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Addressing Untimely Healthcare Access of Veterans Receiving Care Through the Veteran Healthcare Administration (VHA)

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MPA-3999: Capstone Practicum

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Abstract

The Veteran Healthcare Administration (VHA) serves over nine million veterans (Department of Veterans Affairs, 2023). They are responsible for the health and well-being of veterans with service-connected disabilities (Department of Veterans Affairs, 2023). A major focus for the organization is to keep improving access for veterans, as the population continues to grow (Department of Veterans Affairs, 2023). In 2018, congress passed the MISSION Act in hopes of increasing access for veterans. The MISSION Act would expand private healthcare access for veterans through the Veteran Community Care Program (VCCP) (MISSION ACT, 2018). Despite the initial benefits of the program, the MISSION Act failed to address many of the underlying problems related to inaccessible healthcare. As of 2024, the VHA continues to struggle with providing access due to administrative failures, data collection shortcomings, and a growing physician shortage, which continues to contribute to long wait times. This paper aims to help provide practical solutions, which will help provide veterans with timely and accessible healthcare appointments. In researching the topic possible avenues were found to improve accessibility, such as self-scheduling, telehealth expansion, and comprehensive legislation to set comprehensive wait time standards. Without immediate action to implement new legislative and administrative policies to address the VHA's shortcomings, millions of veterans will continue to struggle to get the timely care they deserve.

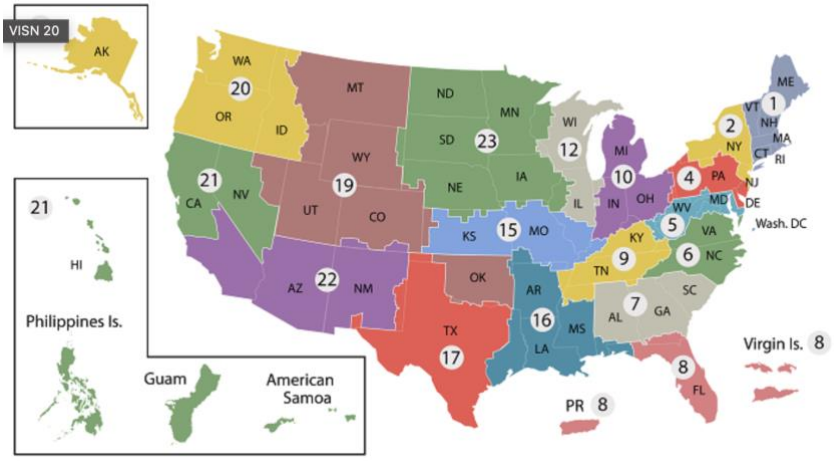
Keywords: *Healthcare, Veterans Affairs (VA), MISSION Act 2018, Self-Scheduling, Physicians, Veteran Healthcare Administration (VHA), Veterans, SCHEDULES Act 2024, Telehealth, MyHealtheVet*

About the Organization

The Veteran Healthcare Administration (VHA) is a component of Veterans Affairs (VA), which provides benefits and services to veterans (Department of Veterans Affairs, 2023). The VHA is primarily a direct care provider that has 1,321 health facilities across the country, including 172 Veterans Affairs Medical Centers (VAMC), and 1,138 outpatient clinics (Department of Veterans Affairs, 2023). These locations serve over nine million veterans who are enrolled in the VA healthcare program, making it the largest integrated healthcare system in the United States (Congressional Research Service, 2023). These centers are regionally divided into the Veterans Integrated Service Networks (VISNs) system. Figure 1 shows which states belong to each region of the VISN.

Figure 1.

Veterans Integrated Service Network (VISNs). (Department of Veterans Affairs, n.d.).



The VHA was established in 1991, with the mission to give aid to veterans who had been disabled during active service in any branch of the military (Petersen, 2015). Today, these injuries are referred to as service-connected disabilities. Over the years, eligibility for VHA care

has been expanded to veterans who have non-service-connected disabilities as well as their families (Congressional Research Service, 2023). Overall, the mission of the VHA is to provide health care to veterans that improve their health and well-being (Department of Veterans Affairs, 2023). Beyond this, the VHA has other responsibilities including conducting medical research and training new healthcare professionals. Further, the VHA serves as both a backup to the Department of Defense (DoD) medical systems during national security emergencies and a national disaster medical system and assists in federal emergency response efforts (Congressional Research Service, 2023).

To ensure quality care is delivered to veterans, the VHA has created a variety of different facilities. These include; community-based outpatient clinics, community living centers, domiciliary, and veteran centers (Department of Veterans Affairs, 2023). Community-based outpatient clinics are designed to make access to healthcare easier. They are set up across the country and provide common outpatient services such as health and wellness visits. Currently, the VHA is looking to expand these centers into more rural areas to further increase accessibility to health care services (Department of Veterans Affairs, 2023). Community living centers are skilled nursing facilities that serve veterans with chronic stable conditions (i.e. dementia). A domiciliary provides a variety of care to veterans with a range of medical problems such as medical, psychiatric, vocational, education, or social problems (Department of Veterans Affairs, 2023). The key aspect of this type of care center is that veterans can receive their care in a safe, secure, homelike environment. Finally, veteran centers are places where veterans who served in combat zones can go to undergo counseling and outreach services. These centers are also available to families who are dealing with issues related to military service (i.e. the loss of a family member) (Department of Veterans Affairs, 2023).

To be eligible to receive care from the VHA, members of the military must transition from active duty to veteran status. Those who are still enrolled in active duty must find care through private health coverage or non-VHA public health coverage (Board on Healthcare Services, 2018). This is a long process that requires several important "handoffs" from the DoD-based providers to VA providers (Board on Healthcare Services, 2018). Due to the complications often experienced during this transition, many people are forced to face risks in their quality of care, relationships with care providers, and even pauses in treatment (Board on Healthcare Services, 2018).

After this process is completed, a veteran is placed into one of two eligibility categories: a veteran who is guaranteed care or a veteran who may be able to receive care as long as resources are available. Veterans that fall into the first category are those with service-connected disabilities, who have received either a Medal of Honor, or a Purple Heart, former prisoners of war (POWs), World War II veterans, and those who were exposed to toxic substances (Congressional Research Service, 2023). Veterans who fall into the second category have to go through a longer process to receive care. First, they must be enrolled in the VHA healthcare system which guarantees that they will pay no premiums, deductibles, or coinsurance. They are then placed into one of eight priority groups and wait to see if they will be able to get an appointment (Congressional Research Service, 2023). Some qualifications must be met for an individual to be considered a veteran which differs by state. In Massachusetts, if a soldier saw conflict, it is required that they have served for at least 90 days with one day during "wartime" and a last discharge or were released under honorable conditions (Commonwealth of Massachusetts, n.d.). In peace times, it is required that a person has served for 180 days and has a last discharge or was released under honorable conditions. Further, there are eligibility

requirements for any dependents of a veteran to receive benefits through the VA. Some of these categories include: the spouse, widow, widower of a veteran, anyone who acted as a parent of the individual for five years before they began their wartime service, and any children until their 19th birthday (Commonwealth of Massachusetts, n.d.).

If an individual is deemed eligible for a standard medical package there is a wide range of health care that they have access to such as gender-specific medical services, prescription drugs, prosthetics, sensory aids, long-term care, and social support services (Congressional Research Service, 2023). Beyond this, there are also many benefits not commonly seen in private health insurance packages including travel reimbursement for medical appointments, family caregiver stipends, homeless veterans programs, and dental. A whole health approach also exists, which provides acupuncture, mindfulness, tai chi, yoga, and other integrative health services (Congressional Research Service, 2023). As this list of benefits suggests, there are many differences between the benefits provided by the VHA and those that are included in private healthcare plans.

A key feature of the VHA is that all services are combined "under one roof". The systems are all interconnected and focused on giving specified care to veterans (Shulkin, 2016). One example of this is that while less than 50 percent of private practice primary care providers (PCPs) regularly screen for post-traumatic stress disorder (PTSD), the VHA employs specialists who routinely screen for PTSD related to military service (Shulkin, 2016). Further, less than 20 percent of PCPs have the cultural competence required to record and treat the military histories of veterans (Shulkin, 2016). These omissions in care are significant gaps for veterans, especially for those who have seen active duty in wartime. Research suggests that between 14 and 16 percent of veterans who served in Afghanistan or Iraq suffer from PTSD or depression. As of

2023, there have been 2.8 million active-duty members deployed to Iraq, Afghanistan, or other combat areas; this means in the past two decades there have been between 392,000 and 448,000 who have been affected by these very serious mental health issues (Inoue et al., 2023). Because of this, it is crucial that when veterans receive any kind of health care, they are cared for by people who are well-versed in these issues.

According to a nationwide Medicare survey, veterans rated the quality of care they received at VHA hospitals higher than that at private healthcare facilities (Lawrence, 2023). This is why the issue surrounding wait times is such an important topic. According to one study, looking at hospital cases from 2012-2017, VHA hospitalizations had a lower probability of mortality for older patients compared to those in non-VHA hospitals (Chow et al., 2023). Further, when investigating serious mental illness cases throughout this study, VA hospitals had 1,989 and 1,792 cases of comorbidity respectively for younger (less than 65 years old) and older (over 65 years old) patients. This compares to non-VHA hospitals which had 3,928 and 6,283 cases of comorbidity in serious mental illness cases for younger and older patients respectively (Chow et al., 2023). The care that the VHA provides is incredibly necessary, and yet there are many barriers veterans must face to gain access to this health care.

History of the Veteran Healthcare Administration

The beginning of veteran healthcare started with the creation of President Lincoln's authorization for the National Home for Disabled Volunteer Soldiers (NHDVS) in March 1865 (Petersen, 2015). This was created to provide medical care to Union and Navy veterans (Petersen, 2015). The slow expansion of care for veterans would occur, with key legislation in 1920 allowing the government to pay for veterans to get private care, drastically improving access to healthcare (Petersen, 2015). Due to U.S. involvement in World War II, the government

sought to drastically expand the institution in 1945. The Department of Medicine and Surgery would be signed into public law, which would allow the VA to retain and recruit medical personnel, conduct studies, and create VA hospital affiliations (Petersen, 2015). This new system of care allowed the government to help address many of the concerns and medical conditions that veterans experienced after World War II (Petersen, 2015). The new department would lay the foundation and framework for modern-day American healthcare.

The next major influx of veterans needing healthcare access would occur after the Korean and Vietnam wars (Marmar et al., 2015). Roughly 30 percent of all Vietnam veterans would experience PTSD whether it be from what they saw or the actions they took (Marmar et al., 2015). After the war, it took veterans years to receive care given the mass influx of need. Although veterans were putting claims forward, years of research and debate around the subject would delay care for many veterans who were exposed to the toxic and cancerous chemical known as Agent Orange (Panangala & Shed, 2014). One book titled *Born on the Fourth of July*, would become a rallying cry and representation of Vietnam veterans' experience in the healthcare system (Patrick, 2022). The author, Ron Kovic, accounts his experience at a Brooklyn VA hospital with unresponsive nurses and veterans in pain unable to receive the care they needed (Patrick, 2022). The sheer number of veterans at facilities like the one in Brooklyn led veterans, like Ron Kovic, to advocate for an improved veteran healthcare system (Patrick, 2022). Many veterans would attach to his story and create a movement around improving healthcare access and quality for veterans.

