

Dysfunction of Veterans Health Administration and Story behind the Scandal 2014

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Abstract

Department of Veterans Health Administration (VHA) in US is one of the largest executive departments in the nation, providing crucial short and long-term medical assistance to veterans and their families. In April 2014, whistleblowers at the U.S. Department of Veterans Affairs Medical Center in Phoenix, Arizona, exposed rampant wrong-doing and cover-ups heated debates regarding the reasons why veterans are alleged to have died for long time waiting, inappropriate scheduling practices, false record keeping, budget mismanagement, lack of accountability, information gap and secret waiting list. At this point, veterans not only in Phoenix's but also all over the country have been affected by the aforementioned problems. The purpose of this study is to present a systematic review of the available evidence-based news, documents and literature concerning the VHA's scandal of 2014 and to discover the behind causes. It is hoped that this study will inform the reader about how a service providing system faces dysfunction and how performance can be improve. Although this research focuses on a particular event, it constructs a generalized framework for addressing such issues in future. It will set examples for other countries to take proactive as well as preventive measures in response to these events. This model may also be tested in real time environments in small scale in different countries before applying in a large scale.

Key words: The Veteran Health Administration, Performance Dysfunction, The VA scandal 2014.

Introduction: The Veterans Health Administration (VHA) is a part of the United States Department of Veterans Affairs (VA) led by the Secretary of Veterans Affairs for Health. Additionally, the veteran health care system is the largest health provider in the nation (Hicks, J. 2014). It is said that, USA has fought for its veterans as long as they have fought for USA. VHA's missions are to fulfill President Lincoln's promise, 'To care for him who shall have borne the battle, and for his widow, and his orphan' by serving and honoring the men and women who are America's veterans. The department will continue to honor, care for, and compensate veterans in recognition of their sacrifices for USA.

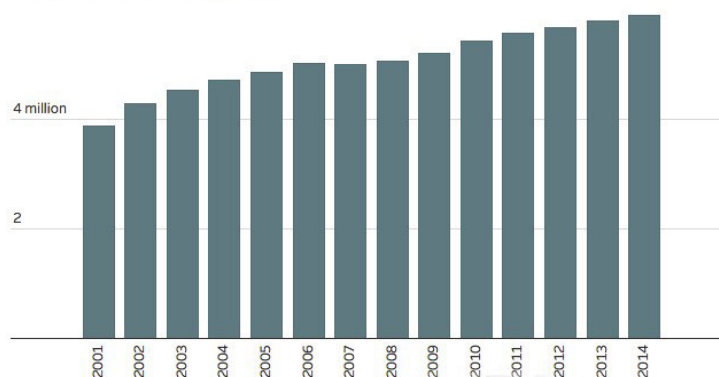
This paper examines: 1) Veteran health care system, history and function 2) the historical, organizational, and political factors that led to the scheduling scandal 2014, 3) how scandal was disseminated throughout the country and consequently handled, and 4) Underlying causes, what types of measurements taken at that time and suggest recommendations for future. More discussions will be needed based on the reasons I found behind the incident. From that, efficient strategies can be developed to fight with these incidents beforehand. Subsequently, the developed approaches can be employed wherever there is any dysfunction in other government agencies whatsoever in future.

Information was gathered, records and data from a variety of sources such as VA website, 2014-15's newspaper, individual research and group research like The Federal Bureau of Investigation (FBI), VA internal groups' existing records and data were reviewed to get complete and accurate picture on VA scandal of 2014.

Veteran Health Care System in USA:

VHA's Services are -primary health care, specialty and inpatient care, preventive health care, pharmacy benefits, emergency care, diagnosis and treatment for mental health and substance abuse (US department of Veterans Affairs' website). The Veteran Health Care Administration is America's largest integrated health care system. There are more than 1700 sites of care, serving on average of 8.76 million each year. ((US department of Veterans Affairs' website). There were approximately 80,000 veterans at the beginning of the civil war. This number increased by more than 1.9 million (confederate soldiers were excluded from veteran services) by the end of the conflict. Veteran benefits were expanded to include services for veteran families in 1862. After World War I, the veteran population expanded by 204,000 and after World War II it raised to one and half times that of World War I. So, the government extended veteran care to include disability compensation, insurance, and vocational rehabilitation. In the 1920s veteran benefits were managed by three separate Federal agencies: the National Home for Disabled Volunteer Soldiers, the Bureau of Pensions of the Interior Department, and the Veterans Bureau.

