STATEMENT OF
DANIEL M. DELLINGER, NATIONAL COMMANDER
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON
"THE STATE OF VA HEALTH CARE"

MAY 15, 2014

The Department of Veterans Affairs (VA) has come under scrutiny by Congress, Veteran Service Organizations, the media**,** and in the veterans' community for its failures in leadership**,** performance**,** and accountability which have resulted in quality of care or patient safety issues that have directly affected veterans. If there is a lack of performance and accountability among a senior executive service employee, the only disciplinary actions the Secretary of Veterans Affairs can take are to issue reprimands or transfer VA senior executive service employees to other VA facilities, even if that lack of performance results in the death of a veteran.

Chairman Sanders, Ranking member Burr, and distinguished members of this Committee, thank you for inviting The American Legion to testify before you today and discuss our views on The State of Healthcare at the Department of Veterans' Affairs.

The allegations of secret waiting lists at the Phoenix Department of Veterans Affairs Medical Center that are now being investigated along with 40 or more patient deaths has rocked the veterans' community. In addition to Phoenix, we now understand that at least six additional VA locations have been identified as participating in veteran patient wait time manipulation just this week. The allegations in Phoenix were not the only reason The American Legion decided to call for leadership change at VA; they were simply the final straw in a long list of systemic leadership failures that include;

- Construction delays and cost overruns
- Patient deaths due to Legionella
- Patient infections due to unsanitary colonoscopy equipment and dental equipment
- Unacceptable wait times for colonoscopies resulting in patient deaths
- The abandonment of efforts to create a true, unified, interoperable joint healthcare record for use in the Department of Defense (DOD) and the Department of Veterans Affairs (VA)
- VA's refusal to answer congressional inquiries
- VA witnesses failure to disclose all relevant truths when testifying before Congress

And the list continues to grow.

Veterans are frustrated and concerned with VA's construction processes and the continued delays and cost overruns. Every day the construction goal is not met for medical centers in Denver, Orlando, or New Orleans, is a day VA is failing to take care of our nation's veterans.

According to a Government Accountability Office Report - Cost Increases and Schedule Delays at the Four Largest Projects – "cost increases ranged from 59 percent to 144 percent representing a total cost increase of nearly $366 million per project with average schedule delays ranging from 14 to 74 months with an average delay of 35 per VA major construction project." In one case, a hospital was completed, but they forgot to install an ambulance bay, which then had to be renegotiated, contracted for, and installed.

During a Subcommittee on Oversight & Investigations hearing in November of 2013 on "Correcting Kerfuffles," there were several complaints on the G.V. (Sonny) Montgomery VA Medical center that cited poor sterilization procedures. The hearing also mentioned that pieces of bone were still attached to surgical instruments that were being used on other patients.

For nearly 18 years, the dental clinic at the Dayton VA Medical Center allowed unsanitary practices, potentially exposing hundreds of patients to hepatitis B and hepatitis C. Dayton VA Medical Center Director Guy Richardson then collected an $11,874 bonus despite an investigation into the exposures. After nine of the exposed patients tested positive Hepatitis B and Hepatitis C, Richardson was promoted.

The American Legion has also spoken out recently regarding the billion dollar botched development of the iEHR – Individual Electronic medical Health Record project. After years of promises and more than a billion dollars wasted, VA simply walked away from the mission and started over in January by reissuing a new procurement request. The American Legion believes that the introduction of a joint Department of Defense and VA electronic health records would have all but eliminated the disability backlog already, yet as of May 6, 2014, 308,285 (52.3%) of all disability claims have been backlogged over 125 days.

VA's claims adjudication accuracy is questionable. The American Legion does not question the ethics of the accuracy, we question the formula utilized. The American Legion's Regional Office Action Review (ROAR) conducts comprehensive and holistic claims reviews, while VA's review looks solely at the claim and not how it may interrelate with other service connected conditions.

