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JOINT APPLIED PROJECT REPORT

ANALYSIS OF THE DEPARTMENT OF VETERANS AFFAIRS' ABILITY TO REGAIN VETERANS' TRUST REGARDING HEALTHCARE WAIT TIMES

June 2018

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ABSTRACT

This project explores whether or not veterans have regained their trust in the appointment process and wait times for healthcare access at the U.S. Department of Veterans Affairs (VA). We explore the perception of appointments and wait times for veterans prior to and after the whistleblower report of April 2014. Through this research and data analysis, it was not possible to state unequivocally that the VA is regaining its trust with veterans regarding their healthcare appointment wait times.

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LIST OF ACRONYMS AND ABBREVIATIONS

CBOCs	Community Based Outpatient Clinics
CID	Clinically Indicated
GAO	Government Accountability Office
PCMH	Primary Care Mental Health
PD	Preferred Date
SHEP	Survey of Health Experiences of Patients
SR	Service Recovery
VA	Department of Veterans Affairs
VACAA	Veteran Access Choice and Accountability Act
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Networks

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I. INTRODUCTION

In April 2014, media outlets, such as CNN, reported a catastrophic problem with the U.S. Department of Veterans Affairs (VA) with news of a whistleblower reporting veterans were dying due to long wait times at the Phoenix VA hospital. These media outlet reports resulted in Congress completing a full investigation into the systemic problem related to long lead times for veterans across the United States. Questions (from Pauley, 2015) that needed to be answered included:

- How long does a veteran have to wait to obtain a doctor's appointment?
- Once a doctor's appointment is scheduled, are any appointments rescheduled by VA?
- Have veterans' wait times improved for doctor appointments?
- Once veterans have made an appointment, do they feel the visit was satisfactory?
- Is there any current data to support the systemic problems with delaying wait times?
- Is there any data showing improvements?

The VA has a survey that was implemented after the 2014 whistleblowing incident in all of the hospitals that addresses the aforementioned questions.

This study is intended to explore whether or not veterans have regained their trust in the appointment process and wait times in healthcare access at the VA. Using survey data from the VA, we explore the perception of appointments and wait times for veterans prior to and after the whistleblower incident in April 2014. This paper takes you through an in-depth literature review, methodology, results, and summary of VA processes used to regain veterans' trust.

The purpose of this literature review was not to build a case for trust or distrust, but to analyze the veteran wait times prior to and after the whistleblower incident. This review will explain the significant wait times and issues prior to April 2014 and the different strategies and processes that the VA has implemented to correct the wait times for the veterans. Since the completion of the analysis, we were not able to determine if VA has regained the trust of the veterans regarding their wait times for getting an appointment with their doctor.

According to a review of the literature by Kehle, Greer, Rutks, and Wilt (2011, p. 2) that was published from 1990 to 2010, "Access to health care has been identified as a critical issue by VA and the larger medical community. Historically, VA has defined access as an individual's ability to obtain the health care they need within an appropriate time frame." As a means to help veterans in rural and underserved areas, Community Based Outpatient Clinics (CBOCs) were established. Kehle et al. report that "Opening the CBOCs resulted in a decrease in travel distance to the closest VA facility for those in the CBOC area. However, CBOCs did not have a significant impact on a number of reported access outcomes" (Kehle et al., 2011, p. 2). "CBOCs attracted more new VA users than the parent VAMCs and led to higher rates of primary care utilization in counties with a CBOCs" (Kehle et al., 2011, p. 2).

A review by Pizer and Prentice (2011, p. 2) revealed that "National health reform is expected to increase how long individuals have to wait between requests for appointments and when their appointment is scheduled. The increase in demand for care due to more widespread insurance will result in longer waits if there is not also a concomitant increase in supply of healthcare services."

> On Wednesday, May 21, Secretary Shinseki directed the Veterans Health Administration (VHA) leadership to personally review their processes to ensure the Department of Veterans Affairs (VA) is doing everything possible to schedule Veterans for their appointments. VA has redoubled its efforts to provide quality care to veterans and has taken steps at national and local levels to ensure timely access to care. VHA has developed the Accelerating Care Initiative, a coordinated, system-wide initiative to accelerate care to veterans. (U.S. Department of Veterans Affairs, 2014c, p. 1)

This initiative has caused the VA to re-invent itself and to refocus on its mission, which is "To fulfill President Lincoln's promise, 'To care for him who shall have borne the battle, and for his widow, and his orphan' by serving and honoring the men and women who are America's veterans" (U.S. Department of Veteran Affairs, n.d.). To further this initiative, on August 7, 2014, President Obama signed a VA-reform legislation that will improve access and care to our veterans by hiring more doctors, nurses and staff. It will also increase veterans' access to their benefits and services and provide veterans with the highest quality of healthcare available (U.S. Department of Veterans Affairs, 2014a).