Inaccessible healthcare would define much of the early years of veteran healthcare expansion but would begin to shift after renaming the organization to the Veteran Healthcare Administration (VHA) in 1991 (Petersen, 2015). Much of the success during this period was

attributed to the leadership of Kenneth Kizer, who was named Under Secretary of the VHA in 1994 (Payne, 2012). The Under Secretary is often a physician who is responsible and in charge of implementing and overseeing new changes to the healthcare system (Payne, 2012). During his five years of holding the position, he implemented major changes. First and foremost, he created Veterans Integrated Service Networks (VISNs) which originally broke the VHA system down into 22 different regions where resources and decision-making were delegated to the leader of VISN (Oliver, 2007). This made decision-making local and more responsive, avoiding the blanket level decision-making which prevented many facilities from adapting to local needs (Oliver, 2007). A second major change Kizer implemented was reducing the number of inpatient beds the VHA provided (Payne, 2012). At the time, the VHA was an aging population, with a large number of open beds, so he decided to restructure the clinic by expanding the number of community clinics and making sure every veteran had access to a primary care physician (Payne, 2012). Community clinics allowed for a low-cost way for many rural veterans to receive dental, medical, and mental health needs (Oliver, 2007). Under his leadership Kizer made sure that each VISN got funding based on the resources needed and the growing veteran population in each population, setting a precedent that the VHA still uses today (Oliver, 2007).

As a result of the work of Kenneth Kizer, the VHA would begin to outpace all other hospitals in the nation. A major study in 2000 found that VHA care outpaced Medicare patients' care in 12 out of 13 categories regarding quality of care for patients (Jha et al., 2003). During this same period, the VHA would launch Vista, one of the first comprehensive Electronic Medical Record (EMR) software (Oliver, 2007). Kizer would invest millions into expanding and improving the database, allowing providers to go back throughout a patient's healthcare experience to see which procedures had the best overall outcome (Oliver, 2007). The program

became so effective that other versions are in place in Egypt, Mexico, and other healthcare systems in the United States (World Vista, n.d.). The benefit of an electronic healthcare system would help streamline the scheduling process and improve the coordination of care at the VHA (Oliver, 2007).

Due to the successes of the VHA, the organization was able to develop a positive image. Even with the positive image, transparency, and honesty were key amongst VHA leadership. Despite political consequences, Kizer emphasized transparency and would even go on to report to Congress that the VHA was responsible for 700 preventable deaths (Payne, 2012). This emphasis on transparency for patients would go on to help create standards for veterans' wait times and increase healthcare options for all veterans (Payne, 2012). Kizer and the VHA hoped that this would position the VHA for a better and more transparent future (Payne, 2012). However, due to the influx of veterans filing claims for care during the Afghanistan War, the administration experienced an extreme demand in the early 2000s, which the organization was not prepared to address (Himmelstein et al., 2007). In a memo in 2002, the Undersecretary of Health stated, "Demand for healthcare exceeds our resources" (Himmelstein et al., 2007). During the early 2000s, the VHA would begin requiring wait times to be below 30 days (Office of Inspector General [OIG], 2005). As a result of unrealistic standards and increasing demand as the war in the Middle East raged on, facilities began misreporting wait times to avoid any administrative backlash (OIG, 2005). A 2005 report, done by the Inspector General, found that the VHA was putting veterans on so-called secret paper lists to hide the long wait times veterans were experiencing (OIG, 2005). Continued failures to address the problem, would be attributed to poor leadership and the growing need as war in the Middle East expanded (OIG, 2007).

False reporting would be a key problem seen with the VHA, creating a stark difference from the data that the VHA released from the actual lived experience of veterans. The problem would return to the public's eye after a Governmental Accountability Office (GAO) report in 2014 described inconsistent scheduling practices and centers that knowingly underreported wait times (Government Accountability Office [GAO], 2014). During that same year, CNN reported the deaths of 40 veterans which were linked directly to long wait times and the incorrect reporting of the Phoenix VA Hospital (Bronstein & Griffin, 2014). The hospital held a secret wait list, which included individuals who had failed to receive any sort of access to care for months. What followed were extensive senate hearings and the passing of a policy known as the Veterans Choice Act of 2014. The Veterans Choice Act officially established the Veterans Choice Program (VCP), which allowed veterans to visit providers outside of the VHA facilities if: they lived more than 40 miles away from a VAMC, faced an excessive burden due to traveling, told they could not schedule an appointment within 30 days, or must travel by boat or air for an appointment ("Veterans Access," 2014). Obama's administration said the stated goal was to help veterans gain access to care and reduce fraud associated with VHA healthcare (Branchley, 2014). The creation of this new program was intended to increase healthcare access, by reducing wait times and minimizing the long journeys veterans were taking for appointments (Branchley, 2014).

Despite the passing of the Veterans Choice Act, veterans would continue to struggle to receive accessible healthcare (Commission on Care, 2016). During the program's tenure, the program was studied extensively by the Commission of Care. The commission, which was established in legislation of the Veterans Choice Act, was responsible for studying the initiative and reporting on the impact of the legislation (Commission on Care, 2016). The Commission of

Care held forums, created an Assessment Report of the VHA, made visits to healthcare facilities, and listened to veterans and healthcare workers (Commission on Care, 2016). What the commission found was that implementation of the program was flawed in both implementation and design, with many VHA facilities being unable to address wait times to avoid lengthy wait times (Commission on Care, 2016). From 2015 to 2016 there were 70,000 more appointments which took veterans more than a month to receive (Commission on Care, 2016). A lack of a standard referral processing time and missing data would lead to the VHA being unable to understand whether the program was beneficial for veterans.

During the election of 2016, healthcare defined a lot of the debate around policy. Senator Bernie Sanders ran on Medicare for All, while Trump promised to get rid of the Affordable Care Act to the bare bones when he entered office (Sicard, 2016). The VHA was not shielded from this debate as given the cornering findings in 2014 and 2016, the debate around veteran's healthcare was a key policy concern for many (Sicard, 2016). Some like Ben Carson wanted to privatize it completely, while others like Bernie Sanders cautioned against privatization due to the effectiveness of VHA care and support for it amongst major veteran organizations (Sicard, 2016). Donald Trump would be one of the few candidates to run on both ideas with the basis of allowing veterans to choose between the private sector and the VHA (Sicard, 2016). In his view, veterans should choose wherever they view as the best option and the government should pay the bill either way (Sicard, 2016). The overarching debate would help create political will for a much-needed change, in hopes of improving timely and accessible care for all veterans.

Background

For the purposes of this paper, it is important to outline how different standards of healthcare will be measured. Accessible healthcare will be considered as that which provides a wide range of coverage, multiple services, timely provisions, and a high-quality workforce (Agency for Healthcare Research and Quality, 2018). The standard for timeliness is more difficult to generally define due to the range of issues an individual may be facing. If a patient is in an emergent situation, the timeliness would need to be immediate. The VHA standard specifies that the average number of days a new patient should have to wait for an appointment to occur should be less than 20 days for primary care and mental health and 28 days for specialty care from the date of the request (GAO, 2023d).

How the VHA has measured appointments has evolved over the years. Before 2014, the VHA measured wait times for new patients based on the date the appointment was created to the date of the actual appointment (OIG, 2022a). As a result of these policies, the wait times would fail to show the time it took to schedule the appointment or delays in appointment creation. During 2014, in conjunction with establishing VCP, the VHA began measuring wait times based on the preferred date or the clinically indicated date (OIG, 2022a). This meant appointment wait times would start when a provider deemed it necessary to have an appointment. Similar issues would occur with this policy, such as if providers took their time to respond to new patient requests the wait times would not show the total wait time. To fix this, in 2016, the VHA would begin the start point on the day of a consultation or referral placement to the day the appointment would occur, in hopes of addressing many of the shortcomings related to the VHA's previous measurement (OIG, 2022a). The VHA continues to work on this methodology, as VHA facilities have reported continued use of measuring wait times with older methodologies (OIG, 2022a).

In the past, attempts have been made to use legislation to solve the problem of wait times, or the amount of time it takes to see a doctor, within the VHA. One key bill that has been passed to meet this goal is the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act (MISSION Act) of 2018 ("VA MISSION Act," 2018). This bill was passed with the support of former President Trump who campaigned with a VA reform package that included allowing veterans to get care from any provider that accepted Medicare if they showed their identification card (Reed, 2015). The MISSION Act helped to improve recruitment of physicians, telehealth across state lines, and expanded access to care outside the VHA through a comprehensive Community Care Program ("VA MISSION Act," 2018). These new requirements would drastically expand VCP, by allowing veterans to choose based on the patient's best medical interest. After the passing of the Veterans Choice Act in 2014, 1.3 million veterans received care outside the VHA and by 2021 that number was above 2.3 million veterans ("Veterans Community Care," 2021).

Of the many different facets contained in this legislation, one of the main purposes was to reduce wait times by consolidating the Veterans Choice Program (VCP) to create the Veterans Community Care Program (VCCP) which expanded eligibility for veterans (Table 1) (Edwards, et al., 2023). The VCCP allows veterans to seek care through non-VHA healthcare providers if the VHA does not offer the medical care a veteran needs, if there is no complete VA medical center in the state, or if the individual is eligible under the Veterans Choice Program (VCP) criteria (the eligibility requirements for VCCP can be found listed in Table 1). The eligibility criteria for VCP are very similar to that of the VCCP in that getting to the nearest VA medical facility would require an extensive travel period for an individual. One key difference, however,

is that under the VCP there must be over a 30-day wait to get an appointment at said nearest facility (Hamilton, n.d).

The problem of wait times has become a more serious topic in recent years. Attention was drawn to it due to multiple Government Accountability Office reports, which talked about the lengthy scheduling practices and lack of set standard for Community Care (GAO, 2023c; GAO, 2023d). To understand how these problems relate to lengthy wait times, it is important to understand the process of making an appointment. First, a veteran must submit a request or referral to a VA center (either a VA facility or a Community Care center). This submission goes under review to make sure that the veteran is eligible to receive care. If it is determined that the individual is allowed to receive care from the facility, communication is opened to discuss schedule preferences, and an appointment is set (GAO, 2023d). This creates authorization for the veteran to receive care within the VHA system. However, after three to 12 months, this authorization expires. This means that if an individual needs care for a longer period of time, they must go through this entire process again (GAO, 2023d).

