b663-11e2-92f3-f291801936b8_story.html.

568 Robert O'Harrow Jr., "Veterans Affairs called it a small-business contract, but a big firm got 90% of the money," The Washington Post, November 13, 2013; http://www.washingtonpost.com/investigations/va-called-it-a-small-business-contract-but-a-big-firm-got-90-percent-of-the-money/2013/11/13/d9a88018-b663-11e2-92f3-f291801936b8_story.html.

569 Robert O'Harrow Jr., "Veterans Affairs called it a small-business contract, but a big firm got 90% of the money," The Washington Post, November 13, 2013; http://www.washingtonpost.com/investigations/va-called-it-a-small-business-contract-but-a-big-firm-got-90-percent-of-the-money/2013/11/13/d9a88018-b663-11e2-92f3-f291801936b8_story.html.

570 Letter from John W. Klein, SBA Suspension and Debarment Official, to Anthony Jimenez, President/CEO of MicroTech, December 20, 2013;

571 "Former Muskogee VA Medical Center Official Guilty Of Accepting Gratuity," News On 6, May 28, 2014; http://www.newson6.com/story/25629944/former-muskogee-va-official-guilty-of-accepting-gratuity.

572 "Former Muskogee VA Medical Center Official Guilty Of Accepting Gratuity," NewsOn6, May 28, 2014; http://www.newson6.com/story/25629944/former-muskogee-va-official-guilty-of-accepting-gratuity.

573 "Former Muskogee VA Medical Center Official Guilty Of Accepting Gratuity," News On 6, May 28, 2014; http://www.newson6.com/story/25629944/former-muskogee-va-official-guilty-of-accepting-gratuity.

574 Andy Marso, "Sexual abuse and suspicious prescriptions at VA hospital," The Topeka Capital-Journal, September 28, 2013; http://m.cjonline.com/news/2013-09-28/sexual-abuse-and-suspicious-prescriptions-va-hospital.

575 Department of Veterans Affairs Office of Inspector General, "Semiannual Report to Congress, Issue 69, October 1—March 31, 2013;" http://www.va.gov/oig/pubs/sars/vaoig-sar-2013-1.pdf (p. 29).

576 Department of Veterans Affairs Office of Inspector General, "Semiannual Report to Congress, Issue 69, October 1—March 31, 2013;" http://www.va.gov/oig/pubs/sars/vaoig-sar-2013-1.pdf (p. 29).

577 Andy Marso, "Sexual abuse and suspicious prescriptions at VA hospital," The Topeka Capital-Journal, September 28, 2013; http://m.cjonline.com/news/2013-09-28/sexual-abuse-and-suspicious-prescriptions-va-hospital.

578 Andy Marso, "Sexual abuse and suspicious prescriptions at VA hospital," The Topeka Capital-Journal, September 28, 2013; http://m.cjonline.com/news/2013-09-28/sexual-abuse-and-suspicious-prescriptions-va-hospital.

579 Andy Marso, "Sexual abuse and suspicious prescriptions at VA hospital," The Topeka Capital-Journal, September 28, 2013; http://m.cjonline.com/news/2013-09-28/sexual-abuse-and-suspicious-prescriptions-va-hospital.

580 Andy Marso, "Sexual abuse and suspicious prescriptions at VA hospital," The Topeka Capital-Journal, September 28, 2013; http://m.cjonline.com/news/2013-09-28/sexual-abuse-and-suspicious-prescriptions-va-hospital.

581 Andy Marso, "Sexual abuse and suspicious prescriptions at VA hospital," The Topeka Capital-Journal, September 28, 2013; http://m.cjonline.com/news/2013-09-28/sexual-abuse-and-suspicious-prescriptions-va-hospital.

582 Andy Marso, "Sexual abuse and suspicious prescriptions at VA hospital," The Topeka Capital-Journal, September 28, 2013; http://m.cjonline.com/news/2013-09-28/sexual-abuse-and-suspicious-prescriptions-va-hospital.

583 Andy Marso, "Sexual abuse and suspicious prescriptions at VA hospital," The Topeka Capital-Journal, September 28, 2013; http://m.cjonline.com/news/2013-09-28/sexual-abuse-and-suspicious-prescriptions-va-hospital.

584 Department of Veterans Affairs Office of Inspector General, "Semiannual Report to Congress, Issue 69, October 1—March 31, 2013;" http://www.va.gov/oig/pubs/sars/vaoig-sar-2013-1.pdf (p. 29).

585 Department of Veterans Affairs Office of Inspector General, "Semiannual Report to Congress, Issue 69, October 1—March 31, 2013;" http://www.va.gov/oig/pubs/sars/vaoig-sar-2013-1.pdf (p. 29).

586 Department of Veterans Affairs Office of Inspector General, "Semiannual Report to Congress, Issue 69, October 1—March 31, 2013;" http://www.va.gov/oig/pubs/sars/vaoig-sar-2013-1.pdf (p. 29).

587 Department of Veterans Affairs Office of Inspector General, "Semiannual Report to Congress, Issue 69, October 1—March 31, 2013;" http://www.va.gov/oig/pubs/sars/vaoig-sar-2013-1.pdf (p. 29).

588 Bill Wadell, "Nurse's Aide Accused of Stealing Crucifix from Dying Veteran," WNEP, January 15, 2014; http://wnep.com/2014/01/15/nurses-aide-accused-of-stealing-crucifix-from-dying-veteran/.

589 Bill Wadell, "Nurse's Aide Accused of Stealing Crucifix from Dying Veteran," WNEP, January 15, 2014; http://wnep.com/2014/01/15/nurses-aide-accused-of-stealing-crucifix-from-dying-veteran/.

590 U.S. Government Accountability Office, "VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit," GAO 14-15-175, March 2014; http://gao.gov/assets/670/661404.pdf.

591 U.S. Government Accountability Office, "VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit," GAO 14-15-175, March 2014; http://gao.gov/assets/670/661404.pdf.

592 U.S. Government Accountability Office, "VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit," GAO 14-15-175, March 2014; http://gao.gov/assets/670/661404.pdf.

593 U.S. Government Accountability Office, "VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit," GAO 14-15-175, March 2014; http://gao.gov/assets/670/661404.pdf.

594 Scott MacFarlane, "Veterans Affairs Scrutinized Over Rehiring of Employee After Fatal Incident," NBC Washington, April 3, 2014; http://www.nbcwashington.com/investigations/Veterans-Affairs-Scrutinized-Over-Rehiring-Employee-After-Fatal-Incident--253275011.html.

595 Scott MacFarlane, "Veterans Affairs Scrutinized Over Rehiring of Employee After Fatal Incident," NBC Washington, April 3, 2014; http://www.nbcwashington.

com/investigations/Veterans-Affairs-Scrutinized-Over-Rehiring-Employee-After-Fatal-Incident--253275011.html.

596 Eric Katz, "VA Rehires Employee Involved in Drunk Driving Tragedy for $100K Job," Government Executive, April 1, 2014; http://www.govexec.com/pay-benefits/2014/04/va-rehires-employee-involved-drunk-driving-tragedy-100k-job/81721/.

597 Scott MacFarlane, "Veterans Affairs Scrutinized Over Rehiring of Employee After Fatal Incident," NBC Washington, April 3, 2014; http://www.nbcwashington.com/investigations/Veterans-Affairs-Scrutinized-Over-Rehiring-Employee-After-Fatal-Incident--253275011.html.

598 Department of Veterans Affairs, Office of Inspector General "January 2014 Highlights;" http://www.va.gov/oig/pubs/highlights/VAOIG-highlights-201401.pdf (p. 2-3).

599 Department of Veterans Affairs Office of Inspector General, Semiannual Report to Congress, "Issue 64, April 1," 2010—September 30, 2010; http://www.va.gov/oig/pubs/sars/vaoig-sar-2010-2.pdf (p. 37).

600 Department of Veterans Affairs, Office of Inspector General "July 2012 Highlights;" http://www.va.gov/oig/pubs/highlights/VAOIG-highlight s-201207.pdf (p. 7).

601 Letter from Richard J. Griffin, Acting Inspector General, to Senator Tom Coburn, April 8, 2014;

602 "Former Veterans Affairs Police Chief Pleads Guilty in Manhattan Federal Court to Participating in Kidnapping Conspiracies," FBI website, January 16, 2014; http://www.fbi.gov/newyork/press-releases/2014/former-veterans-affairs-police-chief-pleads-guilty-in-manhattan-federal-court-to-participating-in-kidnapping-conspiracies.

603 "Former Veterans Affairs Police Chief Pleads Guilty in Manhattan Federal Court to Participating in Kidnapping Conspiracies," FBI website, January 16, 2014; http://www.fbi.gov/newyork/press-releases/2014/former-veterans-affairs-police-chief-pleads-guilty-in-manhattan-federal-court-to-participating-in-kidnapping-conspiracies.

604 "Feds Charge Veterans Affairs Police Chief In Kidnapping Conspiracy," Police magazine, April 15, 2013; http://www.policemag.com/channel/patrol/news/2013/04/15/feds-charge-veterans-affairs-police-chief-in-kidnapping-conspiracy.aspx.

605 "Former Veterans Affairs Police Chief Pleads Guilty in Manhattan Federal Court to Participating in Kidnapping Conspiracies," FBI website, January 16, 2014; http://www.fbi.gov/newyork/press-releases/2014/former-veterans-affairs-police-chief-pleads-guilty-in-manhattan-federal-court-to-participating-in-kidnapping-conspiracies.

606 "Manhattan U.S. Attorney and FBI Assistant Director in Charge Announce Kidnapping Conspiracy Charges Against Massachusetts Veterans Affairs Police Chief and Former New York City High School Librarian; Defendants Allegedly Planned the Abduction, Rape, Torture, and Murder of Multiple Victims," FBI website, April 15, 2013; http://www.fbi.gov/newyork/press-releases/2013/manhattan-u.s.-attorney-and-fbi-assistant-director-in-charge-announce-kidnapping-conspiracy-charges-against-massachusetts-veterans-affairs-police-chief-and-former-new-york-city-high-school-librarian.

607 "Manhattan U.S. Attorney and FBI Assistant Director in Charge Announce Kidnapping Conspiracy Charges Against Massachusetts Veterans Affairs Police Chief and Former New York City High School Librarian; Defendants Allegedly Planned the Abduction, Rape, Torture, and Murder of Multiple Victims," FBI website, April 15, 2013; http://www.fbi.gov/newyork/press-releases/2013/manhattan-u.s.-attorney-and-fbi-assistant-director-in-charge-announce-kidnapping-conspiracy-charges-against-massachusetts-veterans-affairs-police-chief-and-former-new-york-city-high-school-librarian.

608 "Manhattan U.S. Attorney and FBI Assistant Director in Charge Announce Kidnapping Conspiracy Charges Against Massachusetts Veterans Affairs Police Chief and Former New York City High School Librarian; Defendants Allegedly Planned the Abduction, Rape, Torture, and Murder of Multiple Victims," FBI website, April 15, 2013; http://www.fbi.gov/newyork/press-releases/2013/manhattan-u.s.-attorney-and-fbi-assistant-director-in-charge-announce-kidnapping-conspiracy-charges-against-massachusetts-veterans-affairs-police-chief-and-former-new-york-city-high-school-librarian.

609 "Manhattan U.S. Attorney and FBI Assistant Director in Charge Announce Kidnapping Conspiracy Charges Against Massachusetts Veterans Affairs Police Chief and Former New York City High School Librarian; Defendants Allegedly Planned the Abduction, Rape, Torture, and Murder of Multiple Victims," FBI website, April 15, 2013; http://www.fbi.gov/newyork/press-releases/2013/manhattan-u.s.-attorney-and-fbi-assistant-director-in-charge-announce-kidnapping-conspiracy-charges-against-massachusetts-veterans-affairs-police-chief-and-former-new-york-city-high-school-librarian.

610 "Former Veterans Affairs Police Chief Pleads Guilty in Manhattan Federal Court to Participating in Kidnapping Conspiracies," FBI website, January 16, 2014; http://www.fbi.gov/newyork/press-releases/2014/former-veterans-affairs-police-chief-pleads-guilty-in-manhattan-federal-court-to-participating-in-kidnapping-conspiracies.

611 Amber Sutherland and Bob Fredericks, "Cannibal cop's pal told cop: 'She deserves to die'," New York Post, February 27, 2014; http://nypost.com/2014/02/27/cannibal-cops-friends-wanted-to-rape-kill-women-and-kids-prosecutor/.

612 Adam Klasfeld, "NYC Jurors Toughen Up for New Snuff Fantasy Case," Courthouse News Service, February 24, 2014; http://www.courthousenews.com/2014/02/24/65613.htm.

613 Amber Sutherland and Bob Fredericks, "Cannibal cop's pal told cop: 'She deserves to die'," New York Post, February 27, 2014; http://nypost.com/2014/02/27/cannibal-cops-friends-wanted-to-rape-kill-women-and-kids-prosecutor/.

614 "Manhattan U.S. Attorney and FBI Assistant Director in Charge Announce Kidnapping Conspiracy Charges Against Massachusetts Veterans Affairs Police Chief and Former New York City High School Librarian; Defendants Allegedly Planned the Abduction, Rape, Torture, and Murder of Multiple Victims," FBI website, April 15, 2013; http://www.fbi.gov/newyork/press-releases/2013/manhattan-u.s.-attorney-and-fbi-assistant-director-in-charge-announce-kidnapping-conspiracy-charges-against-massachusetts-veterans-affairs-police-chief-and-former-new-york-city-high-school-librarian.

615 William R. Levesque, "Discord divides ranks of Bay Pines VA police," Tampa Bay Times, May 16, 2011; http://www.tampabay.com/news/military/veterans/discord-divides-ranks-of-bay-pines-va-police/1170002.

616 William R. Levesque, "Discord divides ranks of Bay Pines VA police," Tampa Bay Times, May 16, 2011; http://www.tampabay.com/news/military/veterans/discord-divides-ranks-of-bay-pines-va-police/1170002.

617 William R. Levesque, "Discord divides ranks of Bay Pines VA police," Tampa Bay Times, May 16, 2011; http://www.tampabay.com/news/military/veterans/discord-divides-ranks-of-bay-pines-va-police/1170002.

618 William R. Levesque, "Discord divides ranks of Bay Pines VA police," Tampa Bay Times, May 16, 2011; http://www.tampabay.com/news/military/veterans/discord-divides-ranks-of-bay-pines-va-police/1170002.