Number of veterans who use VA health care each year

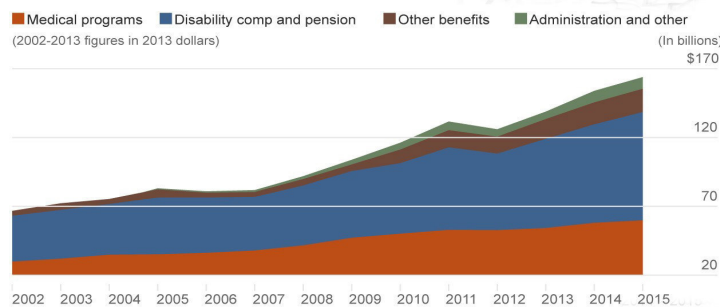


Source: Congressional Research Service

In 1930, President Herbert Hoover created the Veterans Administration (VA), which consolidated those agencies into one entity. VA provides services at approximately 1,300 capacities: which includes hospitals, ambulatory care and community-based outpatient clinics, Veteran Centers, nursing homes and residential rehabilitation treatment programs. Together these health care facilities and the more than 53,000 independent licensed health care practitioners who work within them provide comprehensive care to more than 10 million veterans every year. VHA treated more than 530,000 veterans for Post-Traumatic Stress Disorder in 2011 (more or less every year). From 2002 to 2015, there was an increasing trend in veteran affairs budget, which is obvious in the top right figure in this page.

VHA is focused on improving the health grade of Native American Veterans also. The VA boasts that it “operates the nation’s largest integrated health care system, with a lot of hospitals, clinics, community living centers, emergency counseling centers and other facilities.” (Wikipedia and VHA website).

VA budget: 2002-2015



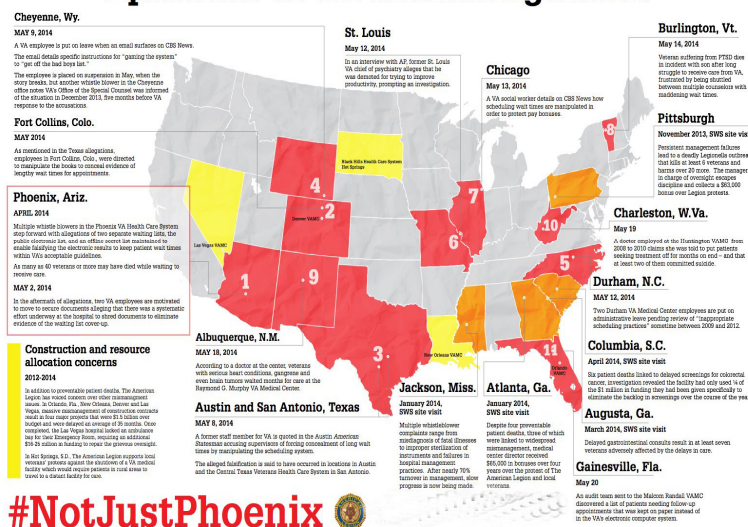
Source: U.S. Department of Veterans Affairs

Veteran Health Administration Scandal 2014: Since few years, corrupt leaders, layers of confusing bureaucracy, lack of accountability, and poor standards of care set the stage for the VA scandal (2015 Case Study Competition by Arthur W. Page Society). The spring of 2014 brought showers of media attention to secret wait lists containing thousands of veterans who had been waiting months for appointments. At the same time there were major problems with scheduling timely access to medical care in at least 60 US armed forces veterans died waiting for care in Phoenix city, Arizona Veterans Health Administration facilities. An FBI investigation revealed delays in treatment, mismanagement, and bureaucratic problem in scheduling throughout the Veterans Health Administration system. A large number of veterans returning from Iraq and Afghanistan war and veterans, who attended Vietnam War at their young age, were the main victims of VHA 2014’s scandal. All prominent national and international newspapers published this groundbreaking news. The veteran Health care mismanagement occurred not only in phoenix, Arizona VHA facilities, but also in Austin, Ft. Collins, and Cheyenne VHA system (CNN, April 30, 2014).