Nearly three years ago The American Legion partnered with the White House and the VA to institute the Fully Developed Claim (FDC) pilot program. The goal for this initiative was for VA and American Legion Service Officers to submit claims that were complete and ready for a rating decision, and wasn't absent any supporting evidence or documentation. VA agreed that they would then process these Fully Developed Claims within 90 days or less. Today, only four VAROs nationwide are meeting the objective for claims with Legion Power of Attorney (POA), four years after the publishing of the fast letter and nearing two years after nationwide implementation. Eight VAROs exceed 200 days on average with Legion POA.

During one of our most recent ROAR visits earlier this year in Seattle, Undersecretary of Benefits Alison Hickey attempted to impede our ROAR team from attending the necessary meetings to satisfy the visit, and then did not allow the proper access for The American Legion to adequately complete the visit. As a result, The Chairman of the House Veterans Affairs Committee sent a letter to VA and offered to accompany The American legion on future visits.

Local facilities are not empowered to address a crisis when it happens. With 152 medical centers to look after nationwide, the VA cannot manage every crisis from Washington. Instead, The American Legion believes VA needs to empower its leadership at medical centers to respond to crises – quickly. With incidents such as the Legionella outbreak in Pittsburgh, the facility had a press release ready to disseminate but VA Central Office never approved it to be sent publicly.

The allegations of secret wait lists in Phoenix have caught some by surprise, and some may call for caution, waiting until the results of VA's Office of the Inspector General (VAOIG) are complete before leaping to conclusions about VA's healthcare system. Unfortunately, Phoenix is not an isolated event, nor is it the first such event to be investigated by VAOIG. Between January 2013 and the present day, VAOIG has conducted 18 investigations in response to concerns about the VA healthcare system. The majority of these investigations dealt with delays in appointment scheduling1, delays in lab results2, and lapses in notifying patients of biopsy results3. More serious investigations addressed patient deaths under emergency care4.

The veterans of The American Legion have a vested interest in ensuring that VA operates efficiently and we were instrumental in seeing that the VA became a cabinet position in the first place. We did so, in order that the Secretary would have the power and authority to serve and fight for the best interests of veterans through the second largest agency within the federal government.

On Monday, May 5, 2014, American Legion staff scheduled a conference call with Dr. Mike Davies, National Director of Systems Redesign to discuss national wait times and was told three days later that Dr. Davies would not be able to meet with The American Legion until June.

The American Legion has a dedicated team that travels around the country visiting VA hospitals, conducts veteran town halls, and speaks directly with VA healthcare and administrative staff. This program is overseen by our System Worth Saving Task Force, and had conducted visits over the past year to problem areas in Pittsburgh, Jackson, Atlanta, Augusta, and Columbia, South Carolina, as well as Phoenix, to attempt to understand the challenges these centers face while trying to provide the best possible healthcare to our nation's veterans. A brief overview of some of these visits can be found in addendum "A" of this testimony.

Overwhelmingly, our taskforce finds that veterans are extremely satisfied with their healthcare team and medical providers. We also find that administrative oversight of VA operations is a constant concern and growing frustration among patients. We've found veterans who are happy when they can get care, but struggling with a system that makes it difficult even to get primary care appointments. While a veteran might wait more than two weeks for most primary care appointments, specialty care appointments can take many months or even years. And when it comes to informing patients of potential problems within the VA system, we find that local

[1] http://www.va.gov/oig/pubs/VAOIG-12-04108-96.pdf
[2] http://www.va.gov/oig/pubs/VAOIG-13-00636-104.pdf
[3] http://www.va.gov/oig/pubs/VAOIG-13-00940-193.pdf
[4] http://www.va.gov/oig/pubs/VAOIG-13-00505-348.pdf

facilities are not empowered to interact with the community and are under restrictive communications lockdowns imposed by VACO.

In addition to our System Worth Saving Taskforce, which is now in its 10th year, American Legion volunteers donate nearly 900,000 hours of service in VA facilities annually at a value of over $19 million, and maintain a network of over 2,900 accredited service officers who assist nearly three-quarter of a million veterans with their disability claims. Wherever veterans interact with VA, The American Legion is there attempting to work within the system to ensure that the VA continues to serve the best interests of veterans. Not only has The American Legion donated millions of dollars to create and support VA programs; we have even sponsored a brain research center that is named after us in Minnesota[5].

