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Growing evidence points to systemic troubles in VA healthcare system

Navy veteran Edward Laird waited two years trying to get an appointment at the VA hospital in Phoenix after a biopsy was ordered for two blemishes on his nose. They turned out to be cancerous, and half his nose had to be cut away. (Courtesy of Edward Laird)

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Reporting From New River, Ariz. —

Three years ago Edward Laird, a 76-year-old Navy veteran, noticed two small blemishes on his nose. His doctor at the Veterans Affairs hospital in Phoenix ordered a biopsy, but month after month, as the blemishes grew larger, Laird couldn't get an appointment.

Laird filed a formal complaint and, nearly two years after the biopsy was ordered, got to see a specialist — who determined that no biopsy was needed. Incredulous, Laird successfully appealed to the head of the VA in Phoenix. But by then, it was too late. The blemishes were cancerous. Half his nose had to be cut away.

“Now I have no nose and I have to put an ice cream stick up my nose at night ... so I can breathe,” Laird said. “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.”

The Phoenix VA Health Care System is under a federal Justice Department investigation for reports that it maintained a secret waiting list to conceal the extent of its patient delays, in part because of complaints such as Laird’s. But there are now clear signs that veterans’ health centers across the U.S. are juggling appointments and sometimes manipulating wait lists to disguise long delays for primary and follow-up appointments, according to federal reports, congressional investigators and interviews with VA employees and patients.

The growing evidence suggests a VA system with overworked physicians, high turnover and schedulers who are often hiding the extent to which patients are forced to wait for medical care.

The 1,700 hospitals and clinics in the VA system — the nation’s largest integrated healthcare network — now handle 80 million outpatient visits a year. Veterans Affairs Secretary Eric K. Shinseki promised to solve growing problems with patient access when he took over in 2009, and he has been successful in some respects: Iraq and Afghanistan veterans are using VA healthcare at rates never seen in past generations of veterans, and a growing number of Vietnam veterans are receiving VA care as they age.

The agency reports it also made substantial progress in reducing wait periods last year, 93% of the time meeting its goal of scheduling outpatient appointments within 14 days of the “desired date.”

But several VA employees have said the agency has been manipulating the data.

“The performance data the VA puts out is garbage — it’s designed to make the VA look good on paper. It’s their ‘everything is awesome’ approach,” said Dr. Jose Mathews, chief of psychiatry at the VA St. Louis Health Care System. “There’s a ‘don’t ask, don’t tell’ policy. Those who ask tough questions are punished, and the others know not to tell.”

Mathews was put under administrative investigation in September after he alleged that long wait times led to poor patient care and what he said were two preventable deaths. He said a suicide attempt by a veteran at the facility was covered up by the hospital after a VA psychiatrist failed to provide follow-up treatment.

Several VA schedulers have told investigators that agency staffers were "gaming the system" by making it appear that appointments set for weeks or months in the future were "desired dates" requested by veterans. In fact, they said, veterans grudgingly accepted future appointments because they felt they had no other choice.

"We found people that were told to change the [appointment] dates to make it look like it was in line with VA guidelines," said Debra Draper, who was part of a team from the Government Accountability Office that interviewed 19 appointment schedulers at four VA medical centers in 2012. The team found that more than half of them failed to correctly record the appointment date patients originally requested.

VA officials say that manipulation of wait lists has occurred only in isolated cases and that the majority of patients get timely access to quality care. VA hospitals since 2004 have consistently ranked higher in customer satisfaction surveys than their counterparts in the private sector, they note, with more than 90% of patients offering positive assessments of their care.

"As we know from the veteran community, most veterans are satisfied with the quality of their VA care, but we must do more to improve timely access to that care," Shinseki said Friday as he announced the resignation of the VA's undersecretary for health, Dr. Robert Petzel, a departure that had been in the works before the recent revelations.

But veterans and current and former agency employees interviewed last week described a dysfunctional bureaucracy in which turnover is high, the number of doctors is insufficient, and patients may be left dangling even when facing life-threatening health problems.

"The evidence is there. They're never going to be able to hide it," said Brian Turner, a military veteran who has worked as a scheduling clerk in VA facilities in Austin and San Antonio.

In Washington state, Navy veteran Walter "Burgie" Burkhartsmeier, 73, had to wait two months to get an MRI exam at a VA facility in Seattle for shooting pains down his left arm.

Eighteen months passed before someone read the MRI results — which showed bony projections on his spinal cord that put him at risk of paralysis if he were struck in the back.

In Texas, Carolyn Richardson, 70, said a VA doctor last year ordered “immediate” chemotherapy for her husband, Army veteran Anson “Dale” Richardson, 66, but a two-month delay robbed him of the chance to fight the throat cancer that killed him Nov. 4.

In Phoenix, Thomas Breen, 71, a Navy veteran with a history of bladder cancer, waited two months last fall for a follow-up appointment at the VA facility there after discovering blood in his urine. His family finally took him to a private hospital that diagnosed him with terminal bladder cancer. He died Nov. 30.