The scandal takes on added significance because the VA has been cited in the debate over health care. In Phoenix alone, some 1,400 to 2000 sick veterans were forced to wait months to see a doctor (CNN, 2014). More than 40 died while waiting for care, and dozens suffered from “clinically significant delays” or “troubling lapses” in the quality of care, according to a report by the VA’s Office of the Inspector General (USA Today, 2014). On September 18, the Washington Times reported that “The VA’s internal auditor admitted that it didn’t

review the cases of 5,600 veterans who were on waiting lists for appointments, so it's possible some of them could have died as the result of the botched care." There were similar efforts to hide wait-times in Austin, Cheyenne, San Antonio, and Pittsburgh; most officials allegedly attempted to cover up deaths. An oversight report from Tom Coburn said that- 'Many veterans who bravely fought for our freedom are losing their lives, not at the hands of terrorists, fatal accidents or enemy combatants, but from friendly fire in the form of medical malpractice and disregard by the Department of Veterans Affairs (VA)'. The FBI says it has opened a criminal investigation of the Veterans Affairs Department, which is grappling with a scandal over long waiting lists to provide care and allegations that paperwork was faked to make delays appear shorter.

Epidemic of VA Mismanagement



#NotJustPhoenix

(Source: VA website, CNN, USA Today, LA Times, Washington Post, 2004 issues)
An internal Veterans Affairs audit released May, 2014 found that tens of thousands of newly returning veterans wait for more than 90 days for medical care, while even more who signed up in the VA system over the past 10 years never got an immediate appointment they requested.

Literature Review: Performance management (PM) includes activities, which ensure that the goals are consistently being met in an effective and efficient manner. Performance management can focus on the performance of an organization, a department, employee, or even the processes to build a product or service, as well as many other areas. By providing trend and a standard against which progress can be monitored, challenging goals can enable people to guide and refine their performance (Locke & Latham, 2002). Performance measurement endorses a process perspective where the focus is on the internal process of quantifying the effectiveness and the efficiency of action with a set of metrics (Neely, Gregory and Platts 1995). However, scholarly writing on performance measurement in government has long featured worry about dysfunctional reactions – in fact, it has frequently focused on dysfunctional responses as much as with functional. These worries evoke the spirit, and often the works, of Merton's (1936) idea of the "unintended consequences of purposive social action", Grizzle's (2000) "performance measurement with dysfunction" and Radin's (2006) Challenging the Performance Movement begins with a discussion, significant documents in these cases. One paper (Smith, 1995) is in fact straightforwardly titled "On the Unintended Consequences of Publishing Performance Data in the Public Sector" that focused performance dysfunction in public sector. Organizational effectiveness mainly reflects a construct perspective in which the focus is on the definition of the concept in terms of assessment, evaluation and conceptualization (Goodman, Pennings 1977). The explanation of effectiveness variation and the search for its true causal structure represent one of the most enduring themes in the study of organizations (March and Sutton 1997). On the other hand, Chakravarthy (1986) identifies different conceptions of effectiveness including profitability, financial-market, multi-stakeholder satisfaction, and quality of firms' transformations. Through such motivational processes, challenging goals often lead to valuable rewards such as acknowledgement, promotions, and/or increases in income from one's work (Latham & Locke, 2006). A performance problem is any gap between Desired Results and Actual Results. Performance improvement is any effort targeted at closing the gap between Actual Results and Desired Results. Performance Management is the process of directing, monitoring and controlling employees and work units in an organization and motivating them to perform at highest levels. (Josey Bass. 2003). Performance management has been defined as management's systematic application of processes aimed at optimizing performance in an organization (Warren, 1982). According to Dixit, (2002), the one distinguishing feature of the public sector is the presence of multiple