The focus for this research study has to do with inpatient wait times as determined by the 2014 whistleblowing incident. However, it is explicitly understood that healthcare takes on many facets, including outpatient services, home healthcare, occupational, physical, speech and mental therapy services. A 2003 Government Accountability Office (GAO) report by Bascetta reports that the "VA is challenged to deliver timely, convenient healthcare to its enrolled veteran population" (p. 1). This obstacle has resulted in significant barriers to receiving timely medical services. Bascetta further reports that efforts to shift care closer to "where veterans live is complicated by stakeholder interests. In addition, the VA's efforts to reduce waiting may be complicated by an anticipated short-term surge in demand for specialty outpatient care" (Bascetta, 2003, p. 2).

Bascetta's 2003 GAO report "found that excessive waiting for VA outpatient care persist" (Bascetta, 2003, p. 8). For example, in August 2001, it was "reported that veterans frequently wait longer than 30 days-VA's access standard-for appointments with specialists at VA delivery locations in Florida and other areas of the country" (Bascetta, 2003, p. 8). Data gathered from tasks forces assigned from the president appears to indicate that there were certain geographic areas where veterans were essentially having a hard time booking an appointment with the VA. Overall, it appears that the average wait time exceeded that of one calendar year. Upon initial assessment, it might have appeared that veterans just had to wait for an appointment for a year, but to completely review any additional barriers that appeared to be delaying timely appointments; the VA implemented a process to examine the scope of the problem. "VA has also taken several actions to

mitigate the impact of long waiting, including limiting enrollment of lower priority veterans and granting priority for appointments to certain veterans with service-connected disabilities" (Bascetta, 2003, p. 10).

According to a 2003 report from the U.S. Department of Veteran Affairs, the VA is working to find ways to shorten wait times for the veterans to be seen by their doctor. The VA understands that a plan of action is needed to improve healthcare access for Veterans. In August of 2003 a directive from the VA summarized their plan to improve and provide better customer service to its veterans, this was referred to as the Service Recovery or (SR). The VA reported that the "SR identifies service failure, classifies its root cause(s), and yields data that can be integrated with other sources of performance measurement to assess and improve the service system" (U.S. Department of Veterans Affairs, 2003, p. 2). This SR plan also includes intrinsic expectation levels that all VA employees are to perform their daily job duties and provide exceptional customer service support whether working in a hospital or non-medical setting. By changing how the employees go about their normal day-to-day work duties, this plan allows for employees to evaluate situations and to make necessary changes that will positively affect the veterans' healthcare experience.

The VA has poured numerous resources into improving their healthcare system with the intention of decreasing wait times for veterans and closely monitoring system processes. In 1998 the VA enacted a policy that would see to it that 90% of veterans in need of some form of medical attention would actually receive an appointment for primary and or specialty care within 30 days (Bascetta, 2001). "To help medical centers meet this goal, VA began collecting patient waiting time data from its outpatient scheduling system" so that wait times could be easily monitored" (Bascetta, 2001, p. 4).

In a 2007 article, Prentice and Pizer reviewed VA policies regarding wait times. These policies were thought to help the VA differentiate types of appointments so the VA could track how long it took for veterans to be seen by their primary physicians. By tracking the different types of appointments, VA employees would have the flexibility to adjust scheduling to reflect the needs of the patients. For example, acute or chronic situations

would become a priority over common illness. Based on the demand, the VA employee would be able to maneuver scheduled appointments to ensure shorter wait times for all the different appointment types. In the same 2007 article by Prentice and Pizer, wait time data obtained from the VA is evaluated to see if there is a correlation between long wait times and a decreased chance of having a healthy recovery. In some instances, the veterans had passed away before their scheduled appointment date with their physician. The data showed that there was a significant difference between veterans that were able to be seen by their physician within 30 days as opposed to the veterans that had over a 30-day wait. The risk of the patient passing away was more likely with those veterans that had to wait more than 30 days for an appointment. On July 11, 2013, Congress introduced the Veterans Access to Timely Medical Appointments Act, stating that the Secretary of Veterans Affairs implement a standardized policy ensuring that veterans enrolled in the VA healthcare system were able to schedule: (1) primary care medical appointments within 7 days of the date requested, and (2) specialty care medical appointments within 14 days of the date requested. Congress did not make this a law; however, VA went forward with implementing these recommendations. Despite these prior initiatives, VA was again being criticized in 2014.