Many different studies have been conducted to test the impact of an expanded VHA health network. Though they tested different parameters, the following studies listed are similar in that they found that wait times consistently exceeded the 30-day maximum required under the VCP. One study from the Journal of General Internal Medicine analyzed the impact of the Community Care Network (CCN) on wait times (Edwards et al., 2023). From 2019 to 2020, they found that of the 54,358 community primary care appointments made, 25 percent were within the CCN. The demographic makeup of the individuals seeking care was a majority white male in rural areas without convenient access to a VA primary care facility. The study concluded that the introduction of the CCN increased wait times by an average of 33.7 days. Further, when

specified to rural areas, the wait times increased by 36.6 days after CCN implementation (Edwards et al., 2023). This shows that the expanded VA network was acting inversely to what was hoped when the MISSION Act was written.

A second study analyzed the impacts of the MISSION Act on primary care as well as mental healthcare. As a part of the MISSION Act, it was decided that if veterans can not find mental healthcare through a VHA facility within 20 days of the request, they can seek help within their community. The previously mentioned study, published by the JAMA Network, found that out of the 588,503 appointments pertaining to mental health care that were made through VHA clinics, the average wait time was 33.6 days. Through the non-VHA clinics, the average wait time was much longer at 43.9 days (Asfaw et al., 2022). In recent years the prevalence of mental illness and substance use in veterans returning from service. These illnesses often include PTSD, depression, and anxiety; which can often be experienced alongside substance abuse (Kline et al, 2022). Approximately one-third of those affected by these disorders do not get the help that they need (Kline et al., 2022). The impacts of mental illness can be catastrophic, especially if left untreated. According to the 2023 National Veteran Suicide Prevention Annual Report from the VA, in 2021 there were 6,392 suicides committed by veterans, an average of 17.5 per day (Office of Mental Health and Suicide Prevention, 2023). These statistics show how critical it is that veterans have easy access to mental health.

Because the MISSION Act was passed just five years ago, it is difficult to claim whether or not it has been a success. Especially, when one considers the unexpected obstacle that was COVID-19. However, the VHA must continue working towards solutions to reduce wait times and increase accessibility for veterans. The VHA provides crucial healthcare that veterans rely on to heal injuries and illnesses that they attained while serving the country. Providing care for

these citizens is essential. This paper hopes to make suggestions as to how veterans can gain easier access to healthcare by identifying the root causes of inaccessible healthcare and providing solutions for the VHA to address them.

Table 1

VA MISSION Guidelines for Community Care (Department of Veterans Affairs, n.d.b)

1. Veteran Needs a Service Not Available at a VA Medical Facility
2. Veteran Lives in a U.S. State or Territory Without a Full-Service VA Medical Facility
3. Veteran Qualifies under the "Grandfather" Provision Related to Distance Eligibility for the Veterans Choice Program
4. VA Cannot Furnish Care within Certain Designated Access Standards
    a. Average Drive Times
        i. Thirty-minute average drive time for PCP, mental health, and institutional care services
        ii. Sixty Minute average drive time for specialty
    b. Appointment Wait times
        i. 20 days for PCP, mental health, and non-institutional extended care
        ii. 28 days for specialty care from the date of request
    c. Twenty days from the date of request for primary care, mental healthcare, and non-institutional extended care services, unless the Veteran agrees to a later date.
    d. Twenty-eight days for specialty care from the date of request
5. It is the Veteran's Best Medical Interest
6. A VA Service Line Does Not Meet Certain Quality Standards

Method

The current paper used a mixed method analysis to understand the struggle to untimely and inaccessible veteran healthcare. In preliminary research, it was found that data around metrics regarding wait times, scheduling times, and hiring process have had reliability and validity concerns (GAO, 2023a; GAO, 2023b). Reports done by the OIG and GAO would note that inconsistent measurement throughout given VHA facilities led to some misleading data points around wait times, physician shortages, and referral scheduling (GAO, 2023b; GAO, 2023c; OIG, 2023b). As a result, it was crucial to bring in other private studies and qualitative research relating to inaccessible care to get a complete understanding of the severity and significance of the problem. The qualitative data would help create a better understanding and show why there is a disconnect between what the VHA is reporting and what veterans and physicians are experiencing within the institution. Investigative pieces were brought in to help show the impact of many of the policies in which government reports and testimony were found. Since the issue of veteran healthcare is very emotional and personal, the solutions and challenges are grounded in government reporting and testimonies. These reports are key to reporting on VHA healthcare as they provide complete access to data, personnel, and strategies to implement VHA healthcare. Although the VHA has become more transparent, many policies or metric scales are still only available to those working within the organization. As a result, these reports and government testimonies provide a firm grounding to analyze the problem and help to understand the struggles and lived experiences of what is being reported, regarding qualitative data. Given the complexity of the topic, a mixed-method approach allowed us to paint a clearer picture of the veteran experience and VHA struggles and success.

Challenge

A lack of accessible care for veterans is a key challenge that the organization is seeking to address. Access to healthcare has been defined as, "the timely use of personal health services to achieve the best health outcomes ("Access to Care", n.d.). Factors such as wait times, driving distances, telehealth availability, and patient satisfaction, have been used to understand whether care is accessible. The VHA has focused on wait times as the primary factor to understand whether healthcare is accessible for veterans (Asfaw et al., 2022). Its most recent reporting had veterans receiving care through the VA at a wait time of 28 days and 35 days for VCCP appointments (Asfaw et al., 2022). The current goal is to decrease both VHA and Community Care appointment wait times, all while improving patient satisfaction by 10 percent (Peabody et al., n.d.). Challenges around the reliability of data, lengthy hiring process, poor policy implementation, and the large rural demographic all contribute to the challenge of providing accessible and timely care for veterans. The MISSION Act aimed to increase the accessibility of care for veterans, but due to shortcomings of the act, coupled with failed VHA policy and challenging veteran demographics, the VHA has struggled to meet its goals of increasing accessibility for veterans (Veterans Association, 2018).

The return to civilian life is often burdensome, due to new responsibilities, lack of community support, and lost purpose (Morin, 2011). This is why 44 percent of veterans who returned home from the War in Afghanistan and Iraq described the experience as difficult (Morin, 2011). According to one study, navigating the healthcare system was also seen as a contributing factor to a difficult retirement (Cheney et al., 2018). Veterans also noted the long distances to appointments, the stigma associated with mental health, and a lack of understanding of available healthcare options as key reasons why they struggled to access healthcare (Cheney et

al., 2018). The realm of veteran healthcare is confusing for many and there exist concerns among veterans that if they seek mental healthcare, they could lose their jobs, benefits, or even visitations of their family (Cheney et al., 2018). Specifically, patients with PTSD are worried that a diagnosis could cost them their clearance or impact future employment (Cheney et al., 2018). This is a major reason why estimates vary for those with PTSD in the military from 10 to 30 percent of all veterans (Kintzle et al., 2018). Due to the fear, inaccessibility, and struggles associated with veteran healthcare, recent research has found that 56 percent of veterans who likely have PTSD do not receive any sort of mental healthcare (Ranney et al., 2023). Veterans are at higher risk for mental health disorders such as PTSD, depression, and anxiety, which contributes to about 109 veterans dying from suicide each day (Department of Veterans Affairs, 2022). Without proper access, it only furthers the rate of death and leaves many veterans' health concerns untreated.

One of the unique struggles of the VHA is that they must find ways to serve all veterans throughout the country. This includes the over 2.8 million rural veterans who receive care through the VHA every year (Office of Research, n.d.). The MISSION Act intended to use rural hospitals and clinics to address the VHA's access concerns for rural veterans (Albanese et al., 2020). Specifically, the VHA saw, each year, that rural veterans drove longer for appointments and on average across specialties waited longer (Albanese et al., 2020). To address this, they would rely heavily on rural physicians outside of the VHA network. Concerns around over-reliance would occur, due to the subsequent closing of over 136 rural hospitals and continued concern of over 500 on the verge of closing (American Hospital Association, 2022; “Rural Hospitals,” 2024). Although there are benefits to relying on outside physicians, only 11 percent of physicians operate in rural communities (Isaacs, 2019). This is why studies found that

counties that were 40 miles away from the nearest facility had a 37 percent greater chance of using VHA healthcare (Ohl et al., 2018). Given the lack of infrastructure and funding for rural hospitals and clinics to address rural shortages, many rural veterans are driving longer distances for appointments (Isaacs, 2019; Ohl et al., 2018). One study found that rural veterans were traveling an extra 14 million miles for appointments because their nearest VHA facility did not have the needed specialties or resources to address a given patient's issues (Hahn et al., 2023). For rural veterans' transportation and distance were seen as the main barriers to accessible care for veterans (Buzza, 2011).

Another problem is appointments in the private sector have also been seeing an increase in inaccessibility. The average wait time across five specialties was reported to be 26 days, which is an increase of 24 percent since 2004 (AMN Healthcare, 2022). In specialties in which the VHA has struggled to meet demands, such as mental health, Community Care was also seen to have longer wait times in the private sector (AMN Healthcare, 2022). The COVID-19 pandemic would worsen mental, physical, and financial well-being, especially among rural veterans (American Psychological, n.d.). The ripple effect of the pandemic made it hard for veterans to receive accessible care because veterans were being forced to wait 34 days for a VHA appointment in mental health and 44 days for an appointment in Community Care due to the massive influx of mental health needs (Asfaw et al., 2022). Despite the MISSION Act's focus on addressing rural concerns, there still exists a high need to focus on rural concerns due to the lack of comprehensive policy around addressing rural healthcare concerns.

With growing healthcare needs amongst veterans, the VHA continues to struggle to track how long veterans are waiting for a given appointment. Inaccurate data has historically contributed to the struggle for accessible care with inaccurate data scandals occurring in 2005

and 2014. Similar findings of inaccurate data would occur between 2019 and 2021, with an Inspector General report stating the inaccurate ways in which the VHA was gathering wait time data (OIG, 2022a). A major reason for this was a lack of clear communication about how to measure wait times. In the Inspector General's report, they found that facilities were using different methodologies to measure wait times (OIG, 2022a). Some starting points in VHA facilities were when the doctor put in the referral and others were when the appointment was created by a scheduler. In one example, they found that appointments taking 29 days to be scheduled were being viewed as quick appointments because the wait time measurements did not include the time taken for an appointment to be scheduled (OIG, 2022a). There was no intent for the VHA to mislead patients, but without major changes, the organization would continue to fail to provide transparent and accurate information regarding wait times (OIG, 2022a).

Failure to set realistic standards and collect accurate data has been a challenge the VHA has dealt with for years. In 2018, the Inspector General recommended setting average wait times for VCCP appointments and VHA appointments as a way of providing veterans with up-to-date information on how to get the quickest appointment (GAO, 2020). Since the MISSION Act did not require standards that the VHA had to meet, it took until 2023 for the VHA to establish a comprehensive standard for VHA facilities. Community Care appointments still do not have standard wait time measurements that facilities must meet (GAO, 2023b). Due to the lack of a clear standard and oversight around VCCP wait time, veterans are either not given information about wait times or are given estimates based on physician experience with a given clinic (GAO, 2020). Since there also exists a variation among different specialties, having incomplete data makes it hard to take the more targeted approach of addressing specific specialty shortages. With the lack of standard metrics and ways to reduce VCCP wait times, staff report feeling unable to

have any control over the process (GAO, 2020). This is a major shortcoming of the MISSION Act as it only states the vague language of scheduling patients in a timely manner, leaving room for interpretation from the VHA and Community Care providers (MISSION Act, 2018).