619 William R. Levesque, "Discord divides ranks of Bay Pines VA police," Tampa Bay Times, May 16, 2011; http://www.tampabay.com/news/military/veterans/discord-divides-ranks-of-bay-pines-va-police/1170002.

620 William R. Levesque, "Discord divides ranks of Bay Pines VA police," Tampa Bay Times, May 16, 2011; http://www.tampabay.com/news/military/veterans/discord-divides-ranks-of-bay-pines-va-police/1170002.

621 William R. Levesque, "Discord divides ranks of Bay Pines VA police," Tampa Bay Times, May 16, 2011; http://www.tampabay.com/news/military/veterans/discord-divides-ranks-of-bay-pines-va-police/1170002.

622 Howard Altman, "ER at VA adding police presence," Tampa Tribune, May 11, 2014; http://tbo.com/list/military-news/er-at-va-adding-police-presence-20140511/.

623 John Cuoco, "V.A. Police found in violation after claims of racism," Waco News Channel 25 KXXV-TV, June 8, 2010; http://www.kxxv.com/story/12617677/va-police-found-in-violation-after-claims-of-racism.

624 John Cuoco, "V.A. Police found in violation after claims of racism," Waco News Channel 25 KXXV-TV, June 8, 2010; http://www.kxxv.com/story/12617677/va-police-found-in-violation-after-claims-of-racism.

625 John Cuoco, "V.A. Police found in violation after claims of racism," Waco News Channel 25 KXXV-TV, June 8, 2010; http://www.kxxv.com/story/12617677/va-police-found-in-violation-after-claims-of-racism.

626 John Cuoco, "VA Police say racism rampant in department," Waco News Channel 25 KXXV-TV, September 21, 2009; http://www.kxxv.com/story/11171150/va-police-say-racism-rampant-in-department..

627 Keith Rogers, "Review-Journal photographer detained during police investigation of body in VA Medical Center parking lot," March 20, 2014; http://www.reviewjournal.com/news/review-journal-photographer-detained-during-police-investigation-body-va-medical-center-parking.

628 Keith Rogers, "Review-Journal photographer detained during police investigation of body in VA Medical Center parking lot," March 20, 2014; http://www.reviewjournal.com/news/review-journal-photographer-detained-during-police-investigation-body-va-medical-center-parking.

629 Keith Rogers, "Review-Journal photographer detained during police investigation of body in VA Medical Center parking lot," March 20, 2014; http://www.reviewjournal.com/news/review-journal-photographer-detained-during-police-investigation-body-va-medical-center-parking.

630 Keith Rogers, "Review-Journal photographer detained during police investigation of body in VA Medical Center parking lot," March 20, 2014; http://www.reviewjournal.com/news/review-journal-photographer-detained-during-police-investigation-body-va-medical-center-parking.

631 David Perera, "eBenefits PII glitch potentially affected about 1,300 says VA," Fierce Government IT, February 6, 2014; http://www.fiercegovernmentit.com/story/ebenefits-pii-glitch-potentially-affected-about-1300-says-va/2014-02-06.

632 David Perera, "eBenefits PII glitch potentially affected about 1,300 says VA," Fierce Government IT, February 6, 2014; http://www.fiercegovernmentit.com/story/ebenefits-pii-glitch-potentially-affected-about-1300-says-va/2014-02-06.

633 House Committee on Veterans' Affairs, "Witness Testimony of Mr. Gregory Wilshusen, Director, Information Security Issues," U.S. Government Accountability Office, March 25, 2014; http://veterans.house.gov/witness-testimony/mr-gregory-wilshusen.

634 Zach Rausnitz, "Lawmakers may force VA to act on information security," Fierce Government IT, March 26, 2014; http://www.fiercegovernmentit.com/story/lawmakers-may-force-va-act-information-security/2014-03-26#ixzz31XI7Gf2j.

635 Joanna S. Kao, "Information Security Incidents In Government Agencies Continue To Rise," Aljazeera, May 16, 2014; http://america.aljazeera.com/articles/2014/5/16/security-incidentsingovernmentagenciesincreased43percentin2013.html.

636 Joanna S. Kao, "Information Security Incidents In Government Agencies Continue To Rise," Aljazeera, May 16, 2014; http://america.aljazeera.com/articles/2014/5/16/security-incidentsingovernmentagenciesincreased43percentin2013.html.

637 Joanna S. Kao, "Information Security Incidents In Government Agencies Continue To Rise," Aljazeera, May 16, 2014; http://america.aljazeera.com/articles/2014/5/16/security-incidentsingovernmentagenciesincreased43percentin2013.html.

638 Zach Rausnitz, "Lawmakers may force VA to act on information security," Fierce Government IT, March 26, 2014; http://www.fiercegovernmentit.com/story/lawmakers-may-force-va-act-information-security/2014-03-26#ixzz31XI7Gf2j.

639 House Committee on Veterans' Affairs, "Witness Testimony of Mr. Gregory Wilshusen, Director, Information Security Issues," U.S. Government Accountability Office, March 25, 2014; http://veterans.house.gov/witness-testimony/mr-gregory-wilshusen.

640 House Committee on Veterans' Affairs, "Witness Testimony of Mr. Gregory Wilshusen, Director, Information Security Issues," U.S. Government Accountability Office, March 25, 2014; http://veterans.house.gov/witness-testimony/mr-gregory-wilshusen.

641House Committee on Veterans' Affairs, "Witness Testimony of Mr. Gregory Wilshusen, Director, Information Security Issues," U.S. Government Accountability Office, March 25, 2014; http://veterans.house.gov/witness-testimony/mr-gregory-wilshusen.

642 "Exclusive - Robert Gates Extended Interview," The Daily Show with Jon Stewart, January 15, 2014; http://www.thedailyshow.com/watch/wed-january-15-2014/exclusive---robert-gates-extended-interview-pt--2.

643 "Exclusive - Robert Gates Extended Interview," The Daily Show with Jon Stewart, January 15, 2014; http://www.thedailyshow.com/watch/wed-january-15-2014/exclusive---robert-gates-extended-interview-pt--2.

644 "Exclusive - Robert Gates Extended Interview," The Daily Show with Jon Stewart, January 15, 2014; http://www.thedailyshow.com/watch/wed-january-15-2014/exclusive---robert-gates-extended-interview-pt--2.

645 Information provided by the Congressional Research Service to the office of Senator Tom Coburn, May 9, 2014.

646 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http://www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

647 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http://www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

648 Testimony of Nick Tolentino, OIF/OEF combat veteran and former VA employee, before the U.S. Senate Committee on Veterans Affairs, April 25, 2012; http://www.veterans.senate.gov/imo/media/doc/tolentino-4-25-12.pdf.

649 "Hearings 113th Congress," Senate Committee on Veterans' Affairs website, accessed June 6, 2014; http://www.veterans.senate.gov/hearings.

650 "Hearings 113th Congress," U.S. Senate Committee on Veterans Affairs, accessed June 6, 2014; http://www.veterans.senate.gov/hearings?c=113&type=Oversight.

651 Chris Fates, "First on CNN: 'Angered' Shinkseki to speak but say little about growing VA scandal," CNN, May 23, 2014; http://www.cnn.com/2014/05/14/us/va-scandal-eric-shinseki-reaction/.

652 Press Release, "Senate VA Committee GOP Request Oversight Hearings," Senator Richard Burr, May 22, 2014; http://www.burr.senate.gov/public/index.cfm?FuseAction=PressOffice.PressReleases&ContentRecord_id=78c37029-d877-2796-9e4b-707729df037b.

653"Hearings," Senate Committee on Veterans' Affairs website, accessed June 6, 2014; http://www.veterans.senate.gov/hearings?c=111&type=Oversight .

654 "VA watchdog says federal prosecutors involved in scandal probe, charges possible," Fox News, May 15, 2014; http://www.foxnews.com/politics/2014/05/15/shinseki-va-testimony-watchdog/.

655 "Hearings 113th Congress," Senate Committee on Veterans' Affairs website, accessed June 6, 2014; http://www.veterans.senate.gov/hearings.

656 Hearings 113th Congress," Senate Committee on Veterans' Affairs website, accessed June 6, 2014; http://www.veterans.senate.gov/hearings.

657 Office of Senator Tom Coburn, "Wastebook 2012," appendix, page 132; http://www.coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=b7b23f66-2d60-4d5a-8bc5-8522c7e1a40e.

Endnotes

658 "Hearings 112th Congress," Senate Committee on Veterans' Affairs website, accessed April 18, 2014; http://www.veterans.senate.gov/hearings?c=112&type=Oversight.

659 Gregg Zoroya, "VA treatment records falsified, probe finds," USA Today, May 4, 2014; http://www.usatoday.com/story/news/nation/2014/05/04/va-healthcare-delays-treatment-phoenix-cheyenne-deaths/8602117/.

660 "113th Congress Hearings," House Committee on Veterans' Affairs website, accessed April 22, 2014; http://veterans.house.gov/legislation/hearings.

661 "Inspectors General: Veteran Affairs Special Inquiry Report Was Misleading," U.S. Government Accountability Office, GAO/OSI-98-9, May1998; http://www.gao.gov/assets/230/225692.pdf.

662 House of Representatives, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, "Hearing on GAO Report on VA Inspector General Special Inquiry Regarding Patient Deaths at the VA Hospital in Columbia, Missouri and VA Quality Assurance Improvement," May 14, 1998, (Serial No. 105-37). Washington: Government Printing Office, 1998; http://www.gpo.gov/fdsys/pkg/CHRG-105hhrg51114/pdf/CHRG-105hhrg51114.pdf.

663 "Inspectors General: Veteran Affairs Special Inquiry Report Was Misleading," U.S. Government Accountability Office, GAO/OSI-98-9, May1998; http://www.gao.gov/assets/230/225692.pdf.

664 House of Representatives, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, "Hearing on GAO Report on VA Inspector General Special Inquiry Regarding Patient Deaths at the VA Hospital in Columbia, Missouri and VA Quality Assurance Improvement," May 14, 1998, (Serial No. 105-37). Washington: Government Printing Office, 1998; http://www.gpo.gov/fdsys/pkg/CHRG-105hhrg51114/pdf/CHRG-105hhrg51114.pdf.

665 House of Representatives, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, "Hearing on GAO Report on VA Inspector General Special Inquiry Regarding Patient Deaths at the VA Hospital in Columbia, Missouri and VA Quality Assurance Improvement," May 14, 1998, (Serial No. 105-37). Washington: Government Printing Office, 1998; http://www.gpo.gov/fdsys/pkg/CHRG-105hhrg51114/pdf/CHRG-105hhrg51114.pdf.

666 House of Representatives, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, "Hearing on GAO Report on VA Inspector General Special Inquiry Regarding Patient Deaths at the VA Hospital in Columbia, Missouri and VA Quality Assurance Improvement," May 14, 1998, (Serial No. 105-37). Washington: Government Printing Office, 1998; http://www.gpo.gov/fdsys/pkg/CHRG-105hhrg51114/pdf/CHRG-105hhrg51114.pdf.

667 Terry Ganey, "Records Show Battle to Prosecute Nurse," St. Louis (MO) Post-Dispatch, June 9, 2002.

668 "Hearings 113th Congress," U.S. Senate Committee on Veterans Affairs, accessed April 22, 2014; http://www.veterans.senate.gov/hearings?c=113&type=Oversight.

669 According to the committee's official website, the last two oversight hearings were held May 5, 2010 and April 30, 2014. http://www.veterans.senate.gov/hearings?c=111&type=Oversight.

670 "Exclusive - Robert Gates Extended Interview," The Daily Show with Jon Stewart, January 15, 2014; http://www.thedailyshow.com/watch/wed-january-15-2014/exclusive---robert-gates-extended-interview-pt--2.

671 FY 2015 Budget Submission, "Volume II: Medical Programs and Information Technology Programs, Congressional Submission FY 2015 Funding," http://www.va.gov/budget/docs/summary/Fy2015-VolumeII-MedicalProgramsAndInformationTechnology.pdf (VHA-2).

672 FY 2015 Budget Submission, "Volume II: Medical Programs and Information Technology Programs, Congressional Submission FY 2015 Funding," http://www.va.gov/budget/docs/summary/Fy2015-VolumeII-MedicalProgramsAndInformationTechnology.pdf (VHA-2).

673 Sean Davis, "This Chart Shows Why The VA's Problems Have Nothing To Do With Funding," The Federalist, May 30, 2014; http://thefederalist.com/2014/05/30/this-chart-shows-why-the-vas-problems-have-nothing-to-do-with-funding/.

674 Sean Davis, "This Chart Shows Why The VA's Problems Have Nothing To Do With Funding," The Federalist, May 30, 2014; http://thefederalist.com/2014/05/30/this-chart-shows-why-the-vas-problems-have-nothing-to-do-with-funding/.

675 Sean Davis, "This Chart Shows Why The VA's Problems Have Nothing To Do With Funding," The Federalist, May 30, 2014; http://thefederalist.com/2014/05/30/this-chart-shows-why-the-vas-problems-have-nothing-to-do-with-funding/.

676 Sean Davis, "This Chart Shows Why The VA's Problems Have Nothing To Do With Funding," The Federalist, May 30, 2014; http://thefederalist.com/2014/05/30/this-chart-shows-why-the-vas-problems-have-nothing-to-do-with-funding/.

677 Sean Davis, "This Chart Shows Why The VA's Problems Have Nothing To Do With Funding," The Federalist, May 30, 2014; http://thefederalist.com/2014/05/30/this-chart-shows-why-the-vas-problems-have-nothing-to-do-with-funding/.

678 Scott Bronstein, Nelli Black and Drew Griffin, "Hospital delays are killing America's war veterans," CNN, November 20, 2013; http://www.cnn.com/2013/11/19/health/veterans-dying-health-care-delays/.

679 "Fiscal Year 2015 Balances of Budget Authority, Budget of the U.S. Government," Executive Office of the President Office of Management and Budget, 2014; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2015/assets/balances.pdf (Table 2. Total Unexpended Balances by Agency, FY 2015 Budget).

680 "Fiscal Year 2015 Balances of Budget Authority, Budget of the U.S. Government," Executive Office of the President Office of Management and Budget, 2014; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2015/assets/balances.pdf.