> The Veterans Access to Timely Medical Appointments Act directs the Secretary to: (1) ensure that such policy will provide reliable data regarding the length of time that veterans are waiting for such appointments, (2) issue detailed guidance to the directors of the Veterans Integrated Service Networks to ensure the consistent implementation of such policy, (3) ensure that only VA employees who have completed required training are allowed to schedule medical appointments, and (4) assess the resources of each Network every 180 days to determine the network's ability to meet such scheduling requirements. Requires the Secretary to direct each VA medical center to provide oversight of telephone access and implement the best practices outlined in VA telephone systems improvement guide, including practices to ensure that: (1) calls are answered in a timely manner and patient messages will have a return call within 24 hours, and (2) a call center at each such center is properly staffed to meet the needs of the veteran population served. Directs the Inspector General of VA to submit an annual report on the Secretary's progress in implementing this Act. (Veterans Access to Timely Medical Appointments, 2013)

On May 21, 2014, Secretary Shinseki instructed VHA Leadership to guarantee schedulers are doing everything conceivable to ensure veterans are receiving their appointments in a timely manner (U.S. Department of Veteran Affairs, 2014a). On a national and local level, the VA has reinforced its strengths by increasing its efforts to ensure quality and timely access of care to veterans (U.S. Department of Veteran Affairs, 2014a). The Accelerating Care Initiative program was implemented as a result of this initiative. "The purpose of this initiative it to strengthen access to care in the VA system, while also ensuring flexibility to use private sector care when needed in accordance with VA guidelines" (U.S. Department of Veteran Affairs, 2014c, p. 2). The program also allowed veterans to use the private sector when needed. For non-VA healthcare, the budget allocations allowed for approximately $400 million of VA's budget is for non-VA healthcare (U.S. Department of Veteran Affairs, 2014c, p. 2). In fiscal year 2012 non-VA healthcare was allocated $4.5 billion; in fiscal year 2013—non-VA healthcare $4.8 billion and in the 2014 fiscal year non-VA healthcare was allocated $3.4 billion (U.S. Department of Veteran Affairs, 2014c, p. 2).

The Veterans Access, Choice, and Accountability Act of 2014 (P.L.113-146) guides VA to create a program entitled the Veterans Choice Program. This program enables veterans to receive hospital and medical care services at non-VA hospitals provided they cannot be seen within the 30-day wait time goal.

> VA believes that it may be necessary to make further revisions to its standards for the Veterans Choice Program in the future. Specific metrics may evolve over time, and the prescribed methods of measurement today may not provide a full picture of veterans' experience in accessing VA healthcare in the future. VA has contracted with the Institute of Medicine to independently identify metrics that may be the basis for further changes to this standard. VA will carefully evaluate any recommendations from the Institute of Medicine or other sources and determine the most appropriate means of addressing or changing the standard, if warranted. (U.S. Department of Veterans Affairs, 2014a, p. 2)

The Accelerated Access to Care Initiative has resulted in a substantial achievement, both inside and outside the VA. "Under the new leadership of Secretary Robert A. McDonald, the Department began developing the Road to Veterans Day, a series of quick

actions to make both short-term and long-term changes to VA," ultimately preparing the VA on a long-term course with a successful outcome (U.S. Department of Veterans Affairs, 2014b, p. 2). The main objective of the VA is enhancing the delivery of service to the veteran and renewing the trust with them and all Americans (U.S. Department of Veteran Affairs, 2014b).

Reconstructing trust with veterans and other patrons, Secretary Bob McDonald declares that by traveling to various VA locations and chatting with veterans and representatives and learning as much as could possibly be expected about the VA, he would have the capacity to decide on which procedures should be revamped or streamlined (U.S. Department of Veteran Affairs, 2014b). This initial phase would result in reevaluating employees' performance metrics and assessments. VA is influencing ventures to recover trust with veterans by stimulating VHA personnel to embrace and reaffirm the ICARE values: Integrity, Commitment, Advocacy, Respect, and Excellence. Another progressive step in recapturing trust involves transparency. "VA has posted data online 9 times since June 9, 2014, showing the number of appointments on waiting lists and the average wait times at each medical center across the country" (U.S. Department of Veteran Affairs, 2014b, p. 6).

As per a report from the Road to Veterans Day, endeavors to get veterans off waiting lists have included: expanding clinic hours, hiring extra staff, utilizing mobile medical units, and urging high performing medical centers to impart with their best practices with other medical centers throughout the nation.