When considering the root cause of inaccessible care, reports by the Inspector General point to VHA's own policy implementation (OIG, 2023b). A policy known as the VHA Patient Referral Coordination Initiative (RCI) is one example of the VHA's struggle to effectively implement administrative policy. The goal of the initiative was to streamline the referral processing system, allowing qualified medical professionals as part of a Referral Coordination Team (RCT), to make decisions about where to send patients and the options that were available to veterans (OIG, 2022c). The initiative had positive intentions with the hopes of relieving the administrative burden, which was negatively impacting physician job satisfaction and contributing to burnout (Salyers et al., 2013). However, the outcomes of the initiative have had side effects contributing to the ongoing struggle for access. Guidance within the RCI puts financial responsibility on the RCT to make financially responsible decisions (OIG, 2022c). Making decisions around Community Care based on a financial aspect, rather than focusing completely on the quality and accessibility of care. This guidance from the VHA challenges legislation in the MISSION Act, as it allows the RCI to deny care to Community Care if they do not view it as a smart financial decision. Even if the appointment in Community Care is seen as better quality and more accessible, the RCT has been given the power to overrule a given healthcare decision (Castellano, 2021).

Functionally the creation of the RCT puts greater decision-making in the hands of administrators and nurses, rather than the patients' provider. An investigative news outlet out of San Diego, called inewsource, reported the San Diego VHA blocked requests for care because

they did not make fiscal sense (Castellano, 2021). They would use Christine Russell's experience to highlight the impact of the new administrative policy (Castellano, 2021). Despite her doctor's advice and the success of the cancer treatment, the VHA could provide better care and blocked her from accessing her Community Care provider (Castellano, 2021). The ease of access to outside care therefore is challenged by the new initiative and goal of making financially responsible decisions (Castellano, 2021). The Inspector General found major problems with this new policy for several reasons, including insufficient staffing and resources, unreliable data for Community Care wait times, and a lack of required training (OIG, 2022c). A problem found in the Inspector General's investigation was there was no data on the reduction in administrative burden or whether it was leading to quicker scheduling and improved coordination with the VCCP (OIG, 2022c). Despite the positive intent of the initiative, given the fiscal responsibility and lack of clear improvement in referral processing, the policy has failed to increase access to veteran healthcare (OIG, 2022c).

Due to the long referral process and failed administrative policy, the administrative burden and scheduling process continue to impact accessible care for veterans. The GAO in its most recent report stated, "VA has faced long-standing challenges with scheduling [Veterans Health Administration] facility and Community Care appointments as well as ensuring veterans' timely access to care" (GAO, 2023d). In reviewing 21 VAMC facilities, the GAO found that it was on average taking longer than 30 days to schedule an appointment in Community Care (GAO, 2023d). Given the long scheduling time for Community Care, the VHA would seek to shift from the goal of 21 days to seven days. What was harmful about this approach was the VHA gave little to no rationale and in recent reports only 40 percent of VAMCs met the goal half the time (GAO, 2023d). Since the burden on schedulers and physicians has not been

effectively addressed, the GAO believes that these standards may not be possible for facilities to meet (GAO, 2023d). The standards, although beneficial, are not seen to be realistic and the GAO believes that it will further contribute to a long scheduling process (GAO, 2023d).

Another reason the VHA needs to have reasonable goals in terms of scheduling, is general administrative staffing shortages are creating an extra burden on schedulers. Specifically, amongst staffing Community Care positions such as Medical Support Assistants (MSA), who are responsible for tracking, reviewing, and responding to referrals and orders to patients (OIG, 2023b). Since the VHA has failed to fully implement the RCI, MSAs tend to be the ones responsible for processing referrals and scheduling timely appointments. Due to the low pay and immense burden of navigating Community Care 94 percent of VISN managers noted the difficulty in hiring for the position, with 100 percent of them saying it is hard to retain those workers (OIG, 2023b). The VHA has failed to address the issue as the Inspector General found that facilities were misrepresenting the number of MSAs and staff they had by including those who train MSAs or who may work in Community Care (OIG, 2023b). Given the reported burden and increasing caseload because of the MISSION Act, the position is currently experiencing an 11 percent turnover rate (OIG, 2023b). The high turnover rate of vital scheduling positions has led to longer scheduling times and a greater burden on overstaffed MSAs (OIG, 2023b).

Beyond a lack of schedulers, a lack of physicians has also been seen to contribute to untimely access to healthcare. Due to worsening health outcomes and 35 million canceled appointments related to the COVID-19 pandemic, a multitude of specialties have struggled to meet veteran health care needs (American Psychological, n.d.; OIG, 2022d; OIG, 2023c). In the Fiscal Year 2022, out of the 139 facilities surveyed, each facility had at least one occupational shortage (OIG, 2023c). There was a shortage of nurses at 92 percent of the facilities and a

shortage of psychologists at 73 percent of the medical facilities (OIG, 2023c). This shortage has also been seen to increase caseload, administrative responsibilities, and lack of support (Leung et al., 2023a). The shortage has contributed to the increasing burnout of 35 percent of VHA physicians (Leung et al., 2023b). Due to the shortage of physicians going into primary care, gastroenterology, and other fields like psychology, there exists concern in private healthcare that there will not be enough physicians (OIG, 2023c). By 2036, the Association of American Medical Colleges (AAMC) predicts that the United States will be short 86,000 physicians in the United States (Association of American Colleges, 2024). The MISSION Act fails to address the sheer lack of physicians and instead offers 50 scholarships annually to help pay for physicians' schooling (Byrne et al., 2022). In the MISSION Act, the primary focus on physicians was to expand dental scholarships, with a lack of comprehensive legislation around meeting high-need specialties. As physician numbers fail to meet demand, it is expected that veterans in rural regions and those in high-need specialties such as mental health will continue to experience access problems.

Issues around data collection and accurate tracking have also been seen to plague the hiring process. Reporting done by the GAO found that a multitude of VHA medical facilities did not accurately track the onboarding process (GAO, 2023c). Human resource (HR) staff admitted to not using the system that tracks the onboarding process known as USA Staffing (GAO, 2023c). The study found that VISN admitted to not knowing the policy around implementing dates into the system and at times facilities would implement their own systems to track the hiring process (GAO, 2023c). Overall, the investigation found a major weakness in tracking the onboarding process, leading to a lack of clear information on whether the new process was improving hiring speed or whether in some cases slowed it down (GAO, 2023c). This

administrative failure regarding compiling clear information makes it hard for both the HR staff to efficiently hire new people and those looking to be hired (GAO, 2023c). Physicians who have done their residency through the VHA have noted the lack of communication and support those new hires received (Moldestad et al, 2022). One resident said the process of being hired took months and they received little to no communication from HR (Moldestad et al., 2022). Communication was seen to be a big driver for why some residents were pushed away from starting a career at the organization (Moldestad et al., 2022).

Another problem associated with the hiring process relates to the length of the hiring process. A review done by AMN Healthcare, one of the largest healthcare consulting firms, found that the VHA was losing qualified applicants due to its lengthy hiring process ("Hearing on VHA," 2023). They noticed, despite claims of a quick hiring process, that the VHA often took 6 months for clearance on hiring a candidate ("Hearing on VHA," 2023). Since the VHA needs approval from so many different members to hire someone, the process is much longer than that of the private sector ("Hearing on VHA, 2023"). The process to even begin the hiring process has also led to major delays in hiring (Craven & Gordon, n.d.). Unlike the private sector, the VHA is unable to proactively start its search and hiring paperwork until after a physician leaves the clinic (Craven & Gordon, n.d.). All these initial barriers to hiring an employee make it hard for clinics to fulfill positions and contribute to a strenuous hiring process. Due to drug testing and extensive background checks, facilities are expected to hire new employees within a 120-day time frame (GAO, 2023c). This standard reveals a position can go months without a physician, further extending wait times for veterans and worsening the workload on already burdened physicians.

When looking at the issue of access for veterans it is clear that a multitude of factors create a struggle for timely and effective care. It is not one thing that leads to the continued failure to meet the standard, but instead continuing failures in areas like administration. Failures related to slow hiring, slow referral processing, and slow scheduling, all contribute to the struggle for timely and accessible healthcare. The VHA has made noticeable strides in trying to address the issue by emphasizing telehealth appointments. Telehealth is defined as the use of electronic information and telecommunication to provide care when the patient and provider are not physically in the same location at the same time (Gajarawala & Pelkowski, 2021). They have tried to implement new initiatives to address the lack of accessibility, especially for rural veterans. A key initiative to address the problem was The Digital Divide Consult, which involved VHA officials helping veterans gain internet access to help expand telehealth options (OIG, 2023a). However, like the RCI and Reboot Initiative, the Inspector General found in their investigation that physicians and patients were not aware of these options (OIG, 2023a). As a result, 42 percent of rural veterans still lack home internet access (OIG, 2023a). This is a reason why there is such a massive disconnect between the VHA and their patients. The VHA has announced a multitude of initiatives stating the benefits of their ability to reduce physician burnout, improve telehealth access, and increase scheduling (OIG, 2023a; OIG, 2022c). However, veterans and physicians are not experiencing the benefits of these programs. This points to an overarching problem with the VHA, as despite new initiatives being implemented key stakeholders are not feeling their impact.

A major concern for inaccessible care is how it impacts veterans long-term. In terms of health outcomes, waiting for appointments has been seen to worsen health outcomes for those in poorer health and those considered elderly (Pizer & Prentice, 2011). Also, delay in care was

associated with decreases in utilization of care, with research finding that inaccessible care pushes individuals away from getting care (Pizer & Prentice, 2011). Since the pandemic, research on the subject has shown that for over 9,000 citizens who skipped health care due to the pandemic, 1 in 3 would experience worse health outcomes (Gonzalez et al, 2021). As more and more veterans choose to defer care, it will contribute to worse health outcomes and lead them to consider other options outside the VHA which impacts long-term funding. However, options outside of the VHA are limited as one survey showed that nearly two million veterans went without needed health care due to the high cost of insurance (Gaffney et al., 2019). Although private insurance may be feasible for some, researchers from Stanford and UC Berkeley found that for veterans dually enrolled in VA and private insurance, those who used VA healthcare found a 46 percent reduction in 28 day-mortality (Chan et al., 2023). This means veterans were far less likely to die 28 days following the incident, showing the benefits of VHA care and the importance of making it accessible. On top of the health outcomes, it was also on average 21 percent cheaper than private care, meaning that access to VA healthcare not only leads to better health outcomes but is also cheaper in terms of government spending (Chan et al., 2023).