681 "Fiscal Year 2015 Balances of Budget Authority, Budget of the U.S. Government," Executive Office of the President Office of Management and Budget, 2014; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2015/assets/balances.pdf.

682 "NIH Budget: Research for the People," National Institutes of Health website, accessed May 15, 2014; http://www.nih.gov/about/budget.htm.

683 The Department of Veterans Affairs website, accessed May 16, 2014; http://www.va.gov/oig/about/immediate-office.asp.

684 Sidath Viranga Panangala, "Veterans' Medical Care: FY2014 Appropriations," Congressional Research Service, August 14, 2013.

685 Sidath Viranga Panangala, "Veterans' Medical Care: FY2014 Appropriations," Congressional Research Service, August 14, 2013.

686 Shannon Mullen, "Federal worker bonuses cut in half, new figures show; $176.6M paid as sequester, budget cuts hit 1.3 million workers," Asbury Park Press, May 5, 2014; http://www.app.com/article/20140504/NJNEWS2002/305040024/federal-employee-salaries.

687 "VA CONSTRUCTION: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects," Government Accountability Office, April 2013; http://www.gao.gov/assets/660/653585.pdf.

688 "VA CONSTRUCTION: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects," Government Accountability Office, April 2013; http://www.gao.gov/assets/660/653585.pdf.

689 Statement of Lorelei St. James, Director of the Government Accountability Office's Physical Infrastructure Issues, "VA CONSTRUCTION: VA's Actions to Address Cost Increases at Denver and Other Major Medical-Facility Projects," Testimony before the House of Representatives Committee on Veterans' Affairs Subcommittee on Oversight and Investigations, April 2014; http://www.gao.gov/assets/670/662689.pdf. Cannot find cited quotes

690 "VA CONSTRUCTION: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects," Government Accountability Office, April 2013; http://www.gao.gov/assets/660/653585.pdf.

691 Josh Sweigart, "Delay in treatment' a factor in more than 100 deaths at VA centers," Dayton Daily News, May 17, 2014; http://www.mydaytondailynews.

com/news/news/local-military/delay-in-treatment-a-factor-in-more-than-100-death/nfx8G/?icmp=daytondaily_internallink_textlink_apr2013_daytondailystubtomydaytondaily_launch#f3f1da4d.3791925.735371.

692 Josh Sweigart, "Delay in treatment' a factor in more than 100 deaths at VA centers," Dayton Daily News, May 17, 2014; http://www.mydaytondailynews.com/news/news/local-military/delay-in-treatment-a-factor-in-more-than-100-death/nfx8G/?icmp=daytondaily_internallink_textlink_apr2013_daytondailystubtomydaytondaily_launch#f3f1da4d.3791925.735371.

693 Sam Batkins, "Red Tape Challenges to America's Veterans," American Action Forum, July 2, 2013; http://americanactionforum.org/insights/red-tape-challenges-to-americas-veterans.

694 Patrick Howley, "VA Expects To Have More Medical-Care Funding Than It Can Spend For The Fifth Year In A Row," Daily Caller, May 27, 2014; http://dailycaller.com/2014/05/27/va-expects-to-have-more-medical-care-funding-than-it-can-spend-for-the-fifth-year-in-a-row/.

695 Patrick Howley, "VA Expects To Have More Medical-Care Funding Than It Can Spend For The Fifth Year In A Row," Daily Caller, May 27, 2014; http://dailycaller.com/2014/05/27/va-expects-to-have-more-medical-care-funding-than-it-can-spend-for-the-fifth-year-in-a-row/.

696 "Fiscal Year 2015 Budget Submission – Vol II, Medical Programs and Informational Technology Programs," Department of Veterans Affairs, accessed June 9, 2014; http://www.va.gov/budget/docs/summary/Fy2015-VolumeII-MedicalProgramsAndInformationTechnology.pdf (p. VHA-36).

697 Patrick Howley, "VA Expects To Have More Medical-Care Funding Than It Can Spend For The Fifth Year In A Row," Daily Caller, May 27, 2014; http://dailycaller.com/2014/05/27/va-expects-to-have-more-medical-care-funding-than-it-can-spend-for-the-fifth-year-in-a-row/.

698 Sidath Viranga Panangala, "Veterans' Medical Care: FY2014 Appropriations," Congressional Research Service, August 14, 2013.

699 "Fiscal Year 2015 Balances of Budget Authority, Budget of the U.S. Government," Executive Office of the President Office of Management and Budget, 2014; http://www.whitehouse.gov/sites/default/files/omb/budget/fy2015/assets/balances.pdf (Table 2. Total Unexpended Balances by Agency, FY 2015 Budget). Need to find NIH budget.

700 The White House, Office of Management and Budget, "Impacts and Costs of the October 2013 Federal Government Shutdown," Executive Office of the President of the United States, November 2013; http://www.whitehouse.gov/sites/default/files/omb/reports/impacts-and-costs-of-october-2013-federal-government-shutdown-report.pdf.

701 The White House, Office of Management and Budget, "Impacts and Costs of the October 2013 Federal Government Shutdown," Executive Office of the President of the United States, November 2013; http://www.whitehouse.gov/sites/default/files/omb/reports/impacts-and-costs-of-october-2013-federal-government-shutdown-report.pdf.

702 The White House, Office of Management and Budget, "Impacts and Costs of the October 2013 Federal Government Shutdown," Executive Office of the President of the United States, November 2013; http://www.whitehouse.gov/sites/default/files/omb/reports/impacts-and-costs-of-october-2013-federal-government-shutdown-report.pdf.

703 Information provided to the Congressional Research Service by the Department of Veterans Affairs Office of Congressional & Legislative Affairs, December 4, 2013.

704 Scott Bronstein, Nelli Black, and Drew Griffin, "Hospital delays are killing America's war veterans," CNN, November 20, 2013; http://www.cnn.com/2013/11/19/health/veterans-dying-health-care-delays/index.html. Note: The VA has only confirmed 6 deaths, but other sources indicate the number is actually much higher (likely closer to 20 deaths).

705 Scott Bronstein, Nelli Black, and Drew Griffin, "Hospital delays are killing America's war veterans," CNN, November 20, 2013; http://www.cnn.com/2013/11/19/health/veterans-dying-health-care-delays/index.html.

706 U.S. Department of Veterans Affairs Office of the Inspector General, "Healthcare Inspection: Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center, Columbia, SC," Report No. 12-04631-313, September 6, 2013; http://www.va.gov/oig/pubs/VAOIG-12-04631-313.pdf (p. 3).

707 U.S. Department of Veterans Affairs Office of the Inspector General, "Healthcare Inspection: Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center, Columbia, SC," Report No. 12-04631-313, September 6, 2013; http://www.va.gov/oig/pubs/VAOIG-12-04631-313.pdf (p. 6).

708 U.S. Department of Veterans Affairs Office of the Inspector General, "Healthcare Inspection: Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center, Columbia, SC," Report No. 12-04631-313, September 6, 2013; http://www.va.gov/oig/pubs/VAOIG-12-04631-313.pdf (p. 9).

709 Scott Bronstein, Nelli Black, and Drew Griffin, "Hospital delays are killing America's war veterans," CNN, November 20, 2013; http://www.cnn.com/2013/11/19/health/veterans-dying-health-care-delays/index.html.

710 U.S. Department of Veterans Affairs Office of the Inspector General, "Healthcare Inspection: Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center, Columbia, SC," Report No. 12-04631-313, September 6, 2013; http://www.va.gov/oig/pubs/VAOIG-12-04631-313.pdf (p. 9).

711 U.S. Department of Veterans Affairs Office of the Inspector General, "Healthcare Inspection: Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center, Columbia, SC," Report No. 12-04631-313, September 6, 2013; http://www.va.gov/oig/pubs/VAOIG-12-04631-313.pdf (p. 9).

712 U.S. Department of Veterans Affairs Office of the Inspector General, "Healthcare Inspection: Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center, Columbia, SC," Report No. 12-04631-313, September 6, 2013; http://www.va.gov/oig/pubs/VAOIG-12-04631-313.pdf (p. 9).

713 Bryant Jordan, "Congress Questions VA on Tissue Used in Surgeries," Military News, April 2, 2014; http://www.military.com/daily-news/2014/04/02/congress-questions-va-on-tissue-used-in-surgeries.html?comp=700001075741&rank=1.

714 House Committee on Veterans' Affairs, Opening Statement of the Honorable Mike Coffman, Chairman, Oversight and Investigations, "Vendors in the OR – VA's Failed Oversight of Surgical Implants," January 15, 2014; http://veterans.house.gov/opening-statement/hon-mike-coffman-1.

715 Aaron Glantz, "VA pays out $200 million for nearly 1,000 veterans' wrongful deaths," The Center for Investigative Reporting, April 3, 2014; http://www.cironline.org/reports/va-pays-out-200-million-nearly-1000-veterans%E2%80%99-wrongful-deaths-6236.

716 Chriss Street, "The VA and Wrongful Deaths," AmericanThinker.com, April 6, 2014, http://www.americanthinker.com/2014/04/the_va_and_wrongful_deaths.html.

717 Aaron Glantz, "VA pays out $200 million for nearly 1,000 veterans' wrongful deaths," The Center for Investigative Reporting, April 3, 2014; http://www.cironline.org/reports/va-pays-out-200-million-nearly-1000-veterans%E2%80%99-wrongful-deaths-6236.

718 Aaron Glantz, "VA pays out $200 million for nearly 1,000 veterans' wrongful deaths," The Center for Investigative Reporting, April 3, 2014; http://www.cironline.org/reports/va-pays-out-200-million-nearly-1000-veterans%E2%80%99-wrongful-deaths-6236.

719 Aaron Glantz, "VA pays out $200 million for nearly 1,000 veterans' wrongful deaths," The Center for Investigative Reporting, April 3, 2014; http://www.cironline.org/reports/va-pays-out-200-million-nearly-1000-veterans%E2%80%99-wrongful-deaths-6236.

720 Aaron Glantz, "VA pays out $200 million for nearly 1,000 veterans' wrongful deaths," The Center for Investigative Reporting, April 3, 2014; http://www.cironline.org/reports/va-pays-out-200-million-nearly-1000-veterans%E2%80%99-wrongful-deaths-6236.

721 Chriss Street, "The VA and Wrongful Deaths," American Thinker, April 6, 2014; http://www.americanthinker.com/2014/04/the_va_and_wrongful_deaths.html.

722 Chriss Street, "The VA and Wrongful Deaths," American Thinker, April 6, 2014; http://www.americanthinker.com/2014/04/the_va_and_wrongful_deaths.html.

723 Josh Sweigart and Aaron Diamant, "Paying the Price – VA's malpractice tab: $845M in 10 years," WSB-TV and Cox Media Group; http://www.wsbtv.com/VA-lawsuits/.

724 House Committee on Veterans' Affairs, "Hearing on 04/09/2014: A Continued Assessment of Delays in VA Medical Care and Preventable Veteran Deaths – Witness Testimony of Barry Coates, Veteran," http://veterans.house.gov/witness-testimony/barry-coates.

725 Mark Flatten, "Veteran tells Congress he was handed a 'death sentence' by botched care at Veterans Affairs hospital," Washington Examiner, April 9, 2014; http://washingtonexaminer.com/article/2547022#.

726 Josh Sweigart and Aaron Diamant, "Paying the Price – VA's malpractice tab: $845M in 10 years," WSB-TV and Cox Media Group; http://www.wsbtv.com/VA-lawsuits/.

727 Josh Sweigart and Aaron Diamant, "Paying the Price – VA's malpractice tab: $845M in 10 years," WSB-TV and Cox Media Group; http://www.wsbtv.com/VA-lawsuits/.

728 Josh Sweigart and Aaron Diamant, "Paying the Price – VA's malpractice tab: $845M in 10 years," WSB-TV and Cox Media Group; http://www.wsbtv.com/VA-lawsuits/.

729 Department of Veterans Affairs Office of Inspector General, Semiannual Report to Congress, Issue 69, October 1, 2012—March 31, 2013; http://www.va.gov/oig/pubs/sars/VAOIG-SAR-2013-1.pdf (p. 25-26).

730 VA Office of Inspector General, Office of Audits and Evaluations, "Review of Alleged Incomplete Installation of Encryption Software Licenses," 12-01903-04, October 11, 2012; http://www.va.gov/oig/pubs/VAOIG-12-01903-04.pdf (p. 2).

731 VA Office of Inspector General, Office of Audits and Evaluations, "Review of Alleged Incomplete Installation of Encryption Software Licenses," 12-01903-04, October 11, 2012; http://www.va.gov/oig/pubs/VAOIG-12-01903-04.pdf (p. 2).

732 VA Office of Inspector General, Office of Audits and Evaluations, "Review of Alleged Incomplete Installation of Encryption Software Licenses," 12-01903-04, October 11, 2012; http://www.va.gov/oig/pubs/VAOIG-12-01903-04.pdf (p. i).

733 VA Office of Inspector General, Office of Audits and Evaluations, "Review of Alleged Incomplete Installation of Encryption Software Licenses," 12-01903-04, October 11, 2012; http://www.va.gov/oig/pubs/VAOIG-12-01903-04.pdf (p. 3).

734 VA Office of Inspector General, Office of Audits and Evaluations, "Review of Alleged Incomplete Installation of Encryption Software Licenses," 12-01903-04, October 11, 2012; http://www.va.gov/oig/pubs/VAOIG-12-01903-04.pdf (p. 2).

735 VA Office of Inspector General, Office of Audits and Evaluations, "Review of Alleged Incomplete Installation of Encryption Software Licenses," 12-01903-04, October 11, 2012; http://www.va.gov/oig/pubs/VAOIG-12-01903-04.pdf (p. 1).

736 VA Office of Inspector General, Office of Audits and Evaluations, "Review of Alleged Incomplete Installation of Encryption Software Licenses," 12-01903-04, October 11, 2012; http://www.va.gov/oig/pubs/VAOIG-12-01903-04.pdf (p. 2-3).

737 Mary Lou Byrd, "VA Spends Close to $500 Million on Conference Room, Office Makeovers Under Obama," Washington Free Beacon, May 15, 2014; http://freebeacon.com/issues/va-spends-close-to-500-million-on-conference-room-office-makeovers-under-obama/.

738 Mary Lou Byrd, "VA Spends Close to $500 Million on Conference Room, Office Makeovers Under Obama," Washington Free Beacon, May 15, 2014; http://freebeacon.com/issues/va-spends-close-to-500-million-on-conference-room-office-makeovers-under-obama/.