principles which influences the optimal performance measurement and incentive structure. Moreover, as a service provider, the public sector will be faced with the difficulties of quantifying their main performance measures such as customer satisfaction, and quality of service (Jackson, 1990); which also mainly rely on human resources who being calculative receptors have discretion over their effort and hence need consistent monitoring and directing near the organization's goals (Neely, 1995). Traditionally, performance management is viewed to be the responsibility of instant supervisor (Cardy and Dobbins, 1994). Finally, many of the modern employees now expect to be more involved in determining the performance management that affects them (Mohrman et al., 1989). A well-functioning performance management process should facilitate good management by good managers and reliable persons who are trained as coaches and mentors rather than as evaluators and graders (David, Nathan & Akio Tsuchida, and February 27, 2015). Armstrong (2008) pointed out that, the application of performance management is to improve the organization members' performance by developing the capability of the team and its members through a strategic and integrated system that can encourage organizations to operate and serve successfully. The real efficient government must be democratic and efficient and therefore it must satisfy the demands from people, applying knowledge, honesty, integrity and economy to apprehend the will of the people (Waldo, 1984:131; Lin, 2003:59). Evidence on unintended responses and dysfunctional behaviors is also apparent in the health sector. Goddard et al., (2000), found evidence of gaming concerning efficiency, where respondents were reluctant to produce improvement in costs for fear that the following year's efficiency targets would be set at a higher level. He also noted that "financial regime in which Trusts operate encouraged Trusts to fail to meet their financial target as these were often "bailed out" by the region" (p.105). Similar to the reasons of gaming in the health sector, distortion of data can sometimes be negative; extending waiting times because again there is inclination to provide additional funds to Trusts who fail to meet their objectives (Goddard et al., 2000). In this respect, selecting performance measures that optimally trade off the desire of controllability with the essential of goal alignment are argued to be crucial for the success of PRP (Baker, 2002). Goddard et al., (2002), showed that linking performance measurement to rewards may result in dysfunctional behaviors, including gaming, tunnel vision, misrepresentation, disregarding tasks, and short-termism. Moreover, the level of subjectivity found in the process of measuring performance has proved to have a negative impact on employees' behavior and cause demoralization when it comes to linking pay to performance (Marsden and French, 2011)

Findings and details behind causes of VA scandal: This scandal was published in 2014 and created heated debate nationally. An internal VA audit released on June 9, 2014 found that more than 120,000 veterans were left waiting or never got care and that schedulers were pressured to use unofficial lists or engage in inappropriate practices to make waiting times appear more satisfactory. After that a lot of audits, investigations and findings were conducted by FBI, Internal VA, Obama administration, congressional body, individual researchers and Office of Special council. They revealed some causes-

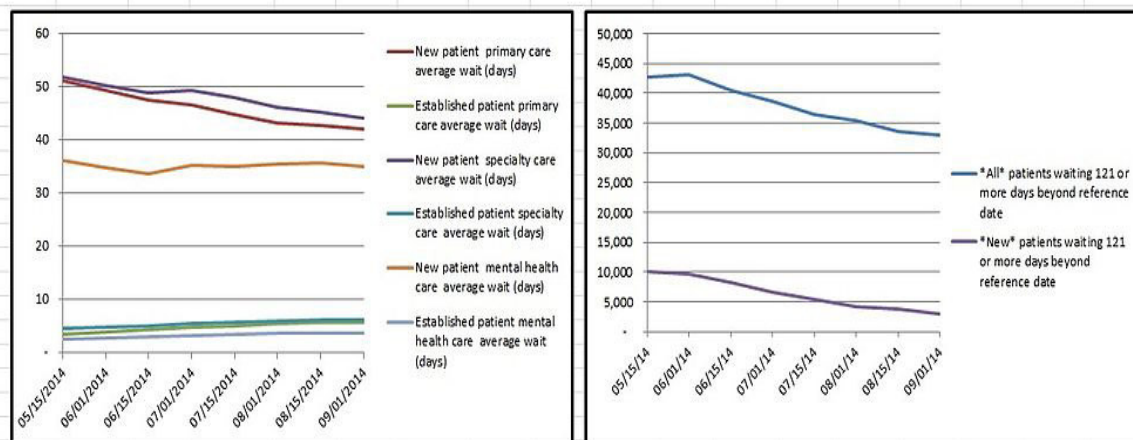
a) Delayed care and patient wait time: An internal Veterans Affairs audit released after scandal (CNN, 2014) said that, more than ten thousands of newly returning veterans had to wait at least 90 days for medical care, while even more who signed up in the VA system over the past 10 years never got a direct appointment. Edward Lilley, a senior field service representative at the American Legion, said that, existing patients are supposed to see a doctor between 14 and 30 days after requesting an appointment. The figures in the audit showed that 57,436 newly enrolled veterans faced a minimum 90-day wait for medical care; 63,869 veterans who enrolled over the past decade requesting an appointment that never happened. VA said that, more than 57,000 patients were waiting for their first visit. They waited at least 90 days for their first appointment for medical care (Washington Post, June 29, 2014). For almost a decade, Office of Inspector General (OIG) and Government Accountability Office (GAO) identified that VHA managers needed to improve efforts for collecting, trending, sorting and analyzing clinical data. The following provides selected highlights in a chronological summary of OIG oversight addressing wait times, scheduling practices, data integrity concerns, and the lack of physician, nurse and staff standards. In some places, veterans have died while waiting for care, also there are an enormous known link between the deaths and delayed care. From performance management theory, we found that delayed care deteriorated the overall veteran care system gradually and the final consequence is this unfortunate scandal.