The VA published a guiding document called the "Blueprint for Excellence" for the Veterans Health Administration. "This document offers a detailed vision of how VA will evolve as a model national health care provider, delivering both excellent health care and an excellent experience to Veterans" (U.S. Department of Veteran Affairs, 2014b, p. 10). The VA document "has ten strategies, the goals of which align with the Road to Veterans Day and VA's strategic plan: transitioning VHA from 'sick care' to 'health care' by delivering personalized, proactive, patient-driven care that focuses on what is important to the Veteran" (U.S. Department of Veteran Affairs, 2014b, p. 10). Because of this

initiative, "more than 1.2 million additional appointments were accomplished in the past four months" (U.S. Department of Veteran Affairs, 2014b, p. 7). These additional appointments equated to the total number of the previous year's timeframe. During this same timeframe, in areas throughout the nation, the "VA made nearly 1.1 million authorizations for Veterans to receive care in the private sector and other non-VA health facilities" (U.S. Department of Veteran Affairs, 2014b, p. 2). This equated to a 46% increase from the previous year. "Since June 2014, VA has worked to identify the full scope of the problems, taken significant corrective actions to fix them, held employees accountable when there is evidence of employee misconduct, and worked to reinforce VA's mission and core value with employees across the country" (U.S. Department of Veteran Affairs, 2014b, p. 4).

Secretary McDonald has quantified that any patient care misconduct and manipulation of data and appointment scheduling will not be allowed at the VA. Presently the VA Department of Justice, Inspector General and the Office of Special Counsel are attempting to research and find a way to address employee misconduct in accordance with the due process rights of employees (U.S. Department of Veteran Affairs, 2014b). Adverse actions have been and will continue to be taken when employees are charged with confirmed allegations of misconduct. The objective is for each dated employee to realize how their day to day activities can affect the lives of veterans both in a positive and negative environment. From June 3, 2014 to November 6, 2014, "over 40 disciplinary actions related to data manipulation or patient care have been proposed or decided by the VA" (U.S. Department of Veteran Affairs, 2014b, p. 4). In some cases, the proposed disciplinary action has included dismissal (U.S. Department of Veteran Affairs, 2014b). "A critical component in regaining public trust is the Department's level of transparency" (U.S. Department of Veteran Affairs, 2014b, p. 6). Since January 9, 2014, the VA has posted data online nine times (U.S. Department of Veteran Affairs, 2014b). This published data shows "the number of appointments on waiting lists and the average wait times at each medical center across the country" (U.S. Department of Veteran Affairs, 2014b, p. 6). This level of transparency will enable the public and the veterans to monitor the progress to see how the wait times have decreased based upon how well the accelerated care to veterans

has advanced. Past endeavors to diminish wait times may have worked on a temporary basis, but unfortunately, the issue returned in 2014. We are testing whether the current endeavors are having an effect.

The VA conducted a survey (Pauley, 2015) that was implemented after the 2014 whistleblowing incident in all of the hospitals to collect feedback from their patients. These surveys (Pauley, 2015) address the questions in Table 1.

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II. METHODOLOGY

This present study was performed to examine the veterans wait times prior to and after the whistleblower incident in Phoenix 2014, where the VA was accused of long wait times and veterans' deaths. VA has since made changes and is working to regain the trust of their veterans, the media and society.

Research was performed to collect data that was used by VA to track wait times prior to the whistleblower incident of 2014. The data prior would then be compared to the data that was collected after the Veterans Access, Choice, and Accountability Act of 2014 (VACAA). Comparing and contrasting the data prior to and after the research will show if VA was meeting the required wait times for veterans to receive their doctor's appointments. Data for this project was obtained from Gregory Pauley (2015), who is the Assistant to the Executive Director for the Access and Clinic Administration Program. This information was gathered from the wait time proclarity cube. The proclarity cube is the software used by the VHA Financial and Clinical Data Mart. This is where VA compiles the wait time statistics and the survey data received from veterans. The data composed in this research entails wait time measurement before and after the Phoenix issue. Gregory Pauley explained in an interview,

> The caveat is that before Phoenix erupted we were measuring all patient categories using a 14-day wait time standard (new patients: 14 days from create date of the appointment, and established patients: 14 days from the desired date for the appointment). Congress basically ordered us to stop using a 14-day standard and move to a 30-day standard (Department of Veteran Affairs, 2014). They also wanted us to stop measuring new and established patients separately and apply the same standard to all, so now we measure wait times for all patients using a standard of 30 days from the clinically indicated (CID) or preferred date (PD) for the appointment. So, the reports that show 14 days waiting times from the past have been discontinued.