739 Mary Lou Byrd, "VA Spends Close to $500 Million on Conference Room, Office Makeovers Under Obama," Washington Free Beacon, May 15, 2014; http://freebeacon.com/issues/va-spends-close-to-500-million-on-conference-room-office-makeovers-under-obama/.

740 Mary Lou Byrd, "VA Spends Close to $500 Million on Conference Room, Office Makeovers Under Obama," Washington Free Beacon, May 15, 2014; http://freebeacon.com/issues/va-spends-close-to-500-million-on-conference-room-office-makeovers-under-obama/.

741 Mary Lou Byrd, "VA Spends Close to $500 Million on Conference Room, Office Makeovers Under Obama," Washington Free Beacon, May 15, 2014; http://freebeacon.com/issues/va-spends-close-to-500-million-on-conference-room-office-makeovers-under-obama/.

742 Kelly Cohen, "South Carolina Veterans Affairs employees misused government purchasing cards, IG finds," Washington Examiner, April 21, 2014; http://washingtonexaminer.com/south-carolina-veterans-affairs-employees-misused-government-purchasing-cards-ig-finds/article/2547535.

743 Kelly Cohen, "South Carolina Veterans Affairs employees misused government purchasing cards, IG finds," Washington Examiner, April 21, 2014; http://washingtonexaminer.com/south-carolina-veterans-affairs-employees-misused-government-purchasing-cards-ig-finds/article/2547535.

744 VA Office of Inspector General, Office of Audits and Evaluations, "Veterans Health Administration: Audit of Engineering Service Purchase Card Practices at the Ralph H. Johnson VA Medical Center, Charleston, South Carolina," 13-02267-124, April 17, 2014; http://www.va.gov/oig/pubs/VAOIG-13-02267-124.pdf (p. 1).

745 VA Office of Inspector General, Office of Audits and Evaluations, "Veterans Health Administration: Audit of Engineering Service Purchase Card Practices at the Ralph H. Johnson VA Medical Center, Charleston, South Carolina," 13-02267-124, April 17, 2014; http://www.va.gov/oig/pubs/VAOIG-13-02267-124.pdf (p. 6).

746 "Audit: Workers at costly Veterans Affairs job center took average of 2 calls a day," Fox News, July 15, 2013; http://www.foxnews.com/politics/2013/07/15/audit-veteran-affairs-spending-millions-on-job-call-centers-where-operators-get/.

747 VA Office of Inspector General, Office of Audits and Evaluations, "Review of Acquisitions Supporting the Veteran Employment Services Office," 13-00644-231, June 25, 2013; http://www.va.gov/oig/pubs/VAOIG-13-00644-231.pdf (p. i).

748 VA Office of Inspector General, Office of Audits and Evaluations, "Review of Acquisitions Supporting the Veteran Employment Services Office," 13-00644-231, June 25, 2013; http://www.va.gov/oig/pubs/VAOIG-13-00644-231.pdf (p. 2).

749 VA Office of Inspector General, Office of Audits and Evaluations, "Review of Acquisitions Supporting the Veteran Employment Services Office," 13-00644-231, June 25, 2013; http://www.va.gov/oig/pubs/VAOIG-13-00644-231.pdf (p. 2).

750 VA Office of Inspector General, Office of Audits and Evaluations, "Review of Acquisitions Supporting the Veteran Employment Services Office," 13-00644-231, June 25, 2013; http://www.va.gov/oig/pubs/VAOIG-13-00644-231.pdf (p. 5).

751 VA Office of Inspector General, Office of Audits and Evaluations, "Review of Acquisitions Supporting the Veteran Employment Services Office," 13-00644-231, June 25, 2013; http://www.va.gov/oig/pubs/VAOIG-13-00644-231.pdf (p. 2).

752 VA Office of Inspector General, Office of Audits and Evaluations, "Review of Acquisitions Supporting the Veteran Employment Services Office," 13-00644-231, June 25, 2013; http://www.va.gov/oig/pubs/VAOIG-13-00644-231.pdf (p. 2).

753 "FY 2015 President's Budget Request," Department of Veterans Affairs, March 5, 2014; http://www.va.gov/budget/docs/summary/Fy2015-BudgetRollout.pdf.

Endnotes

754 Federal IT Dashboard, last accessed June 7, 2014; https://www.itdashboard.gov/portfolios/agency=029.

755 "IT DASHBOARD: Agencies Are Managing Investment Risk, but Related Ratings Need to Be More Accurate and Available," United States Government Accountability Office, December 2013; http://www.gao.gov/assets/660/659666.pdf.

756 "High- Risk Information Technology Projects: Is Poor Management Leading to Billions in Waste?," Hearing before the Federal Financial Management, Government Information, Federal Services, and International Sercurity Subcommittee of the Committee on Homeland Security and Governmental Affairs, United States Senate, 100th Congress, September 20, 2007; http://www.gpo.gov/fdsys/pkg/CHRG-110shrg38844/pdf/CHRG-110shrg38844.pdf.

757 Jason Miller, "Agencies still struggle to manage IT, Senators press OMB officials to reverse repeated history of IT project failures," FCW: The Business of Federal Technology, September 21, 2007; http://fcw.com/Articles/2007/09/21/Agencies-still-struggle-to-manage-IT.aspx.

758 "Witness Testimony of Joel C. Willemssen, Managing Director, Information Technology, U.S. Government Accountability Office," House Committee on Veterans' Affairs, http://veterans.house.gov/prepared-statement/prepared-statement-joel-willemssen-managing-director-information-technology-us.

759 "INFORMATION TECHNOLOGY: Management Improvements Are Essential to VA's Second Effort to Replace Its Outpatient Scheduling System," United States Government Accountability Office, May 2010; http://www.gao.gov/assets/310/305030.pdf.

760 "ELECTRONIC HEALTH RECORDS: VA and DOD Need to Support Cost and Schedule Claims, Develop Interoperability Plans, and Improve Collaboration," United States Government Accountability Office, February 2014; http://www.gao.gov/assets/670/661208.pdf.

761 "FY 2015 President's Budget Request," Department of Veterans Affairs, March 5, 2014; http://www.va.gov/budget/docs/summary/Fy2015-BudgetRollout.pdf.

762 Amy Medici, "Senators point to poor IT management as contributor to VA scandal, Federal Times, June 11, 2014; http://www.federaltimes.com/article/20140611/MGMT02/306110011/Senators-point-poor-management-contributor-VA-scandal?odyssey=nav|head.

763 Based on spending reported by the VA OIG (Report No. 11-04376-81) and VA in its FY 2015 budget submission.

764 "Benefits 21st Century Paperless Delivery of Veterans Benefits," Federal IT Dashboard, last accessed June 7, 2014; https://itdashboard.gov/investment?buscid=468.

765 Bob Brewin, "VA Paperless Claims System 'Spontaneously' Shuts Down," Nextgov, December 5, 2013; http://www.nextgov.com/defense/2013/12/va-paperless-claims-system-spontaneously-shuts-down/74978/.

766 Bob Brewin, "VA Paperless Claims Processing System Shut Down," Nextgov, January 29, 2014; http://www.nextgov.com/defense/2014/01/va-paperless-claims-processing-system-shut-down/77801/?oref=nextgov_breaking_alert.

767 "Witness Testimony of Joel C. Willemssen, Managing Director, Information Technology, U.S. Government Accountability Office," House Committee on Veterans' Affairs, http://veterans.house.gov/prepared-statement/prepared-statement-joel-willemssen-managing-director-information-technology-us#_ftn2.

768 "Review of Alleged Transmission of Sensitive VA Data Over Internet Connections," Department of Veterans Affairs Office of Inspector General, March 6, 2013; http://www.va.gov/oig/pubs/VAOIG-12-02802-111.pdf.

769 5 U.S.C. § 7131; United States Office of Personnel Management, "Labor-Management Relations: Reports on Official Time," OPM; http://www.opm.gov/policy-data-oversight/labor-management-relations/reports-on-official-time/#url=Overview.

770 Vincent Vernuccio, "Official Time: Government Workers Perform Union Duties on the Taxpayers' Dime," Capital Research Center, November 1, 2011; http://capitalresearch.org/2011/11/official-time-government-workers-perform-union-duties-on-the-taxpayers%E2%80%99-dime/.

771 Letter from Secretary Eric K. Shinseki to the Honorable Robert J. Portman, October 28, 2013.

772 Letter from Secretary Eric K. Shinseki to the Honorable Robert J. Portman, October 28, 2013.

773 Letter from Secretary Eric K. Shinseki to the Honorable Robert J. Portman, October 28, 2013.

774 Letter from Secretary Eric K. Shinseki to the Honorable Robert J. Portman, October 28, 2013.

775 Letter from Senator Tom A. Coburn, M.D. and Senator Rob Portman to Eric K. Shinseki, Secretary of the U.S. Department of Veterans Affairs, June 5, 2013; http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=6a4cc6e2-62bf-4ec5-9ccd-ac8e9586ecd0.

776 Letter from Senator Tom A. Coburn, M.D. and Senator Rob Portman to Eric K. Shinseki, Secretary of the U.S. Department of Veterans Affairs, June 5, 2013; http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=6a4cc6e2-62bf-4ec5-9ccd-ac8e9586ecd0.

777 Letter from Senator Tom A. Coburn, M.D. and Senator Rob Portman to Eric K. Shinseki, Secretary of the U.S. Department of Veterans Affairs, June 5, 2013; http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=6a4cc6e2-62bf-4ec5-9ccd-ac8e9586ecd0.

778 Elizabeth MacDonald, "188 VA Workers Do Union Work Full-Time, Senators Say," Fox Business, June 6, 2013; http://www.foxbusiness.com/government/2013/06/06/188-va-workers-do-union-work-full-time-senators-say/.

779 Letter from Secretary Eric K. Shinseki to the Honorable Robert J. Portman, October 28, 2013 (attachment).

780 United States Office of Personnel Management, "Labor-Management Relations: Reports on Official Time – Official Time Usage in the Federal Government Fiscal Year 2011 Survey Responses," http://www.opm.gov/policy-data-oversight/labor-management-relations/reports-on-official-time/#url=cost2011.

781 Government Accountability Office, "2014 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits," GAO-14-343SP, April 2014; http://www.gao.gov/assets/670/662327.pdf (p. 2).

782 Government Accountability Office, "2014 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits," GAO-14-343SP, April 2014; http://www.gao.gov/assets/670/662327.pdf (p. 159).

783 Government Accountability Office, "2014 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits," GAO-14-343SP, April 2014; http://www.gao.gov/assets/670/662327.pdf (p. 159).

784 Government Accountability Office, "2014 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits," GAO-14-343SP, April 2014; http://www.gao.gov/assets/670/662327.pdf (p. 159).

785 Government Accountability Office, "2014 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits," GAO-14-343SP, April 2014; http://www.gao.gov/assets/670/662327.pdf (p. 159).

786 U.S. Department of Veterans Affairs, "Homeless Veterans," accessed May 20, 2014; http://www.va.gov/homeless/about_the_initiative.asp.

787 U.S. Department of Veterans Affairs, "Homeless Programs & Initiatives," accessed May 20, 2014; http://www1.va.gov/HOMELESS/Programs.asp.

788 "Duplicate spending on veterans' care costs billions," UC Davis Health System, June 26, 2012; http://www.ucdmc.ucdavis.edu/publish/news/newsroom/6721; Amal N. Trivedi, MD, MPH; Regina C. Grebla, MGA, MPH, PhD; Lan Jiang, MS; Jean Yoon, PhD; Vincent Mor, PhD; Kenneth W. Kizer, MD, MPH, "Duplicate Federal Payments for Dual Enrollees in Medicare Advantage Plans and the Veterans Health Care System," Journal of the American Medical Association, Volume 308, No. 1 (pp. 67-72), July 4, 2012; http://jama.jamanetwork.com/article.aspx?articleid=1197014.

789 Amal N. Trivedi, MD, MPH; Regina C. Grebla, MGA, MPH, PhD; Lan Jiang, MS; Jean Yoon, PhD; Vincent Mor, PhD; Kenneth W. Kizer, MD, MPH, "Duplicate Federal Payments for Dual Enrollees in Medicare Advantage Plans and the Veterans Health Care System," Journal of the American Medical Association, July 4, 2012, Volume 308, No. 1 (pp. 67-72), http://jama.jamanetwork.com/article.aspx?articleid=1197014.

790 Greg Jaffe, "Cold Calculations: How a backlogged VA determines the true cost of war," Washington Post, May 21, 2014; http://www.washingtonpost.com/sf/national/2014/05/20/after-the-wars-cold-calculations/?hpid=z1.

791 Greg Jaffe, "Wanted Heroes: Trying to piece together the puzzle of veterans' unemployment proves difficult," Washington Post, April 2, 2014; http://www.washingtonpost.com/sf/national/2014/04/02/wanted-heroes/?utm_source=Sailthru&utm_medium=email&utm_term=%2ASituation%20Report&utm_campaign=SITREP%20APRIL%203%202014.

792 Greg Jaffe, "Wanted Heroes: Trying to piece together the puzzle of veterans' unemployment proves difficult," Washington Post, April 2, 2014; http://www.washingtonpost.com/sf/national/2014/04/02/wanted-heroes/?utm_source=Sailthru&utm_medium=email&utm_term=%2ASituation%20Report&utm_campaign=SITREP%20APRIL%203%202014.

793 Government Accountability Office, "Veterans' Employment and Training: Better Targeting, Coordinating, and Reporting Needed to Enhance Program Effectiveness," GAO-13-29, December 2012; http://www.gao.gov/assets/660/650876.pdf.

794 Greg Jaffe, "Wanted Heroes: Trying to piece together the puzzle of veterans' unemployment proves difficult," The Washington Post, WashingtonPost.com, April 2, 2014, http://www.washingtonpost.com/sf/national/2014/04/02/wanted-heroes/?utm_source=Sailthru&utm_medium=email&utm_term=%2ASituation%20Report&utm_campaign=SITREP%20APRIL%203%202014.

795 U.S. Department of Labor, Bureau of Labor Statistics, "Economic News Release – Employment Situation of Veterans Summary," March 20, 2014; http://www.bls.gov/news.release/vet.nr0.htm.