Over the past two weeks The American Legion has received over 500 calls, emails, and online contacts from veterans struggling with the healthcare system nationwide. They cite concerns ranging from the common complaint of substantially delayed appointments, to an inability to receive specialty care. One parent of a veteran in Phoenix spoke painfully of losing their daughter while she waited for care, and one veteran reported calling his local VA medical center for an appointment only to be told "there are no appointments within the next 30 days, please call back in 4 weeks to schedule an appointment." Even if there is not a formal "secret" list at many of these facilities, administrative staff are finding a variety of ways to game the system.

According to Dr. Sam Foote, one of the first whistleblowers to come forward regarding VA's waiting list manipulation accusations, the attempts to create a work around on appointments grew out of a response to VA's attempts to address scheduling problems[6] (More information on this and other recent whistleblower complaints are attached as Addendum "B"). Because there were previous complaints about lengthy wait times at VA facilities, VACO officials made changes to the appointment system to automate the process and prevent employees from lying about wait times. The new electronic system was designed to automatically enter the time the appointment was requested and provide a more accurate assessment of how long it was taking to find appointments for veterans. To circumvent this, VA employees developed strategies to wait until they could guarantee an appointment within two weeks, and only then enter the information into the electronic system[7].

A VA employee in Cheyenne, Wyoming, provided documentation to CBS News that explicitly details how VA employees need to "game the system a bit…when we exceed the 14 day measure, the front office gets very upset, which doesn't help us[8]." There is a culture created, and enforced by leadership within VA that the most important measure is meeting the numbers. This is true whether in the Veterans Health Administration (VHA) or Veterans Benefits Administration (VBA). VA schedulers who can't find appointments for veterans resort to keeping secret lists. VA claims workers who can't keep up with the demanded number of claims per day shred vital documents that could help prove a veteran's disability.

[5] http://brain.umn.edu/about_us.shtml
[6] http://onpoint.wbur.org/2014/05/12/veterans-affairs-scandal-death
[7] Ibid – Dr. Foote
[8] http://www.cbsnews.com/news/email-reveals-effort-by-va-hospital-to-hide-long-patient-waits/

A year later, as the problems continue to mount and the VA appears no closer to solutions, we sadly feel there must be change. VA is in need of a real reformer who is not afraid of exposing the full extent of the problems and bringing all stakeholders in to forge a VA for the 21st century and beyond. When Arlington National Cemetery was beset with a disgusting scandal involving mismarked graves in 2010, they brought in Kathryn Condon to right the ship. During the time of transition, Director Condon reached out to stakeholders including The American Legion for guidance and support. During the crisis, officials at Arlington did not dismiss further discovery of mismanagement issues but rather sought to expose everything while accepting responsibility, and then engaged stakeholders to express how they were amending the system to ensure these problems would never occur again at the nation's most prestigious resting place for our military fallen. The handling of the Arlington crisis is indicative of courageous leadership that owns their own failures and sincerely works to correct deficiencies.

Unfortunately, the response from Undersecretaries Petzel and Hickey at VA has been to question those who would impugn VA's reputation. When VA's accuracy figures were questioned, VA's response was to limit access of those who advocate for veterans[9], rather than sincerely attempt to reform the process and retrain employees to actually end the error prone processing practices. When allegations of dangerous medical practices emerged, Dr. Petzel's first response is to be dismissive[10]. The tone is consistent. The pattern is consistent. It is perhaps most telling that when The American Legion Health Policy Unit contacted the VACO staff responsible for the nationwide scheduling operations last week, that VA staff chose not to engage the community or work with stakeholders to better understand this problem. Instead VACO staff informed The American Legion they could not possibly schedule a meeting until sometime in June to discuss the topic.

We can't wait months for a solution. How many more veterans will die waiting to see doctors? Hearings, reports, analyses and testimonies won't fix this. America's veterans deserve a solution that starts today.