Solutions

In hopes of combatting the poor and skewed data on wait times from the VHA, two Senators, Ossoff (GA-D) and Rick Scott (FL-R), announced a new bipartisan bill, the SCHEDULES Act, or Scheduling for Community Health and Easy Data to Understand for Legislators to Evaluate Services Act of 2024 (SCHEDULES Act, 2024). It aims to implement wait time standards for all VHA appointments, including Community Care, and to allow veterans to have more insight and transparency into when their appointments will be scheduled (Ossoff,

2024). Senator Rick Scott is a Navy veteran and son of a World War II veteran, so he understands first-hand the sacrifices that veterans make and why advocacy surrounding veteran medical care is crucial (Scott, 2024). The bipartisan bill is sponsored by organizations such as the Blinded Veterans Association, Paralyzed Veterans of America, the Wounded Warrior Project, and Disabled American Veterans (Ossoff, 2024). The bill, introduced in January 2024, requires the VHA to submit both a quarterly and annual report to document their success or failure in meeting the established time standards and would also publicly rank VAMCs on how well each facility met standards. The SCHEDULES Act is currently still in the introduced status, as the Senate has read the bill twice and referred it to the Committee on Veterans' Affairs (SCHEDULES Act, 2024). As the VHA has trouble giving clear data on wait times and how they should be measured, increasing transparency will assist in data being more readily available and effectively used.

Through the SCHEDULES Act, a standard for measuring community care wait times could be established, as one is not in place currently (GAO, 2023d). If data is being tracked and reported more consistently, then VHA medical facilities can internally monitor success and relay this information to employees and patients regarding how long wait times tend to be. Additionally, accurate data on wait times would allow for effectiveness to be measured surrounding wait time policies. By requiring reports from each VHA facility on accurate wait time data, this bill can also help the VHA establish a more realistic wait time standard at VHA hospitals, as the current standard of 20 days for primary care and 28 days for specialty care continues to not be met (GAO, 2023d). Obtaining accurate data that can be analyzed from VHA facilities will allow VHA personnel to strive for efficiency and offer timely access to care (Wavetec, 2024). Even with a lack of support in the VHA, the legislation would enforce facilities

to be successful in ensuring quick appointment scheduling, which is a major problem that the GAO and Inspector General have noted (GAO, 2023b). As a result, veterans would no longer have to wait longer than 7 days to just know when they would be seen by their provider.

According to the GAO, in 2022, it was outlined that Community Care appointments were to be scheduled within seven days, but the VHA must analyze this standard for Community Care appointments to consider if it is feasible (GAO, 2023d). Referrals for Community Care appointments come from a veteran's primary care provider, and there must be an established comprehensive wait time standard for community care. The GAO found that the VHA did not have timeliness standards for community care on how many days until the actual appointment occurs, only standards in place for the time between referral and setting up the appointment (GAO, 2023d). Having a maximum wait time standard has been seen to be effective in reducing wait times for countries serving a similar number of citizens (OECD, 2020). For example, in Finland, before the introduction of maximum wait times for mental health care appointments, only 85% of patients were being seen within 90 days (OECD, 2020). After the implementation of the new standard 93% of patients would be seen within the 90-day standard in 2018 (OECD, 2018). Finland is not the only country that experienced the benefits, as Denmark, Canada, and Lithuania all saw a decrease in wait times as a result of implementing maximum wait times (OECD, 2020). A major reason for the benefit of this approach is that maximum wait times are seen to create administrative change and drive improvements to those facilities that are not meeting a given standard (OECD, 2020). To accurately know the wait time for a veteran to receive care, the VHA must craft a wait time standard for Community Care appointments that measures wait time from the time of the referral to the actual appointment date, so that the wait time encompasses how long a patient waits to get care and see their provider. Having a

comprehensive wait time standard will help the VHA to both address given specialties and drive administrative changes and innovation to address given issues that are preventing a given facility from meeting the standard.

One concern of comprehensive wait time standards is that it will create unrealistic expectations for facilities to meet. This is why the VHA must research how long wait times typically are for community care appointments. The VHA can create realistic maximum wait times so that employees and facilities can work towards getting veterans more timely care. By setting realistic wait time standards, the VHA as an organization would have employees who are motivated to reach these attainable metrics. A study performed by the University of Buffalo School of Management revealed that overly ambitious or unrealistic goals set by an organization kill the productivity of their employees (Biddle, 2016). Additionally, research has pointed out that unrealistic goals and metrics can lead to unethical behavior in hopes of meeting unrealistic standards (Lemoine et al., 2016; Gary et al., 2017). If the VHA sets an achievable goal it can help show if scheduling processes need to be changed and allow for goals to seem reasonable and manageable for VHA staff. The SCHEDULES Act will hold VHA facilities responsible for maintaining proper and realistic time standards for both VHA and Community Care appointments. It will also allow veterans to be seen in a timelier manner, measured from the time of a referral to the actual appointment date.

Another factor that could assist in rectifying long wait times for veterans receiving care is an online self-scheduling platform, where patients can go into an online portal and schedule appointments themselves, without the assistance of staff (Woodcock et al., 2022). This allows for increased freedom and transparency for the patients to see schedule availability and pick appointment dates, which in turn improves accessibility (Zhao et al., 2017). Using self-

scheduling software or apps also has been proven to reduce administrative burden, reduce no-show rates, improve patient satisfaction, and decrease wait times (Zhao et al., 2017). An online self-scheduling platform speaks to the growing need for improved accessibility and lower wait times for veterans. The VHA has a current system, on their online patient portal called MyHealtheVet, where patients can request available appointment dates, yet staff and administrators still need to take time to confirm the appointments ("VA Appointments," n.d.). Additionally, this online scheduling feature is limited to certain facilities, the date of the patient's last appointment, and the patient's type of appointment or reason for their visit ("VA Appointments," n.d.). For example, a patient can only schedule a primary care appointment online at a VA facility where they had a primary care appointment in the last two years ("VA Appointments," n.d.). Even though the VHA has an online scheduling portal as an option, in order for them to further increase accessibility, they must switch to using self-scheduling platforms at all facilities to ensure appointments are made promptly. The impact of the initiative will decrease the administrative burden on MSAs and schedulers which are contributing to long scheduling times and even longer wait times (OIG, 2023b). Through self-scheduling it will allow more time for MSAs to reduce the burden on the referral process of positions and allow more time for MSAs and schedulers to help patients set up and establish telehealth appointments (Zhao et al., 2017).

Initially, telehealth platforms were primarily used to assist those with limited access due to geographical location or transportation issues when trying to meet with their providers. Since the COVID-19 pandemic, telemedicine has been used more and more to connect individuals with their providers without having to go see them in person. There are 2.8 million veterans living in rural areas, with barriers to accessing health services, that rely on VHA healthcare (Office of

Research and Development, 2019). If these rural veterans have access to high-speed internet, then telehealth could grant rural patients necessary access to quality healthcare services without traveling long distances, assisting in them getting timely care when needed (Rural Health Information Hub, 2024). In a study on chronic pain patients in San Diego, researchers found that the use of telehealth led to an 82 percent reduction in missed appointments and led to greater overall access, as patients pointed to transportation as a key reason why patients were missing appointments and deferring care (Mathews et al., 2022). Telehealth has been proven to be beneficial in areas where there are limited resources and access to healthcare facilities is limited, such as for veterans in rural areas (Bouabida et al., 2022). Still, the first hurdle to successfully implementing telehealth options to reduce wait times for veterans is the need for mobile devices and the Internet. Currently, 42 percent of rural veterans do not have access to the internet, leaving them little to no experience and means for telehealth appointments (OIG, 2023a). If this digital divide issue is not properly rectified, then the use of telehealth could further exacerbate health disparities in disadvantaged populations such as veterans (Prince et al., 2022). The VHA currently has initiatives in place to ensure that veterans can be set up with the internet to take advantage of telehealth and telemedicine offerings. This is a big step in combating wait time issues, as research has shown that wait times are reduced because of the use of telehealth (Hofstetter et al., 2010).

One initiative the VHA offers is a Digital Divide Consult that pairs veterans with internet access or technology devices so that they can use telehealth platforms and communicate electronically with their VHA care team. The Digital Divide Consultant can help veterans see if they are eligible for discounts on home internet or phone services as well through the Federal Communications Commission's Lifeline program (Staff, 2023). The VHA also offers the option

to lend veterans, without internet-connected devices, a tablet so that they can connect with their VA care team through telehealth. These initiatives were expected to increase telehealth usage. However, due to a lack of oversight and standard operating procedure, an estimated 20,800 patients would not schedule a telehealth appointment following expanded internet access and or reception of a new tablet (OIG, 2022b). The OIG report facilities had no explanation for poor leadership and a lack of clear structure (OIG, 2022b). At one given VAMC facility, one digital divide consultant was aware of the protocol to help veterans set up video calls, while another was completely unaware of a given protocol (OIG, 2022b). With clear communication and the development of a standard operating procedure, as mentioned by the OIG, the VHA can better provide telehealth appointments (OIG, 2022b). It is important that the VHA further invest in this approach but for telehealth medicine to truly increase access, standard operating procedures must be established for telehealth appointments and be communicated clearly to those social workers and Digital Divide Consultants who help with the process.

Despite new initiatives to bridge the digital divide for veterans, rural telemedicine disparities still exist and must be rectified so that the benefits of telehealth offerings can be felt by veterans on all levels (Leung et al. 2023). There must also be work done with VHA staff and patients to ensure that telehealth platforms are being used effectively and efficiently to lower wait times. In a study aimed at learning how to increase the frequency of telemedicine use, especially as it relates to veterans facing homelessness, digital divides, and telemedicine/technology competencies were examined (Prince et al., 2022). Primary care physicians leading the study found that the main barrier to conducting video visits was a lack of a standardized process for scheduling and conducting telemedicine appointments, so they aimed to address this (Prince et al., 2022). The study implemented a process that increased telehealth

visits to ten percent, which is double the initial percentage of usage of five percent before the project began. Beyond pairing veterans with needed digital devices and the internet, they also performed staff interviews, reinforced participation in monthly meetings, conducted live demonstrations of video visit applications, and implemented a flowchart for the standardized workflow of video visits (Prince et al., 2022).

They found that standardized video visit workflows, sustained education on how to perform telehealth visits, and maximizing resources available at the VA proved essential to increasing video visit use and reducing delays in video visit care. The workflow offered a visual flowchart where VA staff could know explicitly what to do at each step of trying to get a patient to use video visits and promote an efficient clinician experience (Prince et al., 2022). The flowchart included prompts such as asking providers if the patient first has access to mobile devices or the internet. If they do not, then it is recommended to pair them up with a Digital Divide Consult (Prince et al., 2022). The flowchart then suggests asking if the patient is literate with technology. If they are, the patient is called to confirm their scheduled video visit or telehealth appointment. If the patient is not literate with technology, then it is recommended that the patient receive a test call before their official appointment (Prince et al., 2022). Then, the video visit appointment call can be conducted at the scheduled time. Assisting providers in what to do before using telehealth platforms will allow for more effective use of telehealth as it relates to increasing accessible care and lowering wait times. The study performed by family medicine physicians proves that implementing workflows could improve the use of telemedicine platforms and increase literacy for patients and providers of these options (Prince et al., 2022). The VHA needs to implement processes that were carried out in the study so that they can increase telehealth use and offer more accessible care.