796 Tom Raum, Associated Press, "Unemployment rate among veterans drops, but remains high," PBS, March 20, 2014; http://www.pbs.org/newshour/rundown/unemployment-rate-among-veterans-drops-remains-high/.

797 Government Accountability Office, "Veterans' Employment and Training: Better Targeting, Coordinating, and Reporting Needed to Enhance Program Effectiveness," GAO-13-29, December 2012; http://www.gao.gov/assets/660/650876.pdf.

798 Government Accountability Office, "Veterans' Employment and Training: Better Targeting, Coordinating, and Reporting Needed to Enhance Program Effectiveness," GAO-13-29, December 2012; http://www.gao.gov/assets/660/650876.pdf (p. 32).

799 Government Accountability Office, "Veterans' Employment and Training: Better Targeting, Coordinating, and Reporting Needed to Enhance Program Effectiveness," GAO-13-29, December 2012; http://www.gao.gov/assets/660/650876.pdf (p. 32).

800 Government Accountability Office, "Veterans' Employment and Training: Better Targeting, Coordinating, and Reporting Needed to Enhance Program Effectiveness," GAO-13-29, December 2012; http://www.gao.gov/assets/660/650876.pdf (p. 32).

801 Government Accountability Office, "Veterans' Employment and Training: Better Targeting, Coordinating, and Reporting Needed to Enhance Program Effectiveness," GAO-13-29, December 2012; http://www.gao.gov/assets/660/650876.pdf (p. 33).

802 Government Accountability Office, "Veterans' Employment and Training: Better Targeting, Coordinating, and Reporting Needed to Enhance Program Effectiveness," GAO-13-29, December 2012; http://www.gao.gov/assets/660/650876.pdf (p. 33).

803 VA Office of Inspector General Office of Audits and Evaluations, "Review of VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2012," 12094241-138, March, 15, 2013; http://www.va.gov/oig/pubs/VAOIG-12-04241-138.pdf (p. 1).

804 VA Office of Inspector General Office of Audits and Evaluations, "Review of VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2012," 12094241-138, March, 15, 2013; http://www.va.gov/oig/pubs/VAOIG-12-04241-138.pdf (p. 1).

805 VA Office of Inspector General Office of Audits and Evaluations, "Review of VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2012," 12094241-138, March, 15, 2013; http://www.va.gov/oig/pubs/VAOIG-12-04241-138.pdf (p. 9).

806 VA Office of Inspector General Office of Audits and Evaluations, "Review of VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2012," 12094241-138, March, 15, 2013; http://www.va.gov/oig/pubs/VAOIG-12-04241-138.pdf (p. 3).

807 VA Office of Inspector General Office of Audits and Evaluations, "Review of VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2012," 12094241-138, March, 15, 2013; http://www.va.gov/oig/pubs/VAOIG-12-04241-138.pdf (p. 3).

808 John Solomon, "VA made stunning $2.2 billion in mistaken payments in 2012," Washington Times, March 17, 2013; http://www.washingtontimes.com/news/2013/mar/17/va-made-stunning-22-billion-in-mistaken-payments-i/?page=all.

809 VA Office of Inspector General Office of Audits and Evaluations, "Review of VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2012," 12094241-138, March, 15, 2013; http://www.va.gov/oig/pubs/VAOIG-12-04241-138.pdf (p. 14).

810 VA Office of Inspector General Office of Audits and Evaluations, "Review of VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2012," 12094241-138, March, 15, 2013; http://www.va.gov/oig/pubs/VAOIG-12-04241-138.pdf (p. 3).

811 John Solomon, "VA made stunning $2.2 billion in mistaken payments in 2012," Washington Times, March 17, 2013; http://www.washingtontimes.com/news/2013/mar/17/va-made-stunning-22-billion-in-mistaken-payments-i/?page=all.

812 John Solomon, "VA made stunning $2.2 billion in mistaken payments in 2012," Washington Times, March 17, 2013; http://www.washingtontimes.com/news/2013/mar/17/va-made-stunning-22-billion-in-mistaken-payments-i/?page=all.

813 John Solomon, "VA made stunning $2.2 billion in mistaken payments in 2012," Washington Times, March 17, 2013; http://www.washingtontimes.com/news/2013/mar/17/va-made-stunning-22-billion-in-mistaken-payments-i/?page=all.

814 VA Office of Inspector General, Office of Audits and Evaluations, "Veterans Health Administration: Audit of Medical Care Collections Fund Billing of VA-Provided Care," 11-00333-254, August 30, 2012; http://www.va.gov/oig/pubs/VAOIG-11-00333-254.pdf.

815 VA Office of Inspector General, Office of Audits and Evaluations, "Veterans Health Administration: Audit of Medical Care Collections Fund Billing of VA-Provided Care," 11-00333-254, August 30, 2012; http://www.va.gov/oig/pubs/VAOIG-11-00333-254.pdf.

816 VA Office of Inspector General, Office of Audits and Evaluations, "Veterans Health Administration: Audit of Medical Care Collections Fund Billing of VA-Provided Care," 11-00333-254, August 30, 2012; http://www.va.gov/oig/pubs/VAOIG-11-00333-254.pdf (p. 2).

817 VA Office of Inspector General, Office of Audits and Evaluations, "Veterans Health Administration: Audit of Medical Care Collections Fund Billing of VA-Provided Care," 11-00333-254, August 30, 2012; http://www.va.gov/oig/pubs/VAOIG-11-00333-254.pdf (p. 2).

818 Rick Maze, "IG: VA fails to bill insurers when it should," Army Times, May 26, 2011; http://www.armytimes.com/article/20110526/NEWS/105260338/IG-VA-fails-bill-insurers-when-should.

819 Rick Maze, "IG: VA fails to bill insurers when it should," Army Times, May 26, 2011; http://www.armytimes.com/article/20110526/NEWS/105260338/IG-VA-fails-bill-insurers-when-should.

820 VA Office of Inspector General, Office of Audits and Evaluations, "Veterans Health Administration: Audit of Medical Care Collections Fund Billing of VA-Provided Care," 11-00333-254, August 30, 2012; http://www.va.gov/oig/pubs/VAOIG-11-00333-254.pdf (p. i).

821 Rick Maze, "VA's 11-day, $221K resort stay draws scrutiny," Federal Times, October 11, 2011; http://www.federaltimes.com/article/20111011/DEPARTMENTS04/110110303/.

822 Rick Maze, "VA's 11-day, $221K resort stay draws scrutiny," Federal Times, October 11, 2011; http://www.federaltimes.com/article/20111011/DEPARTMENTS04/110110303/.

823 Mark Flatten and Jennifer Peebles, "Watchdog: IG blasts 'lax' VA spending, top official resigns," Washington Examiner, October 1, 2012; http://washingtonexaminer.com/watchdog-ig-blasts-lax-va-spending-top-official-resigns/article/2509537.

824 Charles S. Clark, "Veterans Affairs' overspending at conferences linked to poor contract execution," Government Executive, October 5, 2012; http://www.govexec.com/contracting/2012/10/veterans-affairs-overspending-conferences-linked-poor-contract-execution/58619/; Mark Flatten and Jennifer Peebles, "Watchdog: IG blasts 'lax' VA spending, top official resigns," Washington Examiner, October 1, 2012; http://washingtonexaminer.com/watchdog-ig-blasts-lax-va-spending-top-official-resigns/article/2509537.

825 Mark Flatten and Jennifer Peebles, "Watchdog: IG blasts 'lax' VA spending, top official resigns," Washington Examiner, October 1, 2012; http://washingtonexaminer.com/watchdog-ig-blasts-lax-va-spending-top-official-resigns/article/2509537.

826 "Probe slams VA over $6M conference tab, including parody video, official resigns," Fox News, October 1, 2012; http://www.foxnews.com/politics/2012/10/01/probe-slams-va-over-6m-orlando-conferences-official-resigns/.

827 Mark Flatten and Jennifer Peebles, "Watchdog: IG blasts 'lax' VA spending, top official resigns," Washington Examiner, October 1, 2012; http://washingtonexaminer.com/watchdog-ig-blasts-lax-va-spending-top-official-resigns/article/2509537.

828 Mark Flatten, "Updated!: VA's $52k 'Patton' video parody hits the air," Washington Examiner, August 22, 2012; http://washingtonexaminer.com/updated-vas-52k-patton-video-parody-hits-the-air/article/2505621#.UGoZ7U2HIYs.

829 Stephen Losey, "IG: VA's top HR exec lied about his knowledge of conference video," Federal Times, October 1, 2012; http://www.federaltimes.com/article/20121001/TRAVEL02/310010009/IG-VA-8217-s-top-HR-exec-lied-about-his-knowledge-conference-video.

830 Stephen Losey, "IG: VA's top HR exec lied about his knowledge of conference video," Federal Times, October 1, 2012; http://www.federaltimes.com/article/20121001/TRAVEL02/310010009/IG-VA-8217-s-top-HR-exec-lied-about-his-knowledge-conference-video.

831 Stephen Losey, "IG: VA's top HR exec lied about his knowledge of conference video," Federal Times, October 1, 2012: http://www.federaltimes.com/article/20121001/TRAVEL02/310010009/IG-VA-8217-s-top-HR-exec-lied-about-his-knowledge-conference-video.

832 Stephen Losey, "IG: VA's top HR exec lied about his knowledge of conference video," Federal Times, October 1, 2012: http://www.federaltimes.com/article/20121001/TRAVEL02/310010009/IG-VA-8217-s-top-HR-exec-lied-about-his-knowledge-conference-video.

833 "27% of US veterans from Iraq, Afghan wars going hungry: Study," PressTV, May 9, 2014; http://www.presstv.ir/detail/2014/05/09/361948/study-1-in-4-us-veterans-going-hungry/.

834 "27% of US veterans from Iraq, Afghan wars going hungry: Study," PressTV, May 9, 2014; http://www.presstv.ir/detail/2014/05/09/361948/study-1-in-4-us-veterans-going-hungry/.

835 Mark Flatten, "House committee to probe 'culture of irresponsible spending' on Veterans Affairs conferences," Washington Examiner, October 25, 2013; http://washingtonexaminer.com/house-committee-to-probe-culture-of-irresponsible-spending-on-veterans-affairs-conferences/article/2537880.

836 Jim McElhatton, "Another former Obama administration figure pleads the 5th," Washington Times, October 30, 2013; http://www.washingtontimes.com/news/2013/oct/30/ex-va-exec-wont-testify-lavish-conference-spending/?page=all.

837 Mark Flatten and Jennifer Peebles, "Watchdog: IG blasts 'lax' VA spending, top official resigns," Washington Examiner, October 1, 2012; http://washingtonexaminer.com/watchdog-ig-blasts-lax-va-spending-top-official-resigns/article/2509537.

838 Mark Flatten and Jennifer Peebles, "Watchdog: IG blasts 'lax' VA spending, top official resigns," Washington Examiner, October 1, 2012; http://washingtonexaminer.com/watchdog-ig-blasts-lax-va-spending-top-official-resigns/article/2509537.

839 Jim McElhatton, "Another former Obama administration figure pleads the 5th," Washington Times, October 30, 2013; http://www.washingtontimes.com/news/2013/oct/30/ex-va-exec-wont-testify-lavish-conference-spending/?page=all.

840 Mark Flatten, "Unethical behavior' drove wasteful spending at Veterans Affairs conference," Washington Examiner, October 30, 2013; http://washingtonexaminer.com/unethical-behavior-drove-wasteful-spending-at-veterans-affairs-conference/article/2538187. This link includes video clip of VA employees singing karaoke at one of the conferences.

841 Corbin Hiar, "Bush appointee allows VA employee to be overpaid $41,000 and commute to D.C. from Ark.," The Center for Public Integrity, August 17, 2011; http://www.publicintegrity.org/2011/08/17/5805/bush-appointee-allows-va-employee-be-overpaid-41000-and-commute-dc-ark.

842 Corbin Hiar, "Bush appointee allows VA employee to be overpaid $41,000 and commute to D.C. from Ark.," The Center for Public Integrity, August 17, 2011; http://www.publicintegrity.org/2011/08/17/5805/bush-appointee-allows-va-employee-be-overpaid-41000-and-commute-dc-ark.

843 Department of Veterans Affairs Office of Inspector General, "Administrative Investigation: Improper Locality Rate of Pay, Office of Information and Techonolgy, VA Central Office," Report No. 10-02858-07, October 14, 2010; http://www.va.gov/oig/pubs/VAOIG-10-02858-07.pdf (p. 5).

844 Corbin Hiar, "Bush appointee allows VA employee to be overpaid $41,000 and commute to D.C. from Ark.," The Center for Public Integrity, August 17, 2011; http://www.publicintegrity.org/2011/08/17/5805/bush-appointee-allows-va-employee-be-overpaid-41000-and-commute-dc-ark.

845 Corbin Hiar, "Veterans Department official bills government $130,000 for commute to Washington," The Center for Public Integrity, July 28, 2011; http://www.publicintegrity.org/2011/07/28/5411/veterans-department-official-bills-government-130000-commute-washington.

846 Corbin Hiar, "Veterans Department official bills government $130,000 for commute to Washington," The Center for Public Integrity, July 28, 2011; http://www.publicintegrity.org/2011/07/28/5411/veterans-department-official-bills-government-130000-commute-washington.

847 Corbin Hiar, "Veterans Department official bills government $130,000 for commute to Washington," The Center for Public Integrity, July 28, 2011; http://www.publicintegrity.org/2011/07/28/5411/veterans-department-official-bills-government-130000-commute-washington.

848 Corbin Hiar, "Veterans Department official bills government $130,000 for commute to Washington," The Center for Public Integrity, July 28, 2011; http://www.publicintegrity.org/2011/07/28/5411/veterans-department-official-bills-government-130000-commute-washington.

849 Department of Veterans Affairs Office of Inspector General, "Administrative Investigation: Improper Duty Station and Misuse of Travel Funds, VHA, VA Central Office Washington, DC," Report No. 10-02328-192, June 10, 2011; http://www.va.gov/oig/pubs/VAOIG-10-02328-192.pdf (p. 5).

850 VA Office of Inspector General Office of Audits and Evaluations, "Review of Separately Priced Item Purchases for Training Conferences," September 30, 2013; http://www.va.gov/oig/pubs/VAOIG-13-00455-345.pdf (p. 2).

851 VA Office of Inspector General Office of Audits and Evaluations, "Review of Separately Priced Item Purchases for Training Conferences," September 30, 2013; http://www.va.gov/oig/pubs/VAOIG-13-00455-345.pdf (p. 2).