The solution MUST include input in correct measures from the Department of Veterans Affairs, Congress and most importantly the stakeholders – it is absurd to make decisions about what veterans need in their healthcare system without consulting the veterans. As the nation's largest wartime service organization for veterans, The American Legion will not shy away from providing a voice for those veterans.

For many years now, going back to the budget troubles of 2006, Congress has asked VA if they had the resources they need to accomplish their mission. All parties on the Hill, from both sides of the aisle, and both the Senate and House of Representatives, have made abundantly clear that even in this austere time of belt-tightening budget measures, if VA needed funds to provide proper care for veterans, they would find them the money they need. VA has consistently answered that they could execute their plan with the budget they had asked for, a budget usually increased by Congress in the final tally. If VA needs more to accomplish their mission, and

[9] http://www.military.com/daily-news/2014/02/21/lawmaker-says-va-obstructed-legion-quality-review.html
[10] http://www.cnbc.com/id/101187855 "There have been some public kerfuffles in the paper that don't in my mind reflect the Jackson VA facility,"

many VSOs including The American Legion have questioned whether their budget meets their needs, they need leadership with the courage to be honest about those needs.

The American Legion has testified in nearly every hearing before this Committee, and the House Committee on Veterans' Affairs concerning the VA, in which stakeholder testimony is considered and has seen firsthand how the VA has stonewalled congressional requests for information. The American Legion has followed the investigations and requests for information with special concern, as VA has developed a pattern of unresponsiveness to Congress and crises while developing a tendency to downplay legitimate concerns of veterans that do not do service to the veterans in these communities.

While addressing patient deaths at the Jackson VA Medical Center, Undersecretary Robert Petzel referred to the concerns dismissively as "kerfuffles[11]" and in a subsequent follow up visit to that site by American Legion System Worth Saving Task Force members, the facility director was hampered from cooperating with the local veterans and American Legion by VA Central Office restrictions. During the January 2014 visit, facility director Joe Battle was unable to provide the action plan the facility was using to address problems with patient deaths. Director Battle stated he could not release the report because it had not been cleared by VACO. Repeated follow up requests for information to VACO officials by American Legion staff have been met with the response that VHA cannot release this information to The American Legion.

The American Legion believes there must be corrective measures taken. There are several improvements VA could begin implementing to start addressing these issues.

As we are now over a decade into the 21st century, The American Legion believes that VA should also begin implementing 21st century solutions to its problems. In 1998, GAO released a report that highlighted the excessive wait times experienced by veterans trying to schedule appointments, and recommended that VA replace its VISTA scheduling system.[12] To address the scheduling problem, the Veteran's Health Administration (VHA) solicited internal proposals from within VA to study and replace the VISTA Scheduling System, with a Commercial Off-the-Shelf (COTS) software program. VA selected a system, and about 14 months into the project they significantly changed the scope of the project from a COTS solution to an in-house build of a scheduling application. After that, VHA ended up determining that it would not be able to implement any of the planned system's capabilities, and after spending an estimated $127 million over 9 years, The American Legion learned that VHA ended the entire Scheduling Replacement Project in September 2009.[13] We believe that this haphazard approach of fits and starts is crippling any hope of progress.

It has now been over three years since VHA cancelled the Replacement Scheduling Application project, and as of today, The American Legion understands that there is still no workable solution to fixing VA's outdated and inefficient scheduling system. In 2012 The American

[11] http://www.cnbc.com/id/101187855 "There have been some public kerfuffles in the paper that don't in my mind reflect the Jackson VA facility,"
[12] U.S. Medicine Magazine, *VA Leadership Lacks Confidence in New $145M Patient Scheduling System*, May 2009
[13] GAO-10-579, *Management Improvements Are Essential to VA's Second Effort to Replace Its Outpatient Scheduling System*, May, 2010

Legion passed Resolution number 42 that asked the VA to implement a system "To allow VA patients to be able to make appointments online by choosing the day, time and provider and that VA sends a confirmation within 24 hours". Last December, VA published an opportunity for companies to provide adjustments to the VISTA system through the Federal Register – all submissions are due by June 2013. While this is a laudable attempt to address the problem, it hardly seems sufficiently proactive given that the problem has been identified for over fifteen years, and excessive wait times are still being experienced by many veterans across the nation.

