America's Veterans Administration - The Good, The Bad, The Ugly, The Fix

Part Three – The Ugly

This is part three of four studies on the Veterans Administration (VA) and if you missed one please go to www.chronicleonline.com, or my website www.veteranspage.com. The first report addressed some good aspects of the VA, the second some bad problems in VA and in this portion I will cover some really ugly areas of VA's support of America's veterans. Newly appointed Secretary David Shulkin has some very difficult challenges in improving his department. That said, let's take a look at some of those ugly areas.

Bureaucracy in the VA has been a nightmare for decades, creating an unbelievable number of rules and regulations thereby creating thousands of forms and publications that overwhelm administrative and medical personal. I remember discussing it with a VA physician who was totally dismayed by the reduced number of patients he could treat in his new VA position because of the endless regulations, mounds of paperwork and computer input time needed to treat a patient. I note there are 536 different downloadable forms on the VA website. In FY2016 there were 42 new VA regulations published in the Federal Register, another 45 in FY2015, another 44 in FY2014, and another 44 in FY2013. That is 175 new regulations in just four years and the list goes on and on through history. Imagine trying to deal with it as a physician, nurse, administrator, or office worker.

At least Secretary Shulkin is trying to address this fiasco by ordering an existing hiring freeze in the VA central office be maintained because he believes it is too large and unwieldy. He also intends to consolidate 140 offices and has ordered his staff to begin reducing the number of regulations and requirements being levied down through the VA system. We'll see if he is successful, or not, in the very near future.

The biggest ugly issue, as far as I am concerned, is the failure of many medical centers to properly treat our veterans.

Shulkin said there were 14 VA medical centers that provide lower quality care than nearby private sector hospitals. He said all received one star out of five in the VA's internal rating system which the VA released publicly for the first time in December after USA TODAY obtained and published the internal ratings. Other facilities with a one-star ranking include VA hospitals in Detroit, Phoenix, Biloxi, Dublin, Fayetteville, White City, and Fort Harrison. There are definitely many more if you read recent headlines. According to an Office of Inspector General (OIG) report, right in the Secretary's backyard of Washington, the VA hospital staff has had to borrow equipment from private hospitals, plunder supplies and use their own purchase cards to buy essential equipment. The OIG report says sterile equipment was stored in hot, dusty closets and tens of thousands of dollars of supplies were stockpiled without any inventory. Personally, I seriously doubt they were sterile after investigators found some stained surgical equipment. It got worse. A veteran who attended an appointment was thought to depart after it, was reported missing when not returning home and found two days later in a car in the

hospital parking lot. He died. His sister found him after searching and receiving failed multiple responses for two days from the VA hospital to help find him.

Shulkin said he has dispatched teams to help improve the care at those locations. "Veterans shouldn't have to accept low quality care, and they deserve our very best," he said.

Yes, but if problems occur and reportedly were known for years and ignored even near your Department's own headquarters, how bad is it out here in the field?

A recent National Public Radio (NPR) report highlighted problems in the support of veterans. In one instance NPR told a story about a veteran who checked into VA's West Los Angeles Medical Center last year for an angiogram, expecting a routine 30-minute procedure and a weekend hospital stay. But the 68-year-old Marine Corps vet said, instead, "They ran out of food to feed us." Things we were supposed to eat, they didn't have it, said the veteran, who is diabetic and has heart problems.

"They said they were out of it, out of it, out of it. So they brought us potatoes, like small potatoes. I told the gentleman, 'I can't eat potatoes, I'm a diabetic.' He said, 'Well, that's all you're gonna get.' "

He shared his hospital room with three other veterans and was discharged because of the food shortage. Unfortunately, he had to wait more than a month to get the angiogram rescheduled.

Another medical center, the Pittsburgh VA, had an outbreak of Legionnaires Disease killing six veterans, yet shortly thereafter the VA's Regional Director received a $63,000 bonus for his infection prevention policies. Bonuses to a number of senior managers have occurred throughout the VA for decades despite the fact their management was absolutely horrendous.

Some problems result from nursing shortages. There is a serious one at the Little Rock Central Arkansas Veterans Healthcare System. How do they fix it? One step being taken is to close 19 beds in the medical/surgical units to "protect and enhance patient care". This is almost laughable except we have to think of the ugly impact on our veterans needing medical care.

Waiting to see physicians has been a nightmare for many veterans. It has been reported that investigators found employees at 40 VA medical facilities in 19 states and Puerto Rico regularly "zeroed out" veteran wait times and manipulation had in some instances been going on for as long as a decade. VA admitted there had been 23 veteran deaths because of the scheduling manipulation issue. Senator Tom Coburn recently stated that he believes that number may be at least 1000.

These stories are endless and something must be done. Not next year, not later this year, but now. Veterans are dying from lack of good care, from waiting for good care, or from not receiving care whatsoever. Yes, Secretary Shulkin has his hands full trying to fix the VA but, if not successful, he will have our blood on those full hands.

There is one final study coming soon from me on this subject and it will contain recommendations by some organizations and veterans to improve the VA. And, of course, I'll put my two cents in to those recommendations. See you in the next report.

John Stewart
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