Endnotes

852 VA Office of Inspector General Office of Audits and Evaluations, "Review of Separately Priced Item Purchases for Training Conferences," September 30, 2013; http://www.va.gov/oig/pubs/VAOIG-13-00455-345.pdf (p. 16).

853 "Y-- Perry Point MD project # 512A5-10-335 Mansion and Grist Mill Construction and Rehabilitation," Federal Business Opportunities, March 27, 2013; https://www.fbo.gov/index?s=opportunity&mode=form&id=acf1f83a2dd7ed9c69c50fdfdc66f1f3&tab=core&_cview=1.

854 Maryland Historical Trust, "National Register of Historic Places," State of Maryland, accessed May 21, 2014; http://mht.maryland.gov/nr/NRDetail.aspx?HDID=316&FROM=NRMapCE.html.

855 Maryland Historical Trust, "National Register of Historic Places," State of Maryland, accessed May 21, 2014; http://mht.maryland.gov/nr/NRDetail.aspx?HDID=316&FROM=NRMapCE.html.

856 "Y-- Perry Point MD project # 512A5-10-335 Mansion and Grist Mill Construction and Rehabilitation," Federal Business Opportunities, March 27, 2013; https://www.fbo.gov/index?s=opportunity&mode=form&id=acf1f83a2dd7ed9c69c50fdfdc66f1f3&tab=core&_cview=1.

857 David A. Fahrenthold, "As Congress fights over the budget, agencies go on their 'use it or lose it' shopping sprees," The Washington Post, September 28, 2013; http://www.washingtonpost.com/politics/as-congress-fights-over-the-budget-agencies-go-on-their-use-it-or-lose-it-shopping-sprees/2013/09/28/b8eef3cc-254c-11e3-b3e9-d97fb087acd6_story.html.

858 David A. Fahrenthold, "As Congress fights over the budget, agencies go on their 'use it or lose it' shopping sprees," The Washington Post, September 28, 2013; http://www.washingtonpost.com/politics/as-congress-fights-over-the-budget-agencies-go-on-their-use-it-or-lose-it-shopping-sprees/2013/09/28/b8eef3cc-254c-11e3-b3e9-d97fb087acd6_story.html.

859 David A. Fahrenthold, "As Congress fights over the budget, agencies go on their 'use it or lose it' shopping sprees," The Washington Post, September 28, 2013; http://www.washingtonpost.com/politics/as-congress-fights-over-the-budget-agencies-go-on-their-use-it-or-lose-it-shopping-sprees/2013/09/28/b8eef3cc-254c-11e3-b3e9-d97fb087acd6_story.html.

860 U.S. Government Accountability Office, "VA Construction: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects," GAO-13-202, April 2013; http://www.gao.gov/assets/660/653585.pdf.

861 U.S. Government Accountability Office, "VA Construction: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects," GAO-13-202, April 2013; http://www.gao.gov/assets/660/653585.pdf.

862 U.S. Government Accountability Office, "VA Construction: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects," GAO-13-202, April 2013; http://www.gao.gov/assets/660/653585.pdf.

863 Logan Porter, "Cost overruns, delays plague huge Veterans Administration building projects," The Washington Examiner, March 25, 2014; http://washingtonexaminer.com/cost-overruns-delays-plague-huge-veterans-administration-building-projects/article/2546279.

864 Tak Landrock, "VA medical facility opening delayed, again," KDVR, April 22, 2014; http://kdvr.com/2014/04/22/va-medical-facility-opening-delayed-again.

865 Allison Sherry and Michael Booth, "Aurora's new VA hospital has long, costly history," Denver Post, June 16, 2013; http://www.denverpost.com/news/ci_23470410/auroras-new-va-hospital-has-long-costly-history.

866 Allison Sherry and Michael Booth, "Aurora's new VA hospital has long, costly history," Denver Post, June 16, 2013; http://www.denverpost.com/news/ci_23470410/auroras-new-va-hospital-has-long-costly-history.

867 Allison Sherry and Michael Booth, "Aurora's new VA hospital has long, costly history," Denver Post, June 16, 2013; http://www.denverpost.com/news/ci_23470410/auroras-new-va-hospital-has-long-costly-history.

868 U.S. Government Accountability Office, "VA Construction: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects, GAO-13-202, April 2013, http://www.gao.gov/assets/660/653585.pdf (p.9).

869 Press Release, "GAO Report Exposes Cost Increases and Delays in VA Construction Projects," House Committee on Veterans' Affairs, May 8, 2013; http://democrats.veterans.house.gov/press-release/gao-report-exposes-cost-increases-and-delays-va-construction-projects.

870 Allison Sherry, "GAO: Delays cost taxpayers $1.5 billion in VA hospital construction," Denver Post, May 9, 2013; http://www.denverpost.com/localpolitics/ci_23203364/gao-delays-cost-taxpayers-1-5-billion-va.

871 Testimony Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives, "VA Construction: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects," GAO 13-556T, Statement of Lorelei St. James, May 7, 2013; http://www.gao.gov/assets/660/654405.pdf.

872 DiMarkco Chandler, "New VA Hospital Opening Soon in North Las Vegas," Gaurdian Liberty Voice, March 19, 2012; http://guardianlv.com/2012/03/new-va-hospital-opening-soon-in-north-las-vegas/.

873 Conor Shine, VA ready to lift wraps on new $600 million medical center in North Las Vegas," Las Vegas Sun, August 3, 2012; http://www.lasvegassun.com/news/2012/aug/04/va-ready-lift-wraps-new-600-million-medical-center/.

874 DiMarkco Chandler, "New VA Hospital Opening Soon in North Las Vegas," Gaurdian Liberty Voice, March 19, 2012; http://guardianlv.com/2012/03/new-va-hospital-opening-soon-in-north-las-vegas/.

875 Steve Tetreault, "Reid, Heller say 'growing pains' at root of new VA hospital's problems," Las Vegas Review-Journal, March 25, 2014; http://www.reviewjournal.com/news/reid-heller-say-growing-pains-root-new-va-hospital-s-problems.

876 Steve Tetreault, "Reid, Heller say 'growing pains' at root of new VA hospital's problems," Las Vegas Review-Journal, March 25, 2014; http://www.reviewjournal.com/news/reid-heller-say-growing-pains-root-new-va-hospital-s-problems.

877 Steve Tetreault, "Reid, Heller say 'growing pains' at root of new VA hospital's problems," Las Vegas Review-Journal, March 25, 2014; http://www.reviewjournal.com/news/reid-heller-say-growing-pains-root-new-va-hospital-s-problems.

878 Steve Tetreault, "Reid, Heller say 'growing pains' at root of new VA hospital's problems," Las Vegas Review-Journal, March 25, 2014; http://www.reviewjournal.com/news/reid-heller-say-growing-pains-root-new-va-hospital-s-problems; "Senators tackle veterans' backlog issue," Nevada Appeal, March 6, 2014; http://www.nevadaappeal.com/news/lahontanvalley/10490121-113/veterans-backlog-claims-benefits.

879 In 2000, the VA signed a 20-year lease for the existing 55,600 square foot Ernest R. Childers Clinic. In 2005, a 3,000 square foot behavioral health clinic was also leased by the VA in Tulsa. Community Based Outpatient Clinics (CBOC) were established in 1994 as part of the Veteran's Health Administration (VHA) transition n from in-patient based system of care to one focused on ambulatory and primary care. As of 2012, there were 822 of these clinics.

880 "Fiscal Year 2015 Budget Submission – Volume IV, Construction, Long Range Capital Plan and Appendix," Department of Veterans Affairs, accessed June 9, 2014; http://www.va.gov/budget/docs/summary/Fy2015-VolumeIV-ConstructionLongRangeCapitalPlanAndAppendix.pdf (pp. 6-148-6-150).

881 "Fiscal Year 2015 = Budget Submission – Volume IV, Construction, Long Range Capital Plan and Appendix," Department of Veterans Affairs, accessed June 9, 2014;, http://www.va.gov/budget/docs/summary/Fy2015-VolumeIV-ConstructionLongRangeCapitalPlanAndAppendix.pdf (p. 6-151).

882 Randy Krehbiel, "Inhofe will try to save VA clinic funding," Tulsa World, June 7, 2014; http://www.tulsaworld.com/news/government/inhofe-tries-to-save-va-clinic-funding/article_445875e8-a63d-58d1-88cf-fee4b82009d0.html.

883 Shannon Muchmore, "New Muskogee VA patients wait a month for appointments," Tulsa World, June 10, 2014; http://www.tulsaworld.com/news/health/new-muskogee-va-patients-wait-a-month-for-appointments/article_455fbbca-77d1-5585-add5-f6dff23806c9.html.

884 Shannon Muchmore, "New Muskogee VA patients wait a month for appointments," Tulsa World, June 10, 2014; http://www.tulsaworld.com/news/health/new-muskogee-va-patients-wait-a-month-for-appointments/article_455fbbca-77d1-5585-add5-f6dff23806c9.html.

885 Shannon Muchmore, "New Muskogee VA patients wait a month for appointments," Tulsa World, June 10, 2014; http://www.tulsaworld.com/news/health/new-muskogee-va-patients-wait-a-month-for-appointments/article_455fbbca-77d1-5585-add5-f6dff23806c9.html.

886 Shannon Muchmore, "New Muskogee VA patients wait a month for appointments," Tulsa World, June 10, 2014; http://www.tulsaworld.com/news/health/new-muskogee-va-patients-wait-a-month-for-appointments/article_455fbbca-77d1-5585-add5-f6dff23806c9.html.

887 "Fiscal Year 2015 Budget Submission – Volume IV, Construction, Long Range Capital Plan and Appendix," Department of Veterans Affairs, accessed June 9, 2014; http://www.va.gov/budget/docs/summary/Fy2015-VolumeIV-ConstructionLongRangeCapitalPlanAndAppendix.pdf (p. 6-4).

888 "Fiscal Year 2015 Budget Submission – Volume IV, Construction, Long Range Capital Plan and Appendix," Department of Veterans Affairs, accessed June 9, 2014; http://www.va.gov/budget/docs/summary/Fy2015-VolumeIV-ConstructionLongRangeCapitalPlanAndAppendix.pdf (p. 6-4).

889 "Fiscal Year 2015 Budget Submission – Volume IV, Construction, Long Range Capital Plan and Appendix," Department of Veterans Affairs, accessed June 9, 2014; http://www.va.gov/budget/docs/summary/Fy2015-VolumeIV-ConstructionLongRangeCapitalPlanAndAppendix.pdf (p. 6-149).

890 Feds Data Center, accessed June 9, 2014; http://fedsdatacenter.com/.

891 "VA Real Property: Action Needed to Improve the Leasing of Outpatient Clinics," Government Accountability Office, GAO-14-300, April 30, 2014; http://www.gao.gov/products/GAO-14-300.

892 "VA Real Property: Action Needed to Improve the Leasing of Outpatient Clinics," Government Accountability Office, GAO-14-300, April 30, 2014; http://www.gao.gov/products/GAO-14-300.

893 Hearing Transcript on VA's Dubious Contracting Practices: Savannah, House Committee on Veterans' Affairs, March 6, 2012; http://veterans.house.gov/hearing-transcript/vas-dubious-contracting-practices-savannah.

894 Stan Johnson Company, Confidential Offering Memorandum for 325 West Montgomery Crossroads, Savannah, Georgia 31406; http://www.stanjohnsonco.com/property/gsa/va-outpatient-clinic/?prop_id=a0BG000000b2HbaMAE.

895 Chatham County Board of Assessors, 2014 Property Record Card for 325 W Montgomery XR Savannah; http://boa.chathamcounty.org/DesktopModules/ChathamCounty/BoardofAssessors/PropertyRecordCard.aspx?RollYear=2014&PIN=2-0644-01-017.

896 USASpending.gov, PIID: 62318400798; http://usaspending.gov/explore?fiscal_year=all&comingfrom=searchresults&piid=62318400798&typeofview=complete.

897 Tulsa County Assessor, Assessment for 9322 E 41 ST S TULSA 74145; http://www.assessor.tulsacounty.org/assessor-property.php, accessed June 19, 2014.

898 VA FY2015 Congressional Budget Justification, Volume IV: Construction, Long Range Capital Plan and Appendix; http://www.va.gov/budget/products.asp.

899 Schifman, Hadden. "New Gilbert VA Clinic Delivered and Sold," Vizzda News, April 24, 2014; http://vizzdanews.blogspot.com/2014/04/new-gilbert-va-clinic-delivered-and-sold.html.

900 Uken, Cindy. "New VA Clinic brings specialty services closer to Billings-area veterans," Billings Gazette, April 11, 2014; http://billingsgazette.com/news/local/new-va-clinic-brings-specialty-services-closer-to-billings-area/article_d0580455-815f-57f7-80cf-12a5631efefd.html.

901 Land value from the Yellowstone County Assessment Office for 1766 Majestic Lane, Billings, MT

902 Uken, Cindy. "New VA Clinic brings specialty services closer to Billings-area veterans," Billings Gazette, April 11, 2014; http://billingsgazette.com/news/local/new-va-clinic-brings-specialty-services-closer-to-billings-area/article_d0580455-815f-57f7-80cf-12a5631efefd.html.

903 Brunson, Carina. "Groundbreaking held for new VA clinic," Winter Texan Times, August 17, 2012; http://www.wintertexantimes.com/news/local-news/6-local-news/974-groundbreaking-held-for-new-va-clinic.html.

904 Hidalgo County Tax Office, Property Tax Balance for 901 Hackberry Avenue, McAllen, Texas; https://actweb.acttax.com/act_webdev/hidalgo/showdetail2.jsp?can=V011800000000100&ownerno=0.

905 Maurer, Kevin. "Wilmington's new, 85,000-square-foot VA clinic opens," StarNewsOnline, April 30, 2013; http://www.starnewsonline.com/article/20130430/ARTICLES/130439978?p=1&tc=pg.

906 "VA Real Property: Action Needed to Improve the Leasing of Outpatient Clinics," Government Accountability Office, GAO-14-300, April 30, 2014; http://www.gao.gov/products/GAO-14-300.

907 Doyle, Steve. "New $14.7M Huntsville VA outpatient clinic will soon begin rising near Clearview Cancer Institute," AL.com, March 4, 2014; http://blog.al.com/breaking/2014/03/new_147m_huntsville_va_outpati.html.