The American Legion recognizes that over the past decade, VA has taken some steps aimed at improving its scheduling and access to care; we believe that there is still much to be done. In order to adequately address the problems of veterans, The American Legion believes VA should adopt the following steps towards a solution:

1. Devote full effort towards filling all empty staff positions. The problems with mental health scheduling clearly indicate how a lack of available medical personnel can be a large contributing factor to long wait times for treatment. Despite VA's efforts to hire 1,600 new staff, as recently as last month VA was noting only two thirds of those positions had been filled. This does not even address the previous 1,500 vacancies, and stakeholder veterans' groups are left to wonder if VA is adequately staffed to meet the needs of veterans.

   We believe they are not.

   If VA needs more resources to address these staffing needs, The American Legion hopes they will be forthright and open about their needs, and ask for the resources they need to get the job done. The Veteran Service Organizations and Congress have been extremely responsive to get VA the resources they need to fulfill their mission, but VA must be transparent about what their real needs are.

2. Develop a better plan to address appointments outside traditional business hours. With the growing numbers of women veterans who need to balance family obligations and other commitments, our veterans' abilities to meet appointments during regular business hours is greatly hampered. The American Legion believes VA can better address the community's needs with more evening and weekend appointment times. American Legion Resolution number 40 calls on the VA to provide more extended hour options, and believes VA should recruit and hire adequate staff to handle the additional weekend and extended hour appointments for both primary and specialty care.

3. Improve the IT solution. Last year The American Legion also passed resolution number 44, which called on the VA to create a records system that both VBA and VHA could share to better facilitate information exchange. A common system could even synchronize care visits in conjunction with compensation and pension examinations. We had hoped such a system might be included in the improvements brought by the Virtual Lifetime Electronic Record; however VA and DOD appear to be content to pursue individual legacy systems for that project, so veterans must continue to contend with VBA and VHA systems that do not communicate as well as they should. In any case, as

VA looks outward for a solution to their scheduling program, all can agree that the current system is not serving the needs of veterans and needs to be updated.

4. The American Legion urges Congress to enact legislation that provides the Secretary of Veterans Affairs the authority to remove any individual from the senior executive service if the Secretary determines the performance of the individual warrants such removal, or transfer the individual to a General Schedule position at any grade of the General Schedule the Secretary determines appropriate.

5. The American Legion supports legislation and congressional oversight to improve future Department of Veterans Affairs (VA) construction programs, and urges VA to consider all available options, both within the agency and externally, to include, but not limited to the Army Corps of Engineers, to ensure major construction programs are completed on time and within budget.

There is still room for VA to improve their triage processes. The current consult management program needs work to ensure it is providing better triage for veterans in need of life saving procedures. Primary Care Providers have relayed to American Legion System Worth Saving Task Force members concerns that the current triage process has bureaucratic hurdles which make the process frustrating and presents a challenge to retaining top quality Primary Care Providers.

Furthermore, regarding VA's current 14 day wait policy, review of this policy is necessary to determine whether the enforcement is causing problems. The goal to see veterans in a timely manner is crucial; however, care must be taken to see how the regional facilities are viewing the policy. If they are reluctant to report longer wait times up to VACO because of fears of being "put on a Bad List" as relayed in the Cheyenne email[14], then a reassessment of the culture that breeds this attitude is warranted. The observance by VACO of lengthy wait times at a facility should trigger questions to VACO about whether the facility is adequately staffed and resourced to meet the needs of the community. VISNs struggling to meet timeliness standards need to be assessed to determine if they have the tools to treat the veterans in their communities.

Finally, revision of these standards is only as good as the integrity of staff you hire and accountability and transparency for those who break the rules should be disclosed. VA should put a map on their website of hospitals that had issues and what corrective actions were taken to include disciplinary actions such as transfers or reprimands. Veterans ought to be able to see there is a top down and bottom up culture of accountability. That is how to restore trust in the system to the veterans' community.