Patient Wait Time Data Analysis: Counting by Average wait (days)

Date	New patient primary care	Established patient primary care	New patient Specialty care	Established patient primary care	New patient mental health care	Established patient mental health care
05/15/2014	51 days	3.56 days	52 days	4.62 days	36 days	2.57 days
06/01/2014	50	3.89	50	4.85	35	2.72
06/15/2014	48	4.38	49	5.18	34	3.03
07/01/2014	47	4.82	49	5.46	35	3.27
07/15/2014	45	5.13	48	5.70	35.5	3.46
08/01/2014	43	5.48	46	5.89	35.7	3.60
08/15/2014	43	5.77	45	6.15	36	3.70
09/01/2014	42	5.83	44	6.26	35.4	3.74

Patient waiting more than 121 days beyond reference date:

Date	Patient (All) waiting 121 or more days beyond reference date	Patient (New) waiting 121 or more days beyond reference date
15 th may, 2014	42,670	9,988
1 st June, 2014	43,115	9,586
15 th June, 2014	40,545	8,126
1 st July, 2014	38,683	6,573
15 th July, 2014	36,452	5,466
1 st August, 2014	35,317	4,141
15 th August, 2014	33,539	3,783
1 st September, 2014	32,991	3,040



- b) **Fraudulent Scheduling Practices:** Since November 2013, CNN has been reporting on how veterans wait extreme periods for VA health care, causing veteran to die in the process. Scheduling practice is the one of main causes. Robert Petzel, the VA's top official for health affairs testified that health clinics have been using inappropriate scheduling procedures since 2010. As a result of the ongoing VA health care scandal, VA recently conducted a system-wide audit of its scheduling systems and wait times, revealing that almost 120,000 veterans were either waiting longer than 90 days to receive care or had never received a requested appointment at all. Some veterans among the remaining 67,000 waiting for care had enrolled with VA nearly a decade ago, but VA failed to communicate with them for an initial primary care appointment. The VA Inspector General also recently released its findings on appointment wait times in Phoenix, outlining specific problems that led to at least 45 "unacceptable and troubling lapses in follow-up, quality, quantity, coordination and continuity of care." The Inspector General and Controller also determined that veterans seeking to establish care and veterans temporarily relocating to Phoenix faced significant problems accessing care. The report went on to acknowledge that improper scheduling practices were not isolated to Phoenix, but rather rampant across VA, with the Inspector General substantiating many of the 650 allegations lodged at more than 93 facilities. The Inspector General made 24 specific recommendations in the report, which focus on accountability, reporting, training, care coordination, business ethics, quality regulator and customer service, many of these focuses on fraudulent schedule practices. The casual observer may wonder how 67,000 veterans could slip through the cracks in appointment scheduling, or how more than dozens of VA facilities could all easily game the scheduling system with near impunity. However, VA's antiquated appointment-scheduling system coupled with lax oversight among VA's top leadership made it quite easy. For years VA has worried publicly that its 26-year-old scheduling software was woefully inadequate. Built and implemented in the 1980s, VA's appointment-scheduling software, appointment sorting system have not changed much fundamentally although veterans increased two times, working load increased more than four times. From Merton's (1936) idea of the "unintended consequences of purposive social action", Blau's (2011) 'dysfunctional consequences' and Grizzle's (2000) 'performance measurement with dysfunction' we found evidence and dysfunctional responses in VA system since 2010. Most of VA's documents showed dysfunction effect in the delayed care, wait time target and scheduling practices.
- c) **False Record Keeping:** USA Today reported on July, 2014 that, the VA's Office of Medical Inspector found that clerks at a clinic in Fort Collins were instructed on how to falsify records so it appeared that doctors were seeing 14 patients a day, a number within the agency's goal to help reduce the appointment backlog. But VA