908 "VA Real Property: Action Needed to Improve the Leasing of Outpatient Clinics," Government Accountability Office, GAO-14-300, April 30, 2014; http://www.gao.gov/products/GAO-14-300.

909 "VA Real Property: Action Needed to Improve the Leasing of Outpatient Clinics," Government Accountability Office, GAO-14-300, April 30, 2014; http://www.gao.gov/products/GAO-14-300.

910 "VA Real Property: Action Needed to Improve the Leasing of Outpatient Clinics," Government Accountability Office, GAO-14-300, April 30, 2014; http://www.gao.gov/products/GAO-14-300.

911 "VA Real Property: Action Needed to Improve the Leasing of Outpatient Clinics," Government Accountability Office, GAO-14-300, April 30, 2014; http://www.gao.gov/products/GAO-14-300.

912 "VA Real Property: Action Needed to Improve the Leasing of Outpatient Clinics," Government Accountability Office, GAO-14-300, April 30, 2014; http://www.gao.gov/products/GAO-14-300.

913 http://www.stanjohnsonco.com/property/gsa/va-outpatient-clinic/?prop_id=a0BG000000b2HbaMAE

914 Hearing Transcript on VA's Dubious Contracting Practices: Savannah, House Committee on Veterans' Affairs, March 6, 2012; http://veterans.house.gov/hearing-transcript/vas-dubious-contracting-practices-savannah.

915 Hearing Transcript on VA's Dubious Contracting Practices: Savannah, House Committee on Veterans' Affairs, March 6, 2012; http://veterans.house.gov/hearing-transcript/vas-dubious-contracting-practices-savannah.

916 Hearing Transcript on VA's Dubious Contracting Practices: Savannah, House Committee on Veterans' Affairs, March 6, 2012; http://veterans.house.gov/hearing-transcript/vas-dubious-contracting-practices-savannah.

917 Hearing Transcript on VA's Dubious Contracting Practices: Savannah, House Committee on Veterans' Affairs, March 6, 2012; http://veterans.house.gov/hearing-

transcript/vas-dubious-contracting-practices-savannah.

918 "VA Real Property: Action Needed to Improve the Leasing of Outpatient Clinics," Government Accountability Office, GAO-14-300, April 30, 2014; http://www.gao.gov/products/GAO-14-300.

919 http://www.stanjohnsonco.com/property/gsa/va-outpatient-clinic/?prop_id=a0BG000000b2HbaMAE

920 VA FY2015 Congressional Budget Justification, Volume IV: Construction, Long Range Capital Plan and Appendix; http://www.va.gov/budget/products.asp.

921 The DCD Medical Square Foot Cost Guide, DCD: Design Cost Data; http://www.dcd.com/guides/DCD+Medical+Square+Foot+Cost+Guide.html .

922 VA Office of Construction and Facilities Management, Individual VAMC Cost Guides; http://www.cfm.va.gov/cost/vamcPricing.asp?isFlash=2.

923 U.S. Government Accountability Office, "Key Issues – Federal Real Property," accessed May 20, 2014; http://www.gao.gov/key_issues/federal_real_property/issue_summary.

924 U.S. Government Accountability Office, "VA Construction: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects, GAO-13-202, April 2013; http://www.gao.gov/assets/660/653585.pdf. The "VA is one of the largest federal property-holding agencies, with 35,352 acres of land, 5,873 buildings, and over 149 million square feet of medical facilities and administrative space."

925 Jana Winter, "Exclusive: VA Spends Millions to Maintain Vacant and Hazardous Buildings—Cites Limited Funds for Demolition," Fox News, September 1, 2010; http://www.foxnews.com/us/2010/08/31/veteran-affairs-spends-millions-on-hazardous-buildings/.

926 Jana Winter, "Exclusive: VA Spends Millions to Maintain Vacant and Hazardous Buildings—Cites Limited Funds for Demolition," Fox News, September 1, 2010; http://www.foxnews.com/us/2010/08/31/veteran-affairs-spends-millions-on-hazardous-buildings/.

927 Jana Winter, "Exclusive: VA Spends Millions to Maintain Vacant and Hazardous Buildings—Cites Limited Funds for Demolition," Fox News, September 1, 2010; http://www.foxnews.com/us/2010/08/31/veteran-affairs-spends-millions-on-hazardous-buildings/.

928 Jana Winter, "Exclusive: VA Spends Millions to Maintain Vacant and Hazardous Buildings—Cites Limited Funds for Demolition," Fox News, September 1, 2010; http://www.foxnews.com/us/2010/08/31/veteran-affairs-spends-millions-on-hazardous-buildings/.

929 Email from Jon Coen, VA Office of Congressional and Legislative Affairs, to the Office of Senator Tom A. Coburn, M.D., April 17, 2014.

930 Jana Winter, "Exclusive: VA Spends Millions to Maintain Vacant and Hazardous Buildings—Cites Limited Funds for Demolition," Fox News, September 1, 2010; http://www.foxnews.com/us/2010/08/31/veteran-affairs-spends-millions-on-hazardous-buildings/.

931 Department of Veterans Affairs News Release, "St. Cloud VA Medical Center to Install Renewable Energy Systems - $4.7 Million Includes Recovery Act Funds," December 5, 2009; http://www.va.gov/opa/pressrel/docs/Environ_St%20Cloud%20NR.pdf.

932 Tom Steward, "Veterans Affairs wind turbine, built for $2.3 million, stands dormant," Watchdog.org, March 19, 2014; http://watchdog.org/133359/veterans-affairs-minnesota/.

933 Tom Steward, "Veterans Affairs wind turbine, built for $2.3 million, stands dormant," Watchdog.org, March 19, 2014; http://watchdog.org/133359/veterans-affairs-minnesota/.

934 Tom Steward, "Veterans Affairs wind turbine, built for $2.3 million, stands dormant," Watchdog.org, March 19, 2014; http://watchdog.org/133359/veterans-affairs-minnesota/.

935 David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," RAND Corporation, June 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

936 David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," RAND Corporation, June 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

937 "Merritt Hawkins 2014 Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates," Merritt Hawkins, January 2014; http://www.merritthawkins.com/uploadedFiles/MerrittHawkings/Surveys/mha2014waitsurvPDF.pdf.

938 "Merritt Hawkins 2014 Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates," Merritt Hawkins, January 2014; http://www.merritthawkins.com/uploadedFiles/MerrittHawkings/Surveys/mha2014waitsurvPDF.pdf.

939 "Waiting for Care: Examining Patient Wait Times at VA," House Committee on Veterans Affairs Subcommittee on Oversight and Investigations hearing, March 14, 2013; http://veterans.house.gov/sites/republicans.veterans.house.gov/files/documents/113-11_0.pdf.

940 "Veterans Health Administration Interim Report: Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," Department of Veterans Affairs Office of Inspector General, May 28, 2014; http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf.

941 Alicia Parlapiano and Karen Yourish, "Major Reports and Testimony on V.A. Patient Wait Times," The New York Times, May 30, 2014; http://www.nytimes.com/interactive/2014/05/29/us/reports-on-va-patient-wait-periods.html?_r=0. See chart in Appendix.

942 "Veterans Health Administration Interim Report: Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System," Department of Veterans Affairs Office of Inspector General, May 28, 2014; http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf.

943 Matthew Daly, "VA approves more private care for veterans," Associated Press, May 24, 2014; http://bigstory.ap.org/article/apnewsbreak-va-oks-more-private-care-veterans; David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," RAND Corporation, June 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

944 "Fiscal Year 2015 Congressional Budget Submission – Vol II, Medical Programs and Informational Technology Programs," Department of Veterans Affairs, 2014, VHA-36, http://www.va.gov/budget/docs/summary/Fy2015-VolumeII-MedicalProgramsAndInformationTechnology.pdf.

945 Patrick Howley, "VA Expects To Have More Medical-Care Funding Than It Can Spend For The Fifth Year In A Row," The Daily Caller, May 27, 2014; http://dailycaller.com/2014/05/27/va-expects-to-have-more-medical-care-funding-than-it-can-spend-for-the-fifth-year-in-a-row/.

946 David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," RAND Corporation, June 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

947 David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," RAND Corporation, June 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

948 David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," RAND Corporation, June 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

949 Geoff Mulvihill, "New Jersey Hospital to Offer Veterans Priority; New Jersey hospital to offer veterans same-day appointments and health-care navigators," Associated Press/ABC New, http://abcnews.go.com/Health/wireStory/jersey-hospital-offer-veterans-priority-24183791 .

950 Kim Mulford, "Cooper plans 'VIP' service for veterans," Courier-Post, June 17, 2014; http://www.courierpostonline.com/story/news/local/south-jersey/2014/06/17/cooper-plans-vip-service-veterans/10717307/ .

951 Kim Mulford, "Cooper plans 'VIP' service for veterans," Courier-Post, June 17, 2014; http://www.courierpostonline.com/story/news/local/south-jersey/2014/06/17/

cooper-plans-vip-service-veterans/10717307/ .

952 Kim Mulford, "Cooper plans 'VIP' service for veterans," Courier-Post, June 17, 2014; http://www.courierpostonline.com/story/news/local/south-jersey/2014/06/17/cooper-plans-vip-service-veterans/10717307/ .

953 Kim Mulford, "Cooper plans 'VIP' service for veterans," Courier-Post, June 17, 2014; http://www.courierpostonline.com/story/news/local/south-jersey/2014/06/17/cooper-plans-vip-service-veterans/10717307/ .

954 David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," RAND Corporation, June 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

955 Conor Shine, "Shiny, new VA hospital suffers from longtime Nevada malady: doctor shortages," Las Vegas Sun, September 9, 2012; http://www.lasvegassun.com/news/2012/sep/09/shiny-new-va-hospital-suffers-longtime-nevada-mala/.

956 Conor Shine, "Shiny, new VA hospital suffers from longtime Nevada malady: doctor shortages," Las Vegas Sun, September 9, 2012; http://www.lasvegassun.com/news/2012/sep/09/shiny-new-va-hospital-suffers-longtime-nevada-mala/.

957 Steve Tetreault, "Reid, Heller say 'growing pains' at root of new VA hospital's problems," Las Vegas Review-Journal, March 25, 2014; http://www.reviewjournal.com/news/reid-heller-say-growing-pains-root-new-va-hospital-s-problems.

958 Richard A. Oppel, Jr. and Abby Goodnough, "Why So Many V.A. Delays? Too Few Doctors for Starters," The New York Times, May 29, 2014; http://www.nytimes.com/2014/05/30/us/doctor-shortages-cited-in-va-hospital-waits.html?_r=0.

959 "Department of Veterans Affairs Volume II Medical Programs and Information Technology Programs Congressional Submission FY 2015 Funding and FY 2016 Advance Appropriations," Department of Veterans Affairs, Department of Veterans Affairs 2015 Congressional Submission, VHA-30; http://www.va.gov/budget/docs/summary/Fy2015-VolumeII-MedicalProgramsAndInformationTechnology.pdf.

960 Richard A. Oppel, Jr. and Abby Goodnough, "Why So Many V.A. Delays? Too Few Doctors for Starters," The New York Times, May 29, 2014; http://www.nytimes.com/2014/05/30/us/doctor-shortages-cited-in-va-hospital-waits.html?_r=0.

961 Richard A. Oppel, Jr. and Abby Goodnough, "Why So Many V.A. Delays? Too Few Doctors for Starters," The New York Times, May 29, 2014; http://www.nytimes.com/2014/05/30/us/doctor-shortages-cited-in-va-hospital-waits.html?_r=0.

962 Richard A. Oppel, Jr. and Abby Goodnough, "Why So Many V.A. Delays? Too Few Doctors for Starters," The New York Times, May 29, 2014; http://www.nytimes.com/2014/05/30/us/doctor-shortages-cited-in-va-hospital-waits.html?_r=0.

963 "Mental Health Effects of Serving in Afghanistan and Iraq," U.S. Department of Veterans Affairs website, accessed May 30, 2014; http://www.ptsd.va.gov/public/PTSD-overview/reintegration/overview-mental-health-effects.asp.

964 "Mental Health Effects of Serving in Afghanistan and Iraq," U.S. Department of Veterans Affairs website, accessed May 30, 2014; http://www.ptsd.va.gov/public/PTSD-overview/reintegration/overview-mental-health-effects.asp.

965 Peter Cameron, "Vets face shortage of therapists; New program training clinicians in psychology of combat is an attempt to help fill the gap," Chicago Tribune, July 20, 2011; http://articles.chicagotribune.com/2011-07-20/news/ct-x-0720-vets-mental-health-20110720_1_vets-soldiers-project-combat.

966 President Barack Obama, "Executive Order—Improving Access to Mental Health Services for Veterans, Service Members, and Military Families," The White House, August 31, 2012; http://www.whitehouse.gov/the-press-office/2012/08/31/executive-order-improving-access-mental-health-services-veterans-service.

967 David Wood, "VA Mental Health Care Delays, Staff Shortages, Plague Veterans," The Huffington Post, May 24, 2014; http://www.huffingtonpost.com/2014/05/24/va-mental-health-delays_n_5380739.html.

968 David Wood, "VA Mental Health Care Delays, Staff Shortages, Plague Veterans," The Huffington Post, May 24, 2014; http://www.huffingtonpost.com/2014/05/24/va-mental-health-delays_n_5380739.html.

969 David Wood, "VA Mental Health Care Delays, Staff Shortages, Plague Veterans," The Huffington Post, May 24, 2014; http://www.huffingtonpost.com/2014/05/24/va-mental-health-delays_n_5380739.html.

970 David Wood, "VA Mental Health Care Delays, Staff Shortages, Plague Veterans," The Huffington Post, May 24, 2014; http://www.huffingtonpost.com/2014/05/24/va-mental-health-delays_n_5380739.html.

971 David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," RAND Corporation, June 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

972 Abby Goodnough, "Many Veterans Praise Care, but All Hate the Wait," The New York Times, May 31, 2014; http://www.nytimes.com/2014/06/01/us/many-veterans-praise-health-care-but-all-hate-the-wait.html?_r=0.

973 David Wood, "VA Mental Health Care Delays, Staff Shortages, Plague Veterans," The Huffington Post, May 24, 2014; http://www.huffingtonpost.com/2014/05/24/va-mental-health-delays_n_5380739.html.