The American Legion thanks this Committee again for their commitment to seeking answers about the troubling trends emerging in VA. The commitment of all parties to ensuring veterans receive quality healthcare in a safe environment is a sacred duty. Questions concerning this testimony can be directed to The American Legion Legislative Division (202) 861-2700, or lcelli@legion.org

[14] http://www.cbsnews.com/news/email-reveals-effort-by-va-hospital-to-hide-long-patient-waits/

Addendum A

Highlights from The American Legion's recent System Worth Saving Task Force visits;

2013

Pittsburgh, Pennsylvania (Site Visit Nov. 5-6)

- After persistent management failures led to a deadly Legionnaires' disease outbreak in the VA Pittsburgh Healthcare System, VA Pittsburgh director Terry Gerigk Wolf received a perfect performance review and regional director Michael Moreland, who oversees VA Pittsburgh, collected a $63,000 bonus.

Nashville, TN (SWS Visit Nov 13-15)

- Tennessee Valley Healthcare System struggles to fill critical leadership positions across multiple departments. These gaps could cause communication breakdowns between medical center leadership and staff that work in these departments.

El Paso, TX (SWS Visit Nov. 18-20)

- The current situation with the future of William Beaumont Army Medical Center is uncertain and troubling for veterans in the area, and veterans need to know where they will be able to receive their health care.

Huntington, WV (SWS Visit Dec. 9-11)

- Huntington VAMC has found it difficult to recruit talent (surgeons/physicians) due to pay freezes, a lack of bonuses/retention incentives, and the geographical location of the hospital.

Leavenworth, KS (SWS Visit Dec. 9-11)

- Due to the age of the Leavenworth campus (83 years-old), space is an issue. Additionally, because the Kansas Historical Society has designated the Leavenworth campus as a historical site, there are limitations on what infrastructure changes can be made.

2014

Roseburg, Oregon (Site Visit Jan.9-10)

- An active Legionnaire from American Legion Post 61 in Junction City, went to the Roseburg VA Medical Center this past June for what should have been a routine hernia operation. After the surgery, Roseburg VA Medical Center staff told the veteran's daughter, that her father's blood pressure had "dropped suddenly and he was having difficulty breathing." Since the Roseburg VA Medical Center does not have an Intensive Care Unit, the veteran was taken to PeaceHealth Sacred Heart Medical Center at Riverbend in Springfield, Oregon. Unfortunately, the veteran passed away en route PeaceHealth Sacred Heart Medical Center due to "intra-dominal bleeding, shock, hyperkalemia, acidosis, respiratory failure and recent ventral hernia surgery."
- The American Legion is not comfortable with the current status of the medical center following the closure of their Intensive Care Unit. The American Legion recommends that VARHS consider one of the three alternatives: fully reinstating the Intensive Care Unit, standing down all surgical procedures, or strengthening their Memorandum of Understanding with Mercy Medical Center to ensure that an Intensive Care Unit bed will be available in case of emergency, which includes remaining without an ICU and

continue to perform ambulatory procedures that meet the strict criteria established by the VA as appropriate for facilities without an ICU.

Jackson, Mississippi (Site Visit Jan.21-22)

- At the G. V. Sonny Montgomery VA Medical Center in Jackson, MS, multiple whistleblower complaints have been raised by employees who were losing confidence in the medical center's ability to treat veterans. The complaints ranged from improper sterilization of instruments to missed diagnoses of fatal illnesses, as well as hospital management policies.

Butler, Pennsylvania (Site Visit Jan. 8-9)

- An attorney for the prime contractor of a Department of Veterans Affairs outpatient center being built in Butler County declined to comment Friday, July 12, 2013 about the VA's investigation of the contractor that led the agency to stop work on the $75 million project.