A reason that digital consults, device support initiatives, and telehealth platforms are not currently as successful or as widely implemented across the VHA as they could be is due to limited knowledge among patients and providers alike surrounding these topics (OIG, 2023a). A report by the VA's OIG found that the current telehealth offerings do not have a standardized process for doing test calls or demonstrations of the platforms, which impacts accessibility and veteran willingness to use telehealth (OIG, 2023a). Implementing standardized processes and workflow procedures for using telehealth offerings effectively could lead to increased use of telehealth and in turn lead to decreased wait times for gaining accessibility to care. There was also increased success in the use of telehealth when MSAs were helping to set up telehealth calls (OIG, 2023a). There must be increased staffing or administrative personnel who can assist with telehealth options, as this could lead to telehealth being used more and being an effective solution for reducing wait times in the VHA. Due to staffing issues and no standards for the use of telehealth platforms, this process has not been effectively implemented across VHA facilities. The OIG recommends that to improve the scheduling of telehealth or VHA Video Connect (VVC) calls, they must define the required roles and responsibilities of clinical and administrative staff in supporting VVC encounters from the point of scheduling to completion (OIG, 2023). Also, to assist in effectively scheduling telehealth appointments, the VHA should ensure the onboarding materials for learning about scheduling these calls are accurate and constructive (OIG, 2023a). Beyond the onboarding course, VHA can review existing efforts and explore additional avenues to reinforce education on scheduling processes associated with telehealth for schedulers.

Conclusion

The VHA has promised to support and care for the nine million veterans who are enrolled in healthcare through the VA (Congressional Research Service, 2023). With this responsibility comes the expectation that the VA will be successful in fulfilling the needs of veterans and providing them with effective and timely healthcare. However, veterans struggle to get timely care due to the large number of rural veterans, growing physician shortage, and slow scheduling processes (OIG, 2023c; GAO, 2023d). Untimely access to care is propelled by poor data collection in the VHA, a slow hiring process, and faulty administrative policy (VA MISSION Act, 2018). The MISSION Act of 2018 aimed to help in providing care for veterans by expanding Community Care. This was done in hopes of offering veterans more access to providers outside the VA by allowing those who have to drive over 30 minutes or wait beyond 28 days for healthcare to go out of the VA network (VA MISSION Act, 2018). However, the outcome of this legislation would not address many of the underlying causes of the long wait times and inaccessible care. It failed to set standards for Community Care or address any of the administrative shortcomings related to telehealth appointments, and data collection around wait times. Due to the multitude of underlying factors that contribute to untimely access to healthcare, the problem continues to persist despite the comprehensive piece of legislation.

Issues of accessible healthcare for veterans have become significant due to the complexity of the problem. As mentioned, there exist major holes regarding accurate data and overall human capital amongst schedulers and physicians (OIG, 2023b; OIG, 2023c). However, the VHA's failures in both improving the experience for veterans as well as those working for the institution create major barriers to accessible healthcare. Veterans struggle to gain access either through long scheduling times, long distances to appointments, or a lack of internet (GAO,

2023d; Cheney et al., 2018). For physicians they are overburdened by the referral process due to poor policy implementation and increasing patient caseload (Saylers et al., 2013; OIG, 2023b; OIG, 2023c). Improved telehealth access and self-scheduling will allow patients to have greater access to appointments from VHA providers and reduce the frustration related to scheduling. Allowing patients to schedule their own appointments leaves more time for MSAs to help with telehealth appointments and helps to reduce the administrative burden associated with the position. The problem of untimely care requires multiple solutions, which is why the current approach seeks to address different aspects of the challenges that face the VHA. This is why many of the solutions mentioned not only address one aspect of the problem but can help improve the experience of veterans, administrators, and physicians within a given VHA facility.

Without improvement in timely care, veterans may seek to use their private insurance or focus exclusively on private healthcare. The impact of this switch will lead to longer wait times and veterans accessing physicians without experience with veteran health needs (Rasmussen & Farmer, 2023). When RAND studied the difference between VHA facilities and Community Care facilities in the private sector they noticed that very few Community Care physicians had formal training around veteran experience (Rasmussen & Farmer, 2023). This means a greater reliance on the private sector will push more veterans to physicians who will not be as well versed in military culture, cancer risks related to military service, and PTSD associated with military service (Rasmussen & Farmer, 2023). The Deputy of the Undersecretary of Health also noted that greater reliance on the private sector for VA healthcare will limit available specialties for rural veterans and impact overall funding for a given clinic (STATEMENT OF MIGUEL, 2022). This is why improving VHA facilities is as important as improving metrics related to Community Care. An over-reliance on outside providers even within Community Care will

impact available funding for VHA facilities and will offload care to physicians who will not be as skilled in VHA healthcare needs (Rasmussen & Farmer, 2023). Community Care, for this reason, is an important aspect of increasing accessible care but is not the solution.

In recent years the veteran population has become significantly older and thousands of new veterans are receiving healthcare. Currently, almost 50 percent of all veterans who use the VA are 65 and older; as this population ages they will require more specialty care and treatment (Vepsa, 2023). On top of the aging population, Congress continues to expand VHA healthcare with legislation like the PACT Act. The PACT Act would go on to expand VHA healthcare to over 100,000 new veterans who were exposed to toxic chemicals (Heckman, 2024). By not addressing key factors of inaccessible care more veterans will continue to fail to get much-needed care in a timely manner. For veterans, this can be life-changing as longer wait times are associated with an increase in mortality and preventable hospitalization (Pizer & Prentice, 2011). The impact of this inaccessible care is also seen to decrease the utilization of medical facilities, leading many more veterans to avoid needed healthcare due to the burdens associated with access (Pizer & Prentice, 2011). Without decisive action the issue will worsen and will compound as more and more veterans get older and as Congress expands healthcare to more and more veterans who are currently not receiving it.

Failure to provide accessible care and meet the needs of veterans has now contributed to their perception of the military experience as a whole. In a 2021 survey, there was a 12 percent decrease in the number of veterans who would recommend the military to their children compared to 2019 (L'Esperance et al., 2022). One of the main culprits for this drop was healthcare access and the struggles associated with navigating the system (L'Esperance et al, 2022). Many veterans do not feel their healthcare needs are being met, which is impacting

veteran's advocacy and support of the institution. As one veteran explains, "How can I feel comfortable advocating for military service when so many members of our community don’t feel welcome or even have their needs met” (Carlton, 2023). The government needs to take responsibility for this failure, as veterans are the biggest advocates for the institution. The government is unable to control certain negative things related to the military, such as PTSD, trauma, and injuries associated with service. However, they can control how veterans are treated after their service and their overall healthcare needs. Lack of healthcare support should not be the reason why a veteran will not advocate for the military. It is the responsibility of the government to not only improve the system but to truly meet the promise set out by the VHA and support those veterans, who served the United States of America.

References

Actions - S.3598 - 118th Congress (2023-2024): SCHEDULES Act of 2024. (2024, January 17). https://www.congress.gov/bill/118th-congress/senate-bill/3598/all-actions

Albanese, A. P., Bope, E. T., Sanders, K. M., & Bowman, M. (2020). The VA MISSION Act of 2018: a potential game changer for rural GME expansion and veteran health care. *The Journal of Rural Health, 36*(1), 133. https://doi.org/10.1111/jrh.12360

American Hospital Association. (2022). Rural hospital closures threaten access: Solutions to preserve care in local communities. *Chicago, IL: American Hospital Association*.

American Psychological Association. (n.d.). *Psychologists reaching their limits as patients present with worsening symptoms year after year*. https://www.apa.org/pubs/reports/practitioner/2023-psychologist-reach-limits

AMN Healthcare/Merrit Hawkins. (2022). *Survey of Physicians Appointment Wait Times and Medicare and Medicaid Acceptance Rates*. https://www.wahospitalservices.com/wp-content/uploads/2023/06/mha-2022-wait-time-survey.pdf

Asfaw, D., Feyman, Y., and Griffith, K. (2022). *Geographic Variation in Appointment Wait Times for US Military Veterans.* JAMA Network. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2795631.

Association of American Medical College. (2024, March). *The Complexities of Physician Supply and Demand: Projections From 2021 to 2036.* https://www.aamc.org/media/75236/download?attachment

Biddle, M. (2016, April 27). *Organizational goals should be challenging but realistic, study finds*. Organizational goals should be challenging but realistic. https://www.buffalo.edu/news/news-

releases.host.html/content/shared/mgt/news/organizational-goals-should-be-challenging-but-realistic-study-finds.detail.html

Board on Health Care Services Health and Medicine Division (2018). *Evaluation of the Department of Veterans Affairs Mental Health Services.* https://www.ncbi.nlm.nih.gov/books/NBK499503/pdf/Bookshelf_NBK499503.pdf.

Bouabida, K., Lebouché, B., & Pomey, M.-P. (2022). *Telehealth and COVID 19 Pandemic: An Overview of the Telehealth Use, Advantages, Challenges, and Opportunities during COVID 19 Pandemic (Preprint)*. https://doi.org/10.2196/preprints.41385

Branchley, C. (2014, August 7). *President Obama Signs Bill to give the VA the resources it needs*. National Archives and Records Administration. https://obamawhitehouse.archives.gov/blog/2014/08/07/president-obama-signs-bill-give-va-resources-it-needs

Bronstein, S., & Griffin, D. (2014, April 24). *A fatal wait: Veterans languish and die on a VA Hospital's secret list.* CNN. https://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/index.html

Buzza, C., Ono, S., Turvey, C., Wittrock, S., Noble, M., Reddy, G., Kaboli, P., & Reisinger, H. (2011, November 26). Distance is Relative: Unpacking a Principal Barrier in Rural Healthcare. *Journal of General Internal Medicine*. https://pubmed.ncbi.nlm.nih.gov/21989617/

Byrne, J. M., Patel, E. L., Greenberg, P. B., Eason, M., Albanese, A. P., Bope, E. T., ... & Youngblood, P. T. (2022). A First Look at the VA MISSION Act Veteran Health Administration Medical School Scholarship and Loan Repayment Programs. *Federal Practitioner*, *39*(3), 110. https://doi.org/10.12788%2Ffp.0238

Carlton, J. (2023, December 2). *Veterans won't help the recruiting crisis until our issues are addressed*. Task & Purpose. https://taskandpurpose.com/opinion/veterans-recruiting-crisis/

Castellano, J. (November 1, 2021). *The Mission Act is supposed to help US veterans get healthcare outside the VA. For some, it's not working.* https://www.usatoday.com/in-depth/news/investigations/2021/11/01/mission-act-aid-veterans-healthcare-va-isnt-letting-it/8561618002/