974 Abby Goodnough, "Many Veterans Praise Care, but All Hate the Wait," The New York Times, May 31, 2014; http://www.nytimes.com/2014/06/01/us/many-veterans-praise-health-care-but-all-hate-the-wait.html?_r=0.

975 Abby Goodnough, "Many Veterans Praise Care, but All Hate the Wait," The New York Times, May 31, 2014; http://www.nytimes.com/2014/06/01/us/many-veterans-praise-health-care-but-all-hate-the-wait.html?_r=0.

976 Abby Goodnough, "Many Veterans Praise Care, but All Hate the Wait," The New York Times, May 31, 2014; http://www.nytimes.com/2014/06/01/us/many-veterans-praise-health-care-but-all-hate-the-wait.html?_r=0.

977 Amy Lipman, "Local VA patients bring complaints to surface," KKCO NBC 11 News, May 29, 2014; http://www.nbc11news.com/home/headlines/Local-VA-patients-bring-complaints-to-surface-261182401.html.

978 Amy Lipman, "Local VA patients bring complaints to surface," KKCO NBC 11 News, May 29, 2014; http://www.nbc11news.com/home/headlines/Local-VA-patients-bring-complaints-to-surface-261182401.html.

979 Amy Lipman, "Local VA patients bring complaints to surface," KKCO NBC 11 News, May 29, 2014; http://www.nbc11news.com/home/headlines/Local-VA-patients-bring-complaints-to-surface-261182401.html.

980 David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," RAND Corporation, June 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

981 Feds Data Center, http://fedsdatacenter.com/ (accessed June 6, 2014).

982 Richard A. Oppel, Jr. and Abby Goodnough, "Why So Many V.A. Delays? Too Few Doctors for Starters," The New York Times, May 29, 2014; http://www.nytimes.com/2014/05/30/us/doctor-shortages-cited-in-va-hospital-waits.html?_r=0.

983 David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," RAND Corporation,

Endnotes

June 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

984 "VA HEALTH CARE: Management and Oversight of Fee Basis Care Need Improvement Report to Congressional Requesters," Government Accountability Office, May 2013; http://www.gao.gov/assets/660/654979.pdf.

985 Public Law 106-117.

986 "VA HEALTH CARE: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit," Government Accountability Office, March 2014; http://www.gao.gov/assets/670/661404.pdf.

987 "VA HEALTH CARE: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit," Government Accountability Office, March 2014; http://www.gao.gov/assets/670/661404.pdf.

988 Rob Johnson, Veterans directed to civilian emergency rooms," Pensacola News Journal, May 16, 2014; http://www.pnj.com/story/news/military/2014/05/15/veterans-directed-civilian-emergency-rooms/9121009/.

989 Rob Johnson, Veterans directed to civilian emergency rooms," Pensacola News Journal, May 16, 2014; http://www.pnj.com/story/news/military/2014/05/15/veterans-directed-civilian-emergency-rooms/9121009/.

990 Rob Johnson, Veterans directed to civilian emergency rooms," Pensacola News Journal, May 16, 2014; http://www.pnj.com/story/news/military/2014/05/15/veterans-directed-civilian-emergency-rooms/9121009/.

991 David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," RAND Corporation, June 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

992 David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," RAND Corporation, June 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

993 David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," RAND Corporation, June 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

994 Abby Goodnough, "Many Veterans Praise Care, but All Hate the Wait," The New York Times, May 31, 2014; http://www.nytimes.com/2014/06/01/us/many-veterans-praise-health-care-but-all-hate-the-wait.html?_r=0.

995 "VA HEALTH CARE: Management and Oversight of Fee Basis Care Need Improvement Report to Congressional Requesters," Government Accountability Office, May 2013; http://www.gao.gov/assets/660/654979.pdf.

996 Department of Veterans Affairs, Office of Rural Health http://www.ruralhealth.va.gov/docs/factsheets/ORH_FactSheet_General_April2013.pdf.

997 Department of Veterans Affairs, Office of Rural Health http://www.ruralhealth.va.gov/docs/factsheets/ORH_FactSheet_General_April2013.pdf.

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

999 "Veterans Transportation and Community Living Initiative Grantee Webinar," U.S. Department of Transportation Federal Transit Administration, July 26, 2012; http://www.fta.dot.gov/documents/VTCLI_2012_Grantee_Webinar_Presentation_FULL.pdf.

1000 "VA HEALTH CARE: Management and Oversight of Fee Basis Care Need Improvement Report to Congressional Requesters," Government Accountability Office, May 2013; http://www.gao.gov/assets/660/654979.pdf.

1001 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/.

1002 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/.

1003 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/.

1004 "VA HEALTH CARE: Management and Oversight of Fee Basis Care Need Improvement Report to Congressional Requesters," Government Accountability Office, May 2013; http://www.gao.gov/assets/660/654979.pdf.

1005 Correspondence from the Congressional Research Service to the office of Senator Tom A. Coburn, April 14, 2014.

1006 Correspondence from the Congressional Research Service to the office of Senator Tom A. Coburn, April 14, 2014.

1007 Darcy Spears, "Veterans being forced to travel out of state for treatment," ABC Action News 13, February 25, 2014; http://www.jrn.com/ktnv/news/contact-13/you-paid-for-it/Veterans-being-forced-to-fly-out-of-state-for-care-247059851.html.

1008 Darcy Spears, "Veterans being forced to travel out of state for treatment," ABC Action News 13, February 25, 2014; http://www.jrn.com/ktnv/news/contact-13/you-paid-for-it/Veterans-being-forced-to-fly-out-of-state-for-care-247059851.html.

1009 Darcy Spears, "Veterans being forced to travel out of state for treatment," ABC Action News 13, February 25, 2014; http://www.jrn.com/ktnv/news/contact-13/you-paid-for-it/Veterans-being-forced-to-fly-out-of-state-for-care-247059851.html.

1010 Darcy Spears, "Veterans being forced to travel out of state for treatment," ABC Action News 13, February 25, 2014; http://www.jrn.com/ktnv/news/contact-13/you-paid-for-it/Veterans-being-forced-to-fly-out-of-state-for-care-247059851.html.

1011 Darcy Spears, "Veterans being forced to travel out of state for treatment," ABC Action News 13, February 25, 2014; http://www.jrn.com/ktnv/news/contact-13/you-paid-for-it/Veterans-being-forced-to-fly-out-of-state-for-care-247059851.html.

1012 Darcy Spears, "Veterans being forced to travel out of state for treatment," ABC Action News 13, February 25, 2014; http://www.jrn.com/ktnv/news/contact-13/you-paid-for-it/Veterans-being-forced-to-fly-out-of-state-for-care-247059851.html.

1013 Darcy Spears, "Veterans being forced to travel out of state for treatment," ABC Action News 13, February 25, 2014; http://www.jrn.com/ktnv/news/contact-13/you-paid-for-it/Veterans-being-forced-to-fly-out-of-state-for-care-247059851.html.

1014 Darcy Spears, "Veterans being forced to travel out of state for treatment," ABC Action News 13, February 25, 2014; http://www.jrn.com/ktnv/news/contact-13/you-paid-for-it/Veterans-being-forced-to-fly-out-of-state-for-care-247059851.html.

1015 "Veterans Health Administration: Audit of the Beneficiary Travel Program," Department of Veterans Affairs Office of Inspector General, February 6, 2013; http://www.va.gov/oig/pubs/VAOIG-11-00336-292.pdf.

1016 Gene Johnson, "Seattle VA fraud case sparks drop in mileage-reimbursement claims," Seattle Times/Associated Press, July 28, 2013; http://seattletimes.com/html/localnews/2021494850_veteranstravelxml.html.

1017 Gene Johnson, "Seattle VA fraud case sparks drop in mileage-reimbursement claims," Seattle Times/Associated Press, July 28, 2013; http://seattletimes.com/html/

Endnotes

localnews/2021494850_veteranstravelxml.html.

1018 "Veterans Health Administration: Audit of the Beneficiary Travel Program," Department of Veterans Affairs Office of Inspector General, February 6, 2013; http://www.va.gov/oig/pubs/VAOIG-11-00336-292.pdf.

1019 "Veterans Health Administration: Audit of the Beneficiary Travel Program," Department of Veterans Affairs Office of Inspector General, February 6, 2013; http://www.va.gov/oig/pubs/VAOIG-11-00336-292.pdf.

1020 "Sixteen Veterans Indicted For Separate Acts To Defraud The Department Of Veterans Affairs," United States Attorney for the Northern District of Ohio website, August 24, 2012; http://www.justice.gov/usao/ohn/news/2012/24augvets.html.

1021 "Sixteen Veterans Indicted For Separate Acts To Defraud The Department Of Veterans Affairs," United States Attorney for the Northern District of Ohio website, August 24, 2012; http://www.justice.gov/usao/ohn/news/2012/24augvets.html.

1022 "Sixteen Veterans Indicted For Separate Acts To Defraud The Department Of Veterans Affairs," United States Attorney for the Northern District of Ohio website, August 24, 2012; http://www.justice.gov/usao/ohn/news/2012/24augvets.html.

1023 Gene Johnson, "Seattle VA fraud case sparks drop in mileage-reimbursement claims," Seattle Times/Associated Press, July 28, 2013; http://seattletimes.com/html/localnews/2021494850_veteranstravelxml.html.

1024 Gene Johnson, "Seattle VA fraud case sparks drop in mileage-reimbursement claims," Seattle Times/Associated Press, July 28, 2013; http://seattletimes.com/html/localnews/2021494850_veteranstravelxml.html.

1025 "Veterans Health Administration: Audit of the Beneficiary Travel Program," Department of Veterans Affairs Office of Inspector General, February 6, 2013; http://www.va.gov/oig/pubs/VAOIG-11-00336-292.pdf.

1026 David I. Auerbach, William B. Weeks, and Ian Brantley, "Health Care Spending and Efficiency in the U.S. Department of Veterans Affairs," RAND Corporation, June 2013; http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR285/RAND_RR285.pdf.

1027 Actual figures for FY 2008-FY 2011 are from VHA Financial Management. Projected totals for FY 2012 and FY 2013 are from 2013 Presidential Budget submission.

1028 "General Bradley's Reply to Legion Charges: Changes Needed, General Says," New York Times, February 2, 1946.

1029 Kenneth W. Kizer and R. Adams Dudley, "Extreme makeover: Transformation of the veterans health care system," Annual Review of Public Health, 2009;30:313-39.

1030 Kenneth Kizer and Ashish Jha, "Restoring Trust in VA Health Care," New England Journal of Medicine, June 4, 2014; http://www.nejm.org/doi/full/10.1056/NEJMp1406852.

1031 Alex Horton," "Busting Myths About VA Health Care Eligibility," VAntage Point, the official blog of the U.S. Department of Veterans Affairs, November 18, 2010; http://www.blogs.va.gov/VAntage/586/busting-myths-about-va-health-care/.

1032 "Health Benefits," U.S. Department of Veterans Affairs website, accessed June 16, 2014; http://www.va.gov/healthbenefits/apply/veterans.asp.

1033 "OPTIONS FOR REDUCING THE DEFICIT: 2014 TO 2023: End Enrollment in VA Medical Care for Veterans in Priority Groups 7 and 8," Congressional Budget Office, November 13, 2013; http://www.cbo.gov/budget-options/2013/44902.

1034 "OPTIONS FOR REDUCING THE DEFICIT: 2014 TO 2023: End Enrollment in VA Medical Care for Veterans in Priority Groups 7 and 8," Congressional Budget Office, November 13, 2013; http://www.cbo.gov/budget-options/2013/44902.

1035 Altschuler, Justin, David Margolius, Thomas Bodenheimer, and Kevin Grumach. (2012) "Estimating a Reasonable Patient Panel Size for Primary Care Physicians With Team-Based Task Delegation," Annals of Family Medicine, 10(5):396-400.

1036 Altschuler, Justin, David Margolius, Thomas Bodenheimer, and Kevin Grumach. (2012) "Estimating a Reasonable Patient Panel Size for Primary Care Physicians With Team-Based Task Delegation," Annals of Family Medicine, 10(5):396-400.

1037 "Veterans Health Administration: Audit of Physician Staffing Levels for Specialty Care Services," VA Office of Inspector General, December 27, 2012, Report No. 11-01827-36.

1038 "Veterans Health Administration: Audit of Physician Staffing Levels for Specialty Care Services," VA Office of Inspector General, December 27, 2012, Report No. 11-01827-36.

1039 "Veterans Health Administration: Audit of Physician Staffing Levels for Specialty Care Services," VA Office of Inspector General, December 27, 2012, Report No. 11-01827-36.

1040 "VA HEALTH CARE: Further Action Needed to Address Weaknesses in Management and Oversight of Non-VA Medical Care," Government Accountability Office, June 18, 2014; http://www.gao.gov/products/GAO-14-696T?source=twitter.

1041 Eric Lichtblau, "V.A. Punished Critics on Staff, Doctors Assert," New York Times, June 15, 2014; http://www.nytimes.com/2014/06/16/us/va-punished-critics-on-staff-doctors-assert.html?_r=0.

1042 "VA Health Care: Improved Oversight and Compliance Needed for Physician Credentialing and Privileging Processes," Government Accountability Office, GAO-10-26, January 2010; http://gao.gov/products/GAO-10-26.

1043 "VA Health Care: Improved Oversight and Compliance Needed for Physician Credentialing and Privileging Processes," Government Accountability Office, GAO-10-26, January 2010; http://gao.gov/products/GAO-10-26.

1044 "VA Health Care: Improved Oversight and Compliance Needed for Physician Credentialing and Privileging Processes," Government Accountability Office, GAO-10-26, January 2010; http://gao.gov/products/GAO-10-26.

1045 "VA Health Care: Improved Oversight and Compliance Needed for Physician Credentialing and Privileging Processes," Government Accountability Office, GAO-10-26, January 2010; http://gao.gov/products/GAO-10-26.

1046 "U.S. Senate Roll Call Votes 113th Congress - 2nd Session. On Passage of the Bill (H.R. 3230, As Amended)" United States Senate, accessed June 23, 2014; http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=113&session=2&vote=00187

1047 Alicia Parlapiano and Karen Yourish, "Major Reports and Testimony on V.A. Patient Wait Times," The New York Times, May 30, 2014; http://www.nytimes.com/interactive/2014/05/29/us/reports-on-va-patient-wait-periods.html?_r=0.