He further expounded that,

> The CID or PD are basically interchangeable except that the CID is usually determined by the provider and is entered in the patient's electronic record for the schedulers to see and use to try to schedule the appointment. The

> CID may be set with patient input but relies on the provider's clinical judgment most heavily. The PD is a date that the patient gives the scheduler as the date the patient wants the appointment to occur. The scheduler then tries to get an appointment as close as possible to what the patient prefers (as long as it is not wildly different from a CID, if the provider has entered a CID). If there has been no previous provider appointment, there won't be a CID and the PD will prevail. Sometimes the patient wants the next available appointment and in that case the PD is set to today. If there is a large difference between a CID and the patient's preferred date, the provider must be consulted by the scheduler to see if it is okay to go with patient's PD. (G. Pauley, personal communication, February 23, 2015)

Before the Phoenix incident, VA tracked wait times for new versus established patients separately. Once the Phoenix incident occurred, VA took a systematic look at the way they were tracking wait times and the outcome of that analysis was that new and established wait times needed to be changed. As the data from the new system of collecting wait times is analyzed, it reveals that established patients' wait times were more comparable before and after the Phoenix incident. The reason for this similarity is due to the consistent methodology of collecting wait time data amongst primary care, specialty care and mental health.

This research (Pauley, 2015) further explores a veteran satisfaction survey reported October 1, 2014. A sample of the questions that the veterans were asked are included in Table 1.

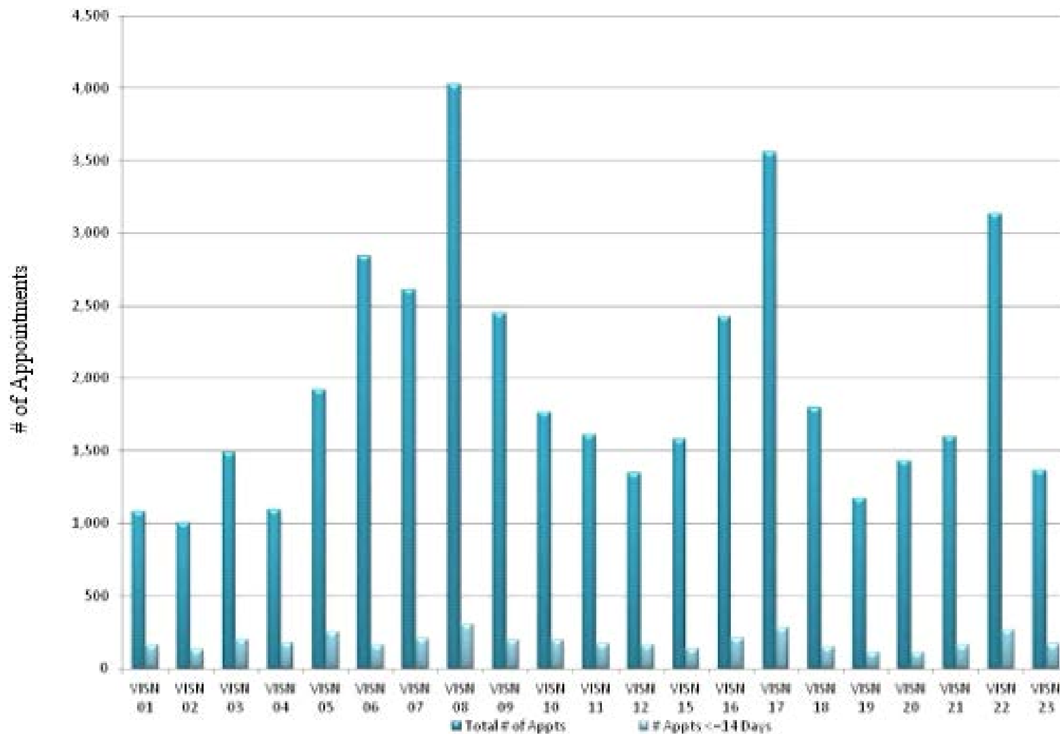
III. RESULTS

In this chapter we first present the appointment wait time for new patients, and then we present the appointment wait time for the established patients—both before and after the passage of VACAA—along with the present total of all patients completed within 30 days after VACAA as of January 2015. Second, we present data from VA satisfaction survey from all 23 VISNs for the month of October, November and December 2014, along with the national averages. VISNs are VA facilities located in different states and countries that have been grouped together and labeled from 1–23. If the facilities are in the same group, they work in conjunction with each other and data is composed of each singularly as well as the group. Based on the VISN numbers, the facilities can be located on a map as a quick reference (see Figure 1).

Figure 1. Map of Veterans Integrated Service Networks. Source: U.S. Department of Veterans Affairs (2015).