CCH Health California. (n.d.). *Primary Care Timely Access Standards.* https://www.commonwealthcarealliance.org/ca/wp-content/uploads/2022/03/Primary-Care-Timely-Access-to-Care-Standards_English_508.pdf

Chan, D. C., Card, D., & Taylor, L. (2023). Is there a VA advantage? Evidence from dually eligible veterans. *American Economic Review*, *113*(11), 3003-3043. https://www.nber.org/papers/w29765

Cheney, A. M., Koenig, C. J., Miller, C. J., Zamora, K., Wright, P., Stanley, R., ... & Pyne, J. M. (2018). Veteran-centered barriers to VA mental healthcare services use. *BMC health services research*, *18*, 1-14. https://doi.org/10.1186%2Fs12913-018-3346-9

Chow, A., Yoon, J., Phibbs, C., Ong, M.,Venneman, M., Redd, A., Kizer, K., Dizon, M., Wong, E., & Zhang, Y. (2023). *Outcomes of Veterans Treated in Veterans Affairs Hospitals vs Non-Veterans Affairs Hospitals.* JAMA Network. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2812416#:~:text=Findings%20In%20this%20cohort%20study,%2C%20gastrointestinal%20hemorrhage%2C%20heart%20failure%2C

Craven, J. & Gordon, S. (n.d.) *The VA's Vacancy Crisis.* Veterans Healthcare Policy Institute. https://veteranspolicy.org/wp-content/uploads/2024/03/VHPIReport-TheVAsVacancyCrisis.pdf

Commision on Care. (2016). *Commission on Care Final Report.* https://permanent.fdlp.gov/gpo69908/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf

Commonwealth of Massachusetts (n.d.). *Eligibility and Service Requirements*. Mass.gov. https://www.mass.gov/info-details/eligibility-and-service-requirements#:~:text=See%20below%20for%20service%20requirements%20and%20exceptions.&text=90%20days%20of%20active%20duty,or%20release%20 under%20 honorable%20 conditions.&text=180%20days%20of%20regular%20active,or%20release%20under%20 honorable%20conditions.

Congressional Research Service (2023). *Introduction to Veterans Health Care.* Congressional Research Service. https://crsreports.congress.gov/product/pdf/IF/IF10555

Department of Veterans Affairs. (n.d.a). *Veterans Integrated Services Networks (VISNs)*. VA.gov. https://www.va.gov/HEALTH/visns.asp#:~:text=Veterans%20Integrated%20Services%20Network%3A%20The,provides%20greater%20access%20to%20care.

Department of Veterans Affairs. (n.d.b). *Veteran Community Care Eligibility.* https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/VA-FS_CC-Eligibility.pdf

Department of Veterans Affairs. (2022). *National Veteran Suicide Prevention Annual Report.* https://news.va.gov/108984/2022-national-veteran-suicide-prevention-annual-report/

Department of Veterans Affairs. (2023). *Veterans Health Administration* https://www.va.gov/health/aboutvha.asp#:~:text=The%20Veterans%20Health%20Administration%20

Edwards, S., Gordon, H., Hickok, A., Weaver, F., Niederhausen, M., Hynes, D., & Govier, J. (2023). *Early Impact of VA MISSION Act Implementation of Primary Care Appointment Wait Time*. Journal of General Internal Medicine. https://link.springer.com/article/10.1007/s11606-022-07800-1#citeas.

Gaffney, A., Himmelstein, D., & Woolhander, S. (2019). *Lack of Care for those who Serve: Healthcare Coverage and Access among US Veterans.* Public Citizen. https://www.citizen.org/wp-content/uploads/Lack-of-Care-for-those-Who-Serve-Final-DS.pdf?eType=EmailBlastContent&eId=1e9e9344-4acd-46ca-b7ee-3bf9862d7ed9

Gajarawala, S. N., & Pelkowski, J. N. (2021). Telehealth benefits and barriers. *The Journal for Nurse Practitioners*, *17*(2), 218–221. https://doi.org/10.1016/j.nurpra.2020.09.013

Gary, M. S., Yang, M. M., Yetton, P. W., & Sterman, J. D. (2017). Stretch goals and the distribution of organizational performance. *Organization Science, 28*(3), 395-410. http://dx.doi.org/10.1287/orsc.2017.1131

Gonzalez, D., Karpman, M., Kenney, G. M., & Zuckerman, S. (2021). Delayed and forgone health care for nonelderly adults during the COVID-19 pandemic. *Washington, DC: Urban Institute*, 16. delayed-and-forgone-health-care-for-nonelderly-adults-during-the-covid-19-pandemic_1.pdf (urban.org)

Government Accountability Office (GAO). (2014). *VA Health Care: VA Lacks Accurate Information about Outpatient Medical Appointment Wait Times, Including Speciality Care Consults.* https://www.gao.gov/assets/gao-14-620t.pdf

Government and Accountability Office (GAO). (2017, March 22). *VHA: Actions needed to better recruit and retain clinical and administrative staff*. https://www.gao.gov/products/gao-17-475t

Government and Accountability Office (GAO). (September, 2020). *Improvements Needed to Help Ensure Timely Access to Care.* https://www.gao.gov/assets/d20643.pdf

Government Accountability Office (GAO). (2023a, January). *The VHA Lacks Reliable Onboarding Data for New Clinical Staff.* https://www.gao.gov/assets/gao-23-105706.pdf

Government and Accountability Office (GAO) (2023b, January 4). *Veterans Health Care: VA actions needed to ensure timely scheduling of specialty care appointments*. https://www.gao.gov/products/gao-23-105617

Government Accountability Office (GAO). (2023c, May 17). *Staffing Challenges and Recommendations for Improvement.* https://www.gao.gov/assets/gao-23-106836.pdf.

Government and Accountability Office (GAO). (2023d, November 10). *VA Has Taken Steps to Improve Its Scheduling Process, But Additional Actions Are Needed.* https://www.gao.gov/assets/d24107112.pdf

Hahn, Z., Hotchkiss, J., Atwood, C., Smith, C., Totten, A., Boudreau, E., Folmer, R., Chilakamarri, P., Whooley, M., & Sarmiento, K. (2023). Travel burden as a measure of healthcare access and the impact of telehealth within the veterans health administration. *Journal of general internal medicine*, *38*(Suppl 3), 805-813. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10356728/

Hamilton, R. (n.d.) *What You Need To Know About The Veterans Choice Program.* Veterans Place Washington Boulevard. https://www.veteransplaceusa.org/what-you-need-to-know-about-the-veterans-choice-program/

Hearing On VHA Recruitment and Retention: Is Bureaucracy Holding Back a Quality Workforce?. The House Committee on Veterans Affairs. (May 17, 2023). (Will Morse). https://docs.house.gov/meetings/VR/VR03/20230517/115928/HHRG-118-VR03-Wstate-MorseW-20230517.pdf

Heckman, J. (2024, February 26). *VA Launches Historic Health Care Expansion Under Accelerated PACT Act Eligibility timeline*. Federal News Network - Helping feds meet their mission. https://federalnewsnetwork.com/veterans-affairs/2024/02/4900319/

Himmelstein, D. U., Lasser, K. E., McCormick, D., Bor, D. H., Boyd, J. W., & Woolhandler, S. (2007). Lack of health coverage among US veterans from 1987 to 2004. *American Journal of Public Health, 97*(12), 2199-2203. https://doi.org/10.2105%2FAJPH.2006.106302

Hofstetter, P. J., Kokesh, J., Ferguson, A. S., & Hood, L. J. (2010). The impact of telehealth on wait time for Ent Specialty Care. *Telemedicine and E-Health, 16*(5), 551–556. https://doi.org/10.1089/tmj.2009.0142

Inoue, C., Jackson, C., Shawler, E., Jordan, C., & Moore, M. (2023). *Veteran and Military Mental Health Issues.* StatPearls Publishing. https://pubmed.ncbi.nlm.nih.gov/34283458/.

Isaacs, B. (2019). Save rural health care: time for a significant paradigm shift. *Journal of Osteopathic Medicine, 119*(9), 551-555. https://doi.org/10.7556/jaoa2019.098

Jha, A. K., Perlin, J. B., Kizer, K. W., & Dudley, R. A. (2003). Effect of the transformation of the Veterans Affairs Health Care System on the quality of care. *New England Journal of Medicine, 348*(22), 2218-2227. https://doi.org/10.1056/nejmsa021899

Kintzle, S., Barr, N., Corletto, G., & Castro, C. A. (2018, August). PTSD in US veterans: The role of social connectedness, combat experience and discharge. *MDPI Healthcare* (Vol. 6, No. 3, p. 102). https://doi.org/10.3390%2Fhealthcare6030102

Kline, A., Nichter, B., Panza, K., Tsai, J., Harpaz-Rotem, I., Norman, S., & Pietrzak, R. (2022). *Mental Health Care Use Among U.S. Military Veterans: Results From the 2019-2020 National Health and Resilience in Veterans Study.* Psychiatric Services. https://ps.psychiatryonline.org/doi/epdf/10.1176/appi.ps.202100112.

Lawrence, Q. (2023). *VA hospitals are outperforming private hospitals, latest Medicare survey shows*. NPR. https://www.npr.org/2023/06/14/1181827077/va-hospitals-health-care.

Lemoine, G. J., Blum, T. C., & Roman, P. M. (2016). Detrimental effects of "stretch" goals in specialty substance use disorder treatment organizations. *Journal of substance abuse treatment, 64*, 13-23. https://doi.org/10.1016%2Fj.jsat.2016.02.006

L'Esperance, G., Smith, S., & Trent, J. (July 14, 2022). *2021 Military Family Support Programming Survey.* Military Family Advisory Network. https://www.mfan.org/wp-content/uploads/2022/07/Executive-Summary-MFAN-Programming-Survey-Results-2021.pdf

Leung, L. B., Yoo, C., Chu, K., O'Shea, A., Jackson, N. J., Heyworth, L., & Der-Martirosian, C. (2023a). Rates of primary care and integrated mental health telemedicine visits between rural and Urban Veterans Affairs beneficiaries before and after the onset of the COVID-

19 pandemic. *JAMA Network Open*, *6*(3). https://doi.org/10.1001/jamanetworkopen.2023.1864

Leung, L. B., Yoo, C. K., Rose, D. E., Jackson, N. J., Stockdale, S. E., & Apaydin, E. A. (2023b). Telework Arrangements and Physician Burnout in the Veterans Health Administration. *JAMA Network Open*, *6*(10), e2340144-e2340144. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2811120

Marmar, C. R., Schlenger, W., Henn-Haase, C., Qian, M., Purchia, E., Li, M., Horesh, D., Williams, C., Corry, N., Shalev, A...& Kulka, R. A. (2015). Course of posttraumatic stress disorder 40 years after the Vietnam War: Findings from the National Vietnam Veterans Longitudinal Study. *JAMA psychiatry*, *72*(9), 875-881. https://doi.org/10.1001/jamapsychiatry.2015.0803

Mathews, C. P., Convoy, S., Heyworth, L., & Knisely, M. (2022). Evaluation of the use of telehealth video visits for veterans with chronic pain. *Pain Management Nursing*, *23*(4), 418-423. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8934702/

Moldestad, M., Sayre, G., Rinne, S., Kaboli, P. J., Reddy, A., Sanders, K. M., ... & Wong, E. S. (2022). Perspectives on Training and Working in the VHA: Implications for Primary Care Physician Recruitment and Retention. *Academic medicine*, *97*(8), 1175-1183. https://doi.org/10.1097/ACM.0000000000004619

Morin, R. (December 8, 2011). *The Difficult Transition from Military to Civilian Life.* Pew Research Center. https://www.pewresearch.org/social-trends/2011/12/08/the-difficult-transition-from-military-to-civilian-life/

OECD. (2020). Waiting times for health services: next in line. *OECD Health Policy Studies*. https://www.oecd-ilibrary.org/sites/242e3c8c-

en/1/1/index.html?itemId=/content/publication/242e3c8c-en&_csp_=e90031be7ce6b03025f09a0c506286b0&itemIGO=oecd&itemContentType=book#foreword-d1e16

Office of Inspector General. (2005). *Audit of the Veterans Health Administration*. US Department of Veterans Affairs.