- The VA Butler Healthcare Center was scheduled to open in 2015, but the termination of the lease left its future in doubt. The VA broke ground on the center in April 2013. The Department of Veterans Affairs yanked its lease with an Ohio company that was building a $75 million health center for vets in Butler, accusing the firm of "false and misleading representations" during bidding. The VA ordered work halted in June when it began to uncover problems with the project.

- The Department of Veterans Affairs failed to properly check the qualifications of the former developer of an outpatient center in Butler County, according to a highly critical report by the VA's Office of Inspector General released Monday. The report says the VA improperly calculated that a 20-year lease with Westar Development Co., valued at $157 million, would be cheaper than the VA building and owning the $75 million outpatient center on its own.

Atlanta, Georgia (Site Visit Jan. 28)

- Despite four preventable patient deaths, three of which VA's inspector general linked to widespread mismanagement, former Atlanta VA Medical Center Director James Clark received $65,000 in bonuses over four years. Additionally, the facility's current director, Leslie Wiggins, maintains that no employees responsible for the mismanagement linked to the deaths should be fired.

Orlando, Florida/Denver, Colorado (Orlando SWS Visit-Feb.11-12, 2014) (Denver SWS Visit-May 13-14)

- Costs substantially increased and schedules were delayed for Department of Veterans Affairs' (VA) largest medical-center construction projects in Denver, Colorado; Las Vegas, Nevada; New Orleans, Louisiana; and Orlando, Florida. As of November 2012, the cost increases for these projects ranged from 59 percent to 144 percent, with a total cost increase of nearly $1.5 billion and an average increase of approximately $366 million. The delays for these projects range from 14 to 74 months, resulting in an average

delay of 35 months per project. In commenting on a draft of this report, VA contends that using the initial completion date from the construction contract would be more accurate than using the initial completion date provided to Congress; however, using this date would not account for how VA managed these projects prior to the award of the construction contract. Several factors, including changes to veterans' health care needs and site-acquisition issues contributed to increased costs and schedule delays at these sites.

Dallas, Texas (SWS Visit Feb 4-5)

- Dallas VA Medical Center Director Jeff Milligan and regional director Lawrence Biro have received a combined $50,000 in bonuses since 2011 despite a series of allegations from VA workers, patients and family members regarding poor care at the facility as well as more than 30 certification agency complaints against the medical center in the last three years.

Hot Springs, SD (SWS Visit Feb 17-19)

- The VA Black Hills Healthcare System (VABHHS) is going under a reconfiguration proposal which is opposed by the local community. The issue is whether relocating services from the Hot Springs VA Medical Center to the Fort Meade VA Medical Center and the domiciliary to Rapid City are in the best interest of veterans. This would require veterans to travel further to receive their health care.

Augusta, Georgia (Site Visit Mar. 11-12)

- CNVAMC leadership first learned of delays in providing gastrointestinal (GI) services to veterans on August 30, 2012. Of the 4,580 delayed GI consults, a quality management review team determined 81 cases for physician case review. Seven of the 81 cases may have been adversely affected by delays in care. Six of seven institutional disclosures were completed and three cancer-related deaths may have been affected by delays in diagnosis. Factors contributing to the 4,580 patient backlogs included an explosion of baby boomers turning 50 and requiring screening, the medical center's non-anticipation of a spike in GI consult demand, lack of an integrated data base for tracking GI procedures, and GI physician recruitment challenges.

Columbia, South Carolina (SWS visit April 15, 16)

- In September 2013, six deaths were linked to delayed screenings for colorectal cancer at the veterans medical center in Columbia, S.C., the Veterans Affairs Department reported. The VA's inspector general determined that the William Jennings Bryan Dorn VA Medical Center fell behind with its screenings because critical nursing positions went unfilled for months. It also found that only about $275,000 of $1 million provided to the hospital to alleviate the backlog had been used over the course of a year.

Addendum B

Recent developments;

- Former employee, Dr. Sam Foote, claimed the Phoenix system is afflicted by "gross mismanagement of VA resources and criminal misconduct "that produced "systemic patient safety issues and possible wrongful deaths."