hospital officials in Phoenix chose not to report the long wait times to the federal government, so as not to jeopardize the pay bonuses that the hospitals received for keeping wait times short -- i.e., within 14 days of a requested date for an appointment. Instead, hospital administrators sent false documents that dramatically understated the length of time it generally took for VA patients in Phoenix to see a doctor. Claims of false record-keeping and long wait lists have been made for VA facilities across the country following the 2014 scandals, which involved manipulated patient wait-time data. An independent report by the VA Inspector General found falsified records on appointment wait times at the Phoenix medical center. Included in the findings was a more-than three-month discrepancies between reported and actual wait times, and 1,700 veterans absent from wait lists after they had made initial appointments. False record keepings and exposition of those misinformation are very much detrimental for measuring true performance.

- d) **Budget Mismanagement:** Budget management is a major issue for any government organization to perform properly. If budget is not planned and spent well, no organization can run smoothly ultimately leading to a fall in performance. Corruption is the major concern why budget is not managed well. Corruption in the health sector is a major concern. There are two types of corruption found here: one in which there is a gain of direct monetary form and another is non-monetary which involves some unethical behavior that doesn't directly related to financial gain but some kind of other benefit. There are some reports found on budget mismanagement and budget cut. A number of corrupt activities which are identified in the health sector are illegal fees, bribes for unethical procedures, absenteeism, selling of license to unauthorized person, unnecessary medical treatment, deception in billing, abuse of powers, corruption in pharmaceutical supplies etc. Coburn, an Oklahoma Republican and physician, says that if the VA's budget had been properly handled and the right management had been in place, many of these deaths could have been avoided and minimized. The audit detailed with 10 basic point findings, including weaknesses in budget and financial-management processes, administrative and management salary increases that outpaced those of other district employees, excessive and unnecessary travel, misuse of a trust fund, and conflicts of interest.
- e) **Lack of Accountability:** Accountability is essential for every government and non-government sector, it is the heart of health care sector, where one individual/ group justifies and proceeds responsibility for their activities, results. In health sector, the essence of accountability is answerability; being accountable means having the obligation to answer questions regarding decisions and/or actions. Improved accountability in health sector is means for as an element in developing health system performance. Accountability to serve effectively as an organizing principle for health systems reform, analytical and conceptual clarity are required. When practice of accountability exists, people do what they say they'll do. Everyone builds credibility for himself/herself and for the organization by holding themselves and each other accountable. A several audits found that, a large number of VA's hospitals employees don't practice accountability for their own work. A top House Republican is condemning the VA of a "widespread lack of accountability" and secrecy as the embattled agency faces more scrutiny by lawmakers over shoddy services for veterans and mistreatment of employees. When Congress responded to the scandal last summer by passing a sweeping reform bill, the VA Access, Choice and Accountability Act, it was promised that VA officials would be held accountable for the serial failures, cultural and ethical lapses.
- f) **Poor management, collection and system:** A newly released report finds that Veterans Affairs management is not prepared to supply effective day-to-day management and is marked by an inherent lack of responsiveness. The report describes a "corrosive culture marked by poor management and distrust between some VA employees, staffs and management." Wyatt Andrews reports. Poor management is costing the department billions of dollars more and compromising veterans' access to medical care, said Coburn. VA experienced an increase of 46% in outpatient visits from 63 million in 2007 to 92 million in 2013. Also, inpatients treated increased 11% from over 811,000 to nearly 902,000. There are fundamental problems at the Veterans Health Administration of staffing being inadequate for aging [Vietnam veterans](#) and for more recent veterans from Iraq and Afghanistan who may have complex health challenges such as traumatic brain injury, chemical exposure, urological injuries and infectious diseases. 32% of veterans live in village. The rural health care system is not as good as city. The current scandal plaguing the Veterans Affairs Department was caused in part by federal IT projects mismanagement, according to lawmakers.
- g) **Information Gap and Secret Waiting List:** A CNN investigation recently uncovered an additional scheme at Phoenix, Wyoming and Port Collins VA hospital, where records of dead veterans were changed to hide how many died, how many didn't get service while waiting for care. Veterans in Phoenix waited an average 115 days for appointments — five times longer than the Phoenix VA had reported, Griffin said. CNN's reporting before Griffin published that, managers in Phoenix and elsewhere used secret waiting lists and information gap to cover up the amount of time it took for veterans to get appointments.
- h) **Leadership:** In 2009 VA Secretary Eric Shinseki, a Vietnam veteran and the first Asian four-star general, was appointed to lead a major overhaul of the VA. Before VA Secretary he was chief of staff of the US army (Wall Street Journal, 2015). People criticized that success in one sector doesn't mean imply success in another sector.

