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VA Investigations May Be Headed Toward Prosecutions

The May 28 release of a scathing Veterans Administration Office of Inspector General (OIG) report on dishonest scheduling practices at the VA clinics in the Phoenix, Arizona, area has produced calls for — and reports of — investigations for criminal prosecution of the rogue officials who wrote the fraudulent reports.

"What I've heard today is there is no accountability for any of these," Congressman Tim Huelscamp (R-Kan.) noted of VA officials in a May 29 Committee on Veterans Affairs hearing. "35 reports — ten years later, almost a decade later — we are still here trying to get answers asked in 2005." Senator Richard Blumenthal (D-Conn.) echoed Huelscamp's calls for prosecutions, stating: "The more I learn about the misconduct and impropriety at the VA medical facility, the more concerned I am there's evidence of criminal wrongdoing."

According to Fox News,

> The investigation "includes OIG criminal investigators as well as federal prosecutors from the U.S. Attorney's Office in Arizona and the Public Integrity Section of the Justice Department in Washington, D.C." They are working, he said, to "determine any conduct that we discover that merits criminal prosecution."

The interim VA OIG report concluded that the Phoenix VA system had essentially created a waiting list to get on the official electronic waiting list (EWL) and had used other dishonest scheduling practices to make it appear that waiting times for appointments were much shorter than they really were:

> VA national wait time data, which was reported by Phoenix HCS, showed these 226 veterans waited on average 24 days for their primary appointment and only 43 percent waited more than 14 days. However, our review found these 226 veterans waited on average 115 days for their primary care appointment, and an estimated 84 percent waited more than 14 days. Most of the wait time discrepancies occurred because of delays between the veteran's requested appointment date and the date the appointment was created.

The VA OIG outlined four separate means by which VA appointment schedulers were able to game the system, the most prominent of which was by keeping an off-the-books waiting list to get on to the official electronic waiting list. The dishonest scheduling practices were the result of administrative demands from Washington that local facilities adhere to the official goal of no more than 14 days to wait for primary care, and the OIG report noted that a shorter waiting list "is one of the factors considered

for awards and salary increases" for local VA officials.

Veterans Affairs Secretary Eric Shinseki said of the VA OIG report, "The findings are reprehensible to me, to this Department, and to Veterans." He urged that the VA "aggressively and fully implement the remaining OIG recommendations," which include a national study of wait times and scheduling processes of VA clinics across the country. The OIG report stipulated, "We recommend the VA Secretary initiate a nationwide review of veterans on wait lists to ensure that veterans are seen in an appropriate time, given their clinical condition."

The audit by the OIG noted that the secret waiting list meant that they could not identify for certain that veterans applying for medical care under the VA would ever receive their requested healthcare:

> Our work has substantiated serious conditions at the Phoenix HCS. We identified about 1,400 veterans who did not have a primary care appointment but were appropriately included on the Phoenix HCS' EWLs [electronic waiting lists]. However, we identified an additional 1,700 veterans who were waiting for a primary care appointment but were not on the EWL. Until that happens, the reported wait time for these veterans has not started. Most importantly, these veterans were and continue to be at risk of being forgotten or lost in Phoenix HCS's convoluted scheduling process. As a result, these veterans may never obtain a requested or required clinical appointment.

Interestingly, leftists have praised VA medical care for years as a model for ObamaCare to follow.

Delayed care and potential "gaming" of the waiting list is not a new issue with the VA, as Huelscamp noted, and the VA OIG report acknowledged, "Since 2005, the VA Office of Inspector General (OIG) has issued 18 reports that identified, at both the national and local levels, deficiencies in scheduling resulting in lengthy waiting times and the negative impact on patient care."

The OIG report also found multiple other mismanagement allegations during its investigation, which the OIG pledged to investigate as part of its ongoing audit of the Phoenix facilities: "While conducting our work at the Phoenix HCS our on-site OIG staff and OIG Hotline received numerous allegations daily of mismanagement, inappropriate hiring decisions, sexual harassment, and bullying behavior by mid- and senior-level managers at this facility," which the IG is still evaluating.