- Foote and other employees alleged a variety of other institutional breakdowns in Arizona's VA, including:

    - Medical record-keeping so backed up the system is 250,000 pages behind, and millions of records reportedly are missing.
    - A compromised mental-health system where patient suicides doubled in the past few years, while staff suicides also emerged as a serious concern.
    - A swamped emergency room that becomes the last resort for veterans who cannot get appointments with primary-care doctors or specialists. In some cases, VA health system employees have told the newspaper, vets with life-threatening conditions have waited hours without diagnosis or treatment because nurses are overworked and undertrained.
    - Discrimination, cronyism and security breakdowns in the VA police department that endanger the safety of patients and employees.
    - Hostile working conditions that caused an exodus of quality doctors and nurses, producing backlogs in specialty areas such as urology, where bladder cancer and other serious diseases are detected. Patients reportedly are referred to out-of-state VA centers or private physicians for treatment.

- On Sunday, April 27, 2014, a second whistleblower, Dr. Katherine Mitchell reported that "patient appointment records in the Phoenix VA Health Care System were in danger of being destroyed."

- On Sunday, May 4, 2014, a whistleblower reported that clerks at the Department of Veterans Affairs clinic in Fort Collins, Colorado were instructed in 2013 how to falsify appointment records so it appeared the small staff of doctors was seeing patients within the agency's goal of 14 days.

- The VA's official policy is that all patients should be able to see a doctor, dentist or some other medical professional within 14 days of their requested/preferred date. Any wait longer than two weeks is supposed to documented.

Yet on Friday, May 9, 2014 Brian Turner, a Veterans Affairs scheduling clerk based in San Antonio, said that some who called to make appointments at his facility did end up waiting longer, yet such delays were never reported.
For example, he said, they might be told the next available appointment wasn't for several months. It would be scheduled for then, but marked in official files as if the patient had put off their appointment until then by choice.

Addendum B

"What we've been instructed was that -- they are not saying fudged, there is no secret wait list -- but what they've done is come out and just say 'zero out that date,' " Turner said. The "zero," in this case, suggests the patient didn't have to wait at all.

"It could be three months and look like no days (wait)," he added. "It looked like they had scheduled the appointment and got exactly what they wanted."

DANIEL M. DELLINGER
NATIONAL COMMANDER
THE AMERICAN LEGION

Daniel Dellinger of Vienna, VA., was elected National Commander of the 2.4 million-member of The American Legion on August 29, 2013 in Houston, Texas during the 95th national convention of the nation's largest veterans organization.

He became an Army Infantry officer after graduating with a degree in criminology from Indiana University of Pennsylvania. He served at Fort Benning, GA., during the Vietnam War and entered the U.S. Army Reserve in 1972, separating from the service in 1984 at the rank of captain.

A member of the Dyer-Gunnell American Legion Post 180 in Vienna since 1982, he was made a life member in 1990. He has served as post, district and department commander and chaired numerous committees. At the national level, he chaired the Legislative, National Security, and Economic commissions as well as the Aerospace Committee. He served as chairman of the Legislative Council and Membership and Post Activities Committee. He has been a member of the Foreign Relations Council, Policy Coordination, Veterans Planning and Coordinating committees as well as the Legislative Council.

Dellinger is a member of the Sons of the American Legion, Past Commanders and Adjutants Club, Past Department Commander's Club, ANAVICUS and the Citizens Flag Alliance. He has served as a presidential appointee on the Federal Taskforce on SBA Hiring and as vice mayor of the Town of Vienna, Virginia as well as serving three terms as town councilman. He is a member of the Loyal Order of the Moose and the Loyal Order of the Kentucky Colonels.

He owned and operated a construction management and general contracting firm for twenty years specializing in commercial, institutional and industrial construction.

Dellinger and his wife, Margaret, reside in Vienna. Margaret served as American Legion Auxiliary Unit 180 President for four years; daughter, Anne, is a 23-year member of Unit 180; and son, Scott, is a 28-year member of Sons of The American Legion Squadron 180.

Commander. Dellinger's theme is **"Building for Tomorrow – Today."**