In Shinseki case, even highly success in the military sector, he failed when given in charge of the health sector. On May 30, 2014, Shinseki apologized and accepted responsibility for the scandal and resigned from office amid the fallout from the controversy (Chicago Chronicle, May 31, 2014) that lacks responsiveness generally has plagued Leadership Problem- the Veterans Affairs health system and the ability to effectively run things and communicate to employees or veterans said a report submitted to President Barack Obama on May, 2014. Lack of the necessary leadership skills, did not select appropriate candidates for other important positions the VA system inappropriately performed since decade. Leadership and management have defined four functions: planning, organizing, motivating and controlling (Med Jones, 2005). In VA system since 2010, these four functions didn't operate properly. In addition, growing discontent with facility leadership was causing high nursing staff turnover rates, and facility leadership had not addressed clinicians' concerns regarding the resulting impact on patient care, personnel retention, staff morale, health policy and the medical education mission. "VA's leadership has either failed to connect the dots or failed to address this ongoing crisis, which has resulted in patient harm and patient death," Burr said. Shinseki's appearance comes shortly after the White House appointed Deputy Chief of Staff Rob Nabors to oversee the activities at the VA. **Initially, there was no VA response. Secretary Shinseki gave very few interviews about the topic of VA scheduling issues. One interview, he did not address alleged veteran deaths, was with PBS "News Hour" and took place in March 2014, a month before the scandal erupted.** He should have apologized well before now. **Media criticized Shinseki. People said that-** he did not lead our troops; the troops were leading him into a lost battle!

- i) **Gaming Strategies:** It has come to attention that, in order to improve scores on assorted access measures certain facilities have adopted use of inappropriate scheduling practices and hide data sometimes referred to as "gaming strategies." It's been reported that, VA hospitals exhibit better health score fabricating patient data to draw positive attention from the government so that they get more funding and extra facilities.

In response to the scandal VA took short, medium and long-term Steps:

1. Collecting and analyzing voluminous reports, information and documents from VHA information technology systems related to patient scheduling and enrollment.
2. Finding, sorting and reviewing VA related records of patients whose death occurred while on a waiting list, or is alleged to relate to a delay in care.
3. Reviewing performance standards, ratings, ranking and awards of doctors, related persons and staffs.
4. Reviewing past and new complaints to the Office of Inspector General (OIG) Hotline on delays in care, as well as those complaints shared with public by members of Congress or reported by the media.
5. Reviewing other documents and reports relevant to these allegations, including administrative boards of investigations or reports of reviews conducted by VHA's Office of the Medical Inspector.
6. Long term waiting schedule was removed and on spot treatment was practiced. The Phoenix VA Health Care System started timely process enrollment application.
7. President Obama visited and said while progress has been made to improve service, more efforts, special care needed to be taken to restore veterans who rely on the services.
8. Some officials were suspended including doctors, and liable person from hospitals. U.S. Secretary of Veterans Affairs Eric Shinseki placed by Robert A. McDonald and two others on administrative leave pending an outcome to the inspector general's probe.
9. Proposed a new system that would allow listed veterans to seek private health care at government expense (emergency case).
10. VA Secretary had taken immediate action to review and provide appropriate health care to 1,700 veterans and identified as not being on any existing wait list.
11. The Department of Veterans Affairs relaxed some rules for some veterans in rural and small town areas.
12. Started a new patient satisfaction measurement program so that patient can replay, feedback their satisfaction and dissatisfaction.
13. Deployed mobile medical units (quick service unit) to deliver services to veterans waiting care.