Office of Inspector General. (2007). *Audit of the Veterans Health Administration*. US Department of Veterans Affairs.

Office of Inspector General. (2022a, April 7). *Concerns with Consistency and Transparency in the Calculation and Disclosure of Patient Wait Time Data.* US Department of Veterans Affairs. https://www.oversight.gov/sites/default/files/oig-reports/VA/VAOIG-21-02761-125.pdf

Office of Inspector General. (2022b, August 4). *Digital Divide Consults and Devices for VA Video Connect Appointments.* US Department of Veterans Affairs. https://www.oversight.gov/sites/default/files/oig-reports/VA/VAOIG-21-02668-182.pdf

Office of Inspector General (OIG). (2022c, October 27). *Additional Actions Needed to Fully Implement and Assess the Impact of the Patient Referral Coordination Initiative.* US Department of Veterans Affairs. https://www.oversight.gov/sites/default/files/oig-reports/VA/VAOIG-21-03924-234.pdf

Office of Inspector General (OIG). (2022d, November 3). *VHA Progressed in the Follow-Up of Canceled Appointments during the Pandemic but Could Use Additional Oversight Metrics.* Department of Veterans Affairs. https://www.vaoig.gov/sites/default/files/reports/2022-11/VAOIG-21-03777-218.pdf

Office of Inspector General (OIG). (2023a, April 26). *Review of Access to Telehealth and Provider Experience in the VHA During the COVID-19 Pandemic.* Department of Veterans Affairs. https://www.oversight.gov/sites/default/files/oig-reports/VA/VAOIG-21-02805-102.pdf

Office of Inspector General (OIG). (2023b, July 19). *Community Care Department Needs Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff.* US Department of Veterans Affairs. https://www.oversight.gov/sites/default/files/oig-reports/VA/VAOIG-21-03544-111.pdf

Office of Inspector General (OIG). (2023c, August 22). *OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023.* US Department of Veterans Affairs. https://www.vaoig.gov/sites/default/files/reports/2023-08/VAOIG-23-00659-186.pdf

Office of Mental Health and Suicide Prevention (2023). *2023 National Veteran Suicide Prevention: Annual Report.* U.S. Department of Veterans Affairs. https://www.mentalhealth.va.gov/docs/data-sheets/2023/2023-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf.

Office of Research and Development. (2019). *VA Research on Rural Health*. US Department of Veterans Affairs. https://www.research.va.gov/topics/rural_health.cfm

Ohl, M. E., Carrell, M., Thurman, A., Weg, M. V., Hudson, T., Mengeling, M., & Vaughan-Sarrazin, M. (2018). Availability of healthcare providers for rural veterans eligible for purchased care under the veterans choice act. *BMC health services research, 18,* 1-7. https://doi.org/10.1186%2Fs12913-018-3108-8

Oliver, A. (2007). The veterans health administration: an American success story?. *The Milbank Quarterly*, *85*(1), 5-35. https://doi.org/10.1111%2Fj.1468-0009.2007.00475.x

Panangala, S. V., & Shedd, D. T. (2014). *Veterans exposed to agent orange: Legislative history, litigation, and current issues*. Congressional Research Service. https://crsreports.congress.gov/product/pdf/r/r43790

Patrick, B. K. (2022, June 9). *A bullet in Vietnam left Ron Kovic a paraplegic - and a peace activist.* Military.com. https://www.military.com/history/marine-sgt-ron-kovic.html

Payne, D. (2012). How Kizer healed the VA. *BMJ: British Medical Journal (Online)*, *344*. https://doi.org/10.1136/bmj.e3324

Peabody, H., Walton, R., Isaacks, D. (n.d.). *FY24-25 Priority goals.* Performance.gov. https://www.performance.gov/agencies/VA/apg/fy-24-25/#:~:text=By%20September%2030%2C%202025%2C%20VA%20will%20reduce%20or,over%20FY%202023%20Q1%20at%20a%20national%20level.

Petersen, H. (2015, March 2). *Roots of VA Healthcare Started 159 Years Ago.* VA.gov. https://www.va.gov/health/NewsFeatures/2015/March/Roots-of-VA-Health-Care-Started-150-Years-Ago.asp

Pizer, S. D., & Prentice, J. C. (2011). What are the consequences of waiting for health care in the veteran population?. *Journal of General Internal Medicine*, *26*, 676-682. https://doi.org/10.1007%2Fs11606-011-1819-1

Prince, A., Sabio, Y., Effron, L., Abromowitz, M., Reyes, L., Chen, P., Willinger, C., Ng, D., Darnell, J., Kopelson, K., Capone-Newton, P., Cowan, B., Borthwick, K., Penamon, C., & Gelberg, L. (2022). Facing the digital divide: Increasing video visits among veterans

experiencing homelessness. *The Annals of Family Medicine*, *20*(5), 486–486. https://doi.org/10.1370/afm.2861

Ranney, R. M., Maguen, S., Bernhard, P. A., Holder, N., Vogt, D., Blosnich, J. R., & Schneiderman, A. I. (2023). Treatment utilization for posttraumatic stress disorder in a national sample of veterans and nonveterans. *Medical Care*, *61*(2), 87-94. http://dx.doi.org/10.1097/MLR.0000000000001793

Rasmussen, P., & Farmer, C. M. (2023). The promise and challenges of VA Community Care: veterans' issues in focus. *Rand Health Quarterly*, *10*(3). https://www.rand.org/pubs/periodicals/health-quarterly/issues/v10/n3/09.html

Reed, B. (2015, November 1). *Donald Trump releases plan aimed at improving veterans' care*. The Guardian. https://www.theguardian.com/us-news/2015/nov/01/donald-trump-releases-plan-veteran-healthcare

Rural Hospitals at risk of closing. Center for Healthcare Quality and Payment Reform. (2024). https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

Salyers, M. P., Rollins, A. L., Kelly, Y. F., Lysaker, P. H., & Williams, J. R. (2013). Job satisfaction and burnout among VA and community mental health workers. *Administration and Policy in Mental Health and Mental Health Services Research*, *40*, 69-75. https://doi.org/10.1007/s10488-011-0375-7

Shulkin, D. (2016). *Why VA Health Care Is Different.* National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6369034/

Sicard, S. (2016). *Here's Where The 2016 Presidential Candidates Stand on Veterans Issues. Task & Purpose*. https://taskandpurpose.com/news/heres-2016-presidential-candidates-stand-veterans-issues/

Sen. Ossoff introduces bipartisan bill to reduce VA appointment wait times. (2024, January 18). Jon Ossoff U.S. Senator for Georgia. https://www.ossoff.senate.gov/press-releases/sen-ossoff-introduces-bipartisan-bill-to-reduce-va-appointment-wait-times/

Sen. Rick Scott introduces schedules act to increase transparency for access to veteran care. Rick Scott Florida's U.S. Senator . (2024, January 19). https://www.rickscott.senate.gov/2024/1/sen-rick-scott-introduces-schedules-act-to-increase-transparency-for-access-to-veteran-care

Staff, E. (2023, December 27). *VA telehealth services: Bridging the Digital Divide for Veterans*. DisabledVeterans.org. https://www.disabledveterans.org/va-telehealth-services-bridging-the-digital-divide-for-veterans/

STATEMENT OF MIGUEL LAPUZ. House Committee of Veterans Affairs. (2022). (Miguel Lapuz). https://docs.house.gov/meetings/VR/VR03/20220714/114988/HHRG-117-VR03-Wstate-LaPuzM-20220714-U1.pdf

Telehealth and Health Information Technology in rural healthcare overview - rural health information hub. Rural Health Information Hub. (2024, April 12). https://www.ruralhealthinfo.org/topics/telehealth-health-it#:~:text=Telehealth%20services%20allow%20rural%20healthcare,healthcare%20without%20traveling%20long%20distances.

Text - S.2372 - 115th congress (2017-2018): VA MISSION Act of 2018. Congress.gov. https://www.congress.gov/bill/115th-congress/senate-bill/2372/text

The Veterans Community Care Program: Background and early effects. (2021). Congressional Budget Office. https://www.cbo.gov/publication/57583

VA Appointments - Frequently Asked Questions. VA MyHealtheVet. (n.d.). https://www.myhealth.va.gov/va-appointments-faqs#Online

VA Mission Act of 2018, 38 U.S.C. § 101 *et* (2018). https://www.congress.gov/bill/115th-congress/senate-bill/2372/text

Veterans Access, Choice, and Accountability Act of 2014, 38 U.S.C. § 101 *et seq*. (2014). https://www.congress.gov/bill/113th-congress/house-bill/3230

Veterans Association. (June 6, 2018). *Statement by Acting VA Secretary Peter O'Rourke - President Trump signs historic MISSION Act*. VA News. https://news.va.gov/press-room/statement-by-acting-va-secretary-peter-orourke-president-trump-signs-historic-mission-act/

Wavetec. (2024). *How to do patient wait for time analysis for Healthcare efficiency.* https://www.wavetec.com/blog/healthcare/how-to-do-patient-wait-time-analysis/

Woodcock, E., Sen, A., & Weiner, J. (2022). Automated patient self-scheduling: Case study. *Journal of the American Medical Informatics Association*, *29*(9), 1637–1641. https://doi.org/10.1093/jamia/ocac087

World Vista. (n.d.). *About Vista.* https://worldvista.org/AboutVistA

Zhao, P., Yoo, I., Lavoie, J., Lavoie, B. J., & Simoes, E. (2017). Web-based medical appointment systems: A systematic review. *Journal of Medical Internet Research*, *19*(4). https://doi.org/10.2196/jmir.6747