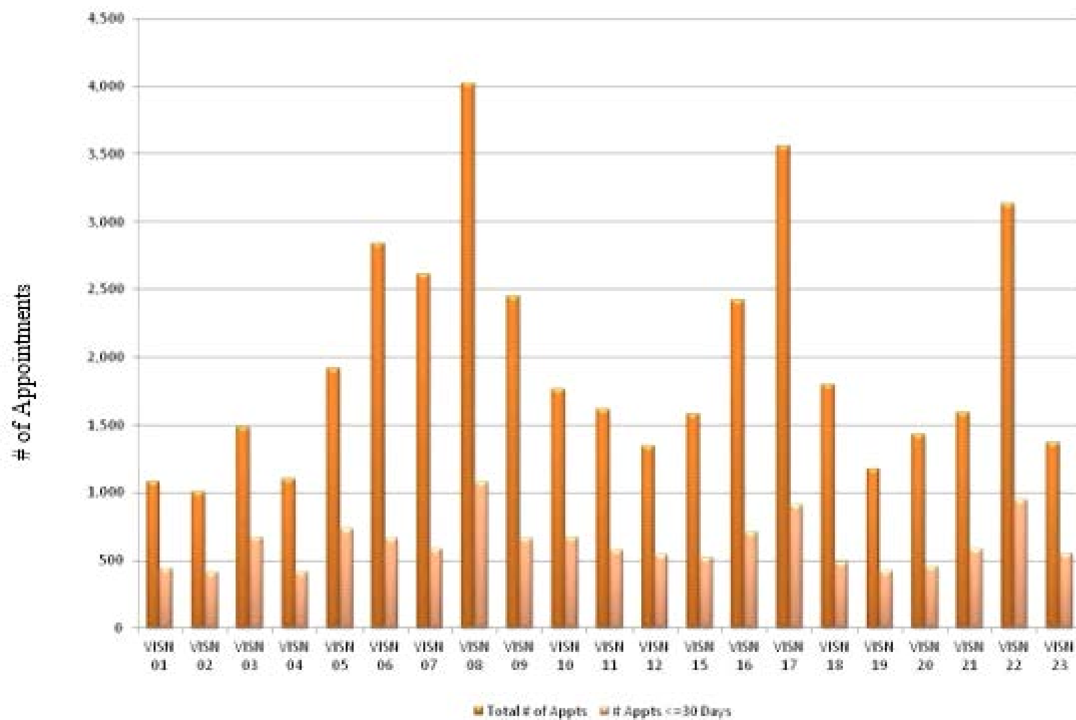
Prior to the Phoenix incident, VA tracked new patients by the created-on date that the patient showed up on the waitlist until the services were completed. The data was tracked according to a 14-day methodology as of January 15, 2014. The new patient prospective wait times 14 days' methodology as of January 15, 2014 (see Figure 2):

Figure 2. New Patient Prospective Wait Times 14 Days' Methodology as of January 15, 2014. Adapted from Pauley (2015).



After the incident, Congress through the Veterans Access Choice and Accountability Act (VACAA) of 2014, VA changed how they tracked wait times and ordered VA to track on 30-day—instead of 14-day—intervals, as it was too difficult to retain and keep up with the information. The following figure 3 shows new patient' information at the time it was tracked using a 30-day methodology as of January 15, 2014.

Figure 3. New Patient Prospective Wait Times 30-Day Target as of January 15, 2014. Adapted from Pauley (2015).



Figures 2 and 3 are included to reflect how information was tracked at the time but they cannot be used to compare if veteran wait times have decreased. The methodology used for new patients' pre-Phoenix incident cannot be compared to post-Phoenix incident. In reviewing both figures for new patients being seen within 14 or 30 days, only approximately 1/4 of new veteran patients were being seen within the allocated timeframe.

Established patients can be compared prior to the Phoenix incident and post-VACAA of 2014 because the methodology was similar. Established patients were tracked according to their desired date or preferred date and a 14-day cycle. Figure 4 shows the established patient's prospective wait times within 30 days as of January 15, 2014, which was prior to the Phoenix incident.

Figure 4. Established Patient Prospective Wait Times within 30 Days as of January 15, 2014. Adapted from Pauley (2015).