New Secretary's Action: In July of 2014 the Senate recruited Robert McDonald as the new VA Secretary. Also two top VA executives were replaced, 53 new positions were added. In regard to the Phoenix, Austin and Wyoming wait list, 146,596 appointments were completed from May to July, and as of August 15, and there were only hundreds veterans who remained on the wait list. Across the country, 226,000 veterans were contacted to get them off a waiting list, which had declined in size by 57%. Over thousands performance plans were amended, which included the deletion of 14-day appointment goals, incentive structure. Finally, every VA health care centers were scheduled to have a face-to-face and mobile team audit by September 30, 2014.

Recommendations for performance development:

1. It is recommended that, VA Secretary review all existing waiting lists at the Phoenix, Austin, and Wyoming Health Care System to identify veterans who may be in dire need of emergency care.

2. The VA Secretary should ensure the Phoenix VA Health Care System timely process enrollment applications and documents.
3. Expand access to affordable health care coverage to all Americans with lower costs (If possible free) and improve quality and care coordination. Never attach investors or entrepreneurs who are too much into profit making from this field, which basically should be a service, based non-profitable venture from top to bottom.
4. Provide ambulance services, Chiropractic care, dental care, durable medicine equipment, and hearing aids. Currently, these are limited and restricted; also eligibility criteria are very limited. So these services should be made available.
5. Ensure VA and the administration propose accurate budget requests for Department of Veterans Affairs health care accounts and ensure Congress acts on such requests to provide timely and sufficient funding for VA that aligns with the recommendations of the Independent Budget.
6. Provide proper investment in VA capital infrastructure to ensure that facilities remain modern and capable of delivering safe, quality service to all veterans who need it.
7. Modernize the VA appointment scheduling and serial system so that it accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veteran.
8. Develop and implement wait time standards based on quality care outcomes and the clinical needs of veterans.
9. Ironically, the veterans who fought for freedom are given the minimum amount of freedom over their own health care decisions. Ensure freedom here.
10. Strengthen accountability protocols for all VA employees - not just VA executives, but also every sector; to ensure that poor-performing employees can be held accountable.
11. Implement ample training for all VA employees that focus on quality customer service, continue improve performance and positive health outcomes.
12. Ease federal hiring protocols for VA health care professionals to ensure that VA can compete with private industry to hire and retain the best health care providers in a timely manner.
13. Implement proper whistleblower protections for VA employees who search to expose and correct improper practices in VA services.
14. Establish the Veterans Health Care Insurance Program (VHCIP) as a program office in the Veterans Health Administration and establish the Veterans Accountable Care Organization (VACO) as a non-profit government corporation fully independent from the Department of Veterans Affairs.
15. Ensure that VA Patient Advocate teams are properly staffed and report directly to VA Central Office, ensuring they can make decisions that best serve the health care needs of the veteran.

Conclusion: The unexpected deaths could be avoided if VA would focus first on its core mission to deliver quality health care and confirm service first. Its efforts would also be aided by discussion of the best organizational structure to consistently provide quality care. We learn that the VA has a history of communication crises, information lags, mismanagement and leadership inefficiency. These limitations led to years of corruption and deceit between regional and federal leaders and system dysfunction. In the wake of the scheduling scandal, silence from VA officials fueled the media fire, making matters worse for everyone. Although most of reforming VA health care already achieved. Some reforms are going to applied, such as- Veterans should be able to choose where to get their health care, health insurance coverage for future veterans, veterans health service should not be driven by the budget and VHA needs accountability. Finally, after the appointment of new VA Secretary Robert McDonald, he used a hands-on approach of personally discussing the matter with face to face virtually anyone who wanted to talk, share, and suggest about it. He appreciated suggestions from reporters to citizens, physicians to patients. It remains to be seen if he can improve the structural integrity and reliability of the VA and walks as well as he talks the talk, the VA would revive. Thus far, one thing is clear: in a very short time, he has effectively used transparency and honesty to improve the damaged brand image of the United States Department of Veterans Affairs. At last health and well-being of the men and women who have bravely and selflessly served this great nation's image and security remains VA's highest priority. In spite of performance dysfunctions found since 2010, there are a lot of effective steps that have been taken to reform and overcome the past scandal and future performance improvement by VA. Although, VA scandal, 2014 seemed to be a great problem initially, the experience to recover from it will enrich us with problem solving knowledge and motivation facing similar types of occurrences in future.

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