Six days later, a clerk from the VA in Phoenix called Breen’s daughter-in-law, Sally Barnes-Breen, to schedule an appointment.

“No. You are too late, sweetheart,” Barnes-Breen said she told the clerk. “He’s dead.”

In Nevada, Sandi Niccum, 78, a blind Navy veteran, was forced to wait five hours for emergency room treatment at a VA facility in North Las Vegas last year. Niccum, who was weeping and pounding the floor with her cane because of intense pain in her abdomen, died less than a month later after a large mass was found. A VA investigation did not link the care delay to her death, but faulted the facility for the long wait and for failing to monitor Niccum.

And in Durham, N.C., two employees were put on administrative leave last week after an internal review uncovered irregularities in appointments, a local VA spokeswoman said.

Some VA employees have said they faced reprisals after they resisted instructions to manipulate appointment books.

Lisa Lee, a medical support assistant at the VA facility in Fort Collins, Colo., said she was transferred and later put on two-week administrative leave when she objected to supervisors’ instructions to manipulate appointment times. She said supervisors did not link her transfer and leave to the appointments issue; she was told instead that her performance had delayed patient care.

“They wanted me to cook the books, and I didn’t do it,” Lee said in a telephone interview from Hawaii, where she now serves with the U.S. Navy. “You’re supposed to do your work and shut up.”

After Lee was transferred, a VA supervisor in June wrote an email to the Fort Collins staff instructing them to manipulate veterans’ appointment requests in order to meet the 14-day directive. In the email, provided by Lee, the official, David Newman, wrote: “Yes, it’s gaming the system a bit. But you have to know the rules of the game you are playing, and when we exceed the 14-day measure, the front office gets very upset, which doesn’t help us.”

In Phoenix, Dr. Katherine Mitchell said she could no longer keep quiet after she got a call from a fellow employee at the VA hospital there on April 27, telling her that patient appointment documents might be in danger of being destroyed that evening.

The call came in the wake of a VA inspector general investigation into the allegations.

Mitchell, who worked in the VA system for 16 years, said she went to the medical center and joined a co-worker in preserving records, including paperwork that she said showed falsified wait times for medical care.

In a six-page letter, Mitchell detailed a series of attempts to voice her concerns about deficiencies at the Phoenix VA through the proper channels. Instead, she was eventually banned from submitting cases to the risk manager at the VA in Phoenix and put on administrative leave last September.

“There has been no significant change in the dysfunctional institutional culture of the Phoenix VA,” Mitchell said in a statement last week. “Employees today still risk backlash for bringing up patient care issues, identifying misuse of facility resources and questioning violations of human resource policy.”

Phoenix has been at the center of the controversy in the wake of reports over the last several weeks from VA employees and veterans there that as many as 40 patients had died while waiting for medical care. The VA’s acting inspector general, Richard J. Griffin, told a congressional committee Thursday that a preliminary review of 17 patient deaths had not shown they were caused by treatment delays.

“It’s one thing to be on a waiting list. It’s another thing to conclude that as a result … that was the cause of death,” Griffin said.

Teams from the VA inspector general’s office began visiting VA facilities nationwide last week to look into appointment scheduling practices and other issues. Griffin said federal prosecutors were investigating possible criminal charges at the Phoenix VA.

Officials at several VA facilities said they were committed to rooting out any improper appointment scheduling procedures and to improving patient care.

In a news conference Wednesday, Cynthia McCormack, director of the VA Medical Center in Cheyenne, Wyo. — which has responsibility for the nearby Fort Collins facility — said she and other managers “misunderstood” VA scheduling policies and had improperly administered them.

“We are now correcting our misunderstanding of how to schedule our veterans,” McCormack said. She added that all VA employees under her supervision — as well as herself — had been “retrained on the VA scheduling directive.”

Paradoxically, independent customer satisfaction surveys have consistently shown that VA patients are as satisfied with their care as patients in private hospitals.

Noble Wilcox, a Vietnam veteran from California, praised the health system for the care he had received the last two decades. He said he had no trouble seeing his primary care doctor at the VA clinic in San Luis Obispo.

“I just call and I get in in a week,” Wilcox said.

Ilya Kurbanov, 28, who injured his back in a 2008 bomb blast in Iraq, said he usually has to wait six to eight weeks to see a primary care physician.

“But don’t get me wrong,” he said. “VA is saving my life.”

The VA’s internal documents show that the troubled agency has known since at least 2008 that employees manipulate the scheduling system to mask delays in care — what a 2010 memo called “gaming strategies.” That memo, written by a VA deputy undersecretary,

listed more than a dozen “inappropriate scheduling practices” at medical facilities dating to 2008.

Two years later, in 2012, a Government Accountability Office report concluded that the VA’s reporting on its medical appointment wait times was “unreliable,” outdated, easily manipulated and in need of complete overhaul.

“The bottom line,” said Draper, who was part of the GAO review team, “is that no one really knows how long veterans are waiting to receive care.”

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