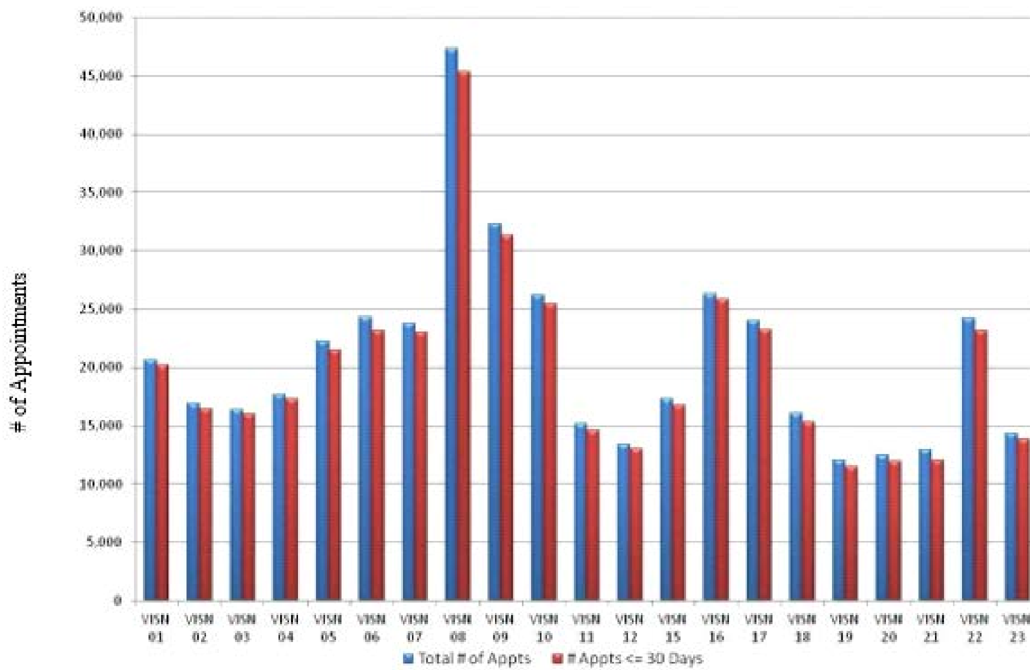
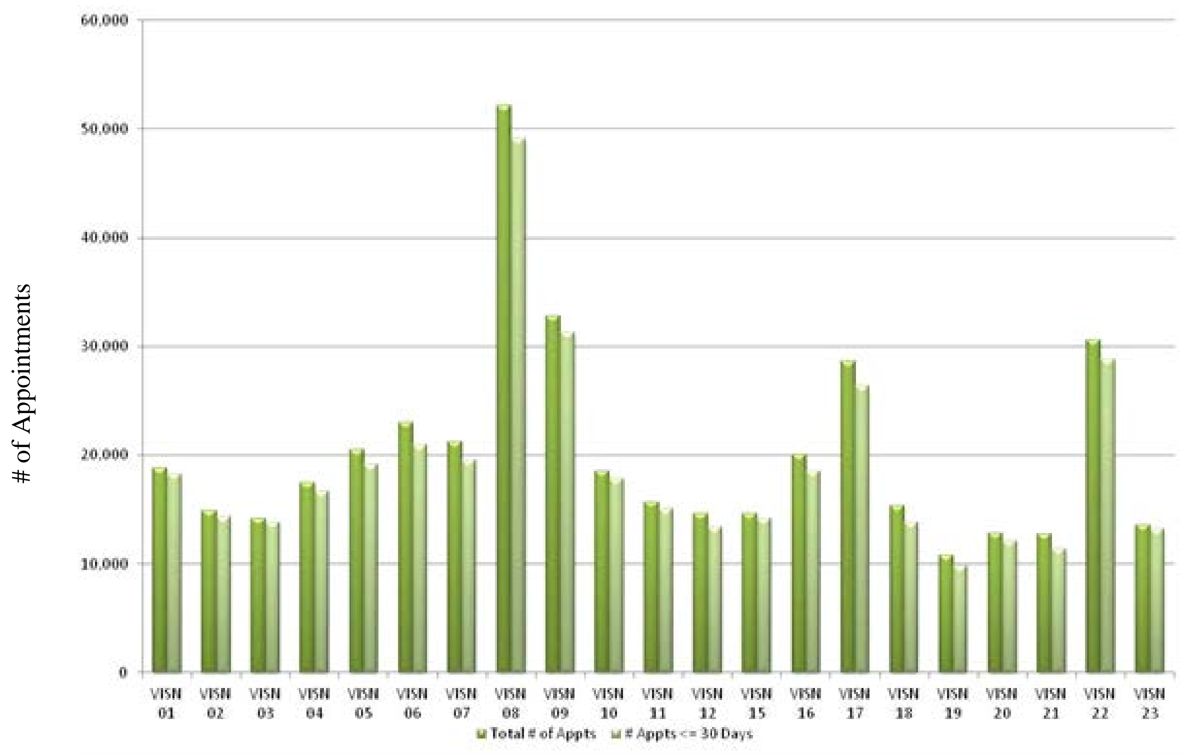


Figure 5 shows the established patient prospective wait times within 30 days as of January 15, 2015, which is post-VACAA.

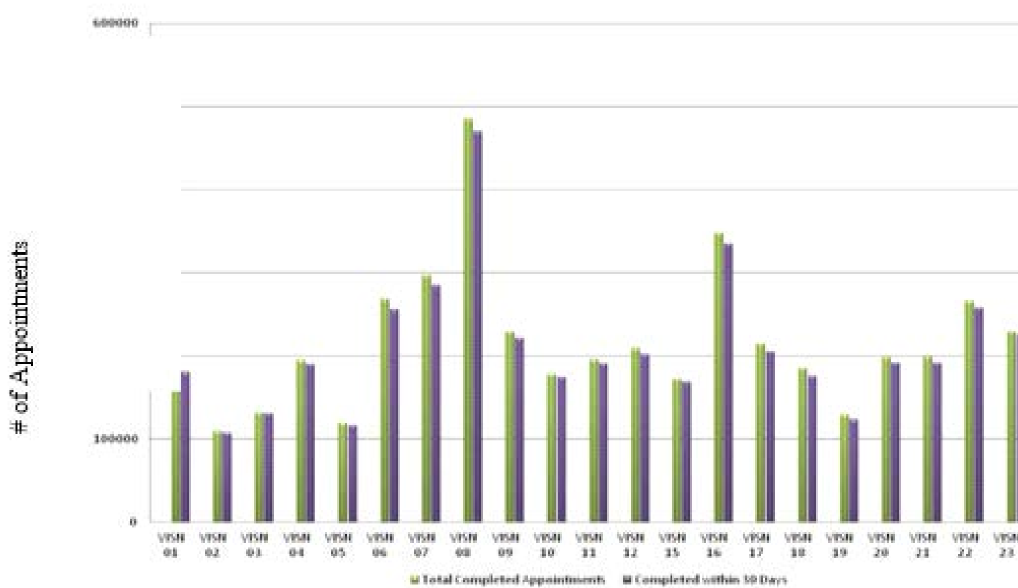
Figure 5. Established Patient Prospective Wait Times within 30 Days as of January 15, 2014, after VACAA. Adapted from Pauley (2015).



According to the data collected in Figures 4 and 5, established patients were seen at a very high percentage rate of 97% or better within the 30-day timeframe both pre- and post-Phoenix incident.

The VA released a data report (Pauley, 2015) that portrays the total amount of veterans that were in the system to have an appointment with a physician and the total amount of veteran appointments that were completed within the 30-day timeframe. The results from the most recent data for all patients using the PD/CID methodology as of January 2015 reveal that over 98% of the veterans were seen within the 30-day timeframe as indicated in Figure 6:

Figure 6. Retrospective Wait Times Desired Date as of January 15, 2014. Adapted from Pauley (2015).



The VA surveyed veterans in all 23 Veterans Integrated Service Networks (VISNs) to get feedback on their response to wait times. The results of the survey are based on the national average of veterans' satisfaction from the months of October, November and December of 2014. The national percentile for veterans' satisfaction results are as follows: 44% of veterans reported that they were able to get an appointment for care as soon as they needed; 52.7% reported that they were able to get a check-up appointment as soon as they needed; 44% reported that when they contacted the provider's office during regular hours they were able to get an answer to their question the same day; 36.7% reported that when they contacted the provider's office after regular hours they were able to get an answer to their medical question as soon as needed; 30% reported that they were able to see the provider within 15 minutes of their appointment time (Pauley, 2015). Complete survey results are indicated in Table 1.

Table 1. Data from Survey of Health Experiences of Patients (SHEP) Primary Care Mental Health (PCMH) Veteran Patient Survey. Adapted from Pauley (2015).

Veteran Survey Questions	Oct FY15	Nov FY15	FY15 Q1	YTD	National AVG
Composite	41.4	41.6	41.5	41.5	41.5
Q6: In the last 12 months, when you phoned this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	43.3	44.8	44	44	44
Q9: In the last 12 months, when you made an appointment for a checkup or routine care with this provider, how often did you get an appointment as soon as you needed?	52.6	52.8	52.7	52.7	52.7
Q14: In the last 12 months, when you phoned this provider's office during regular office hours, how often did you get an answer to your medical question that same day?	44.5	43.4	44	44	44
Q16: In the last 12 months, when you phoned this provider`s office after regular office hours, how often did you get an answer to your medical question as soon as you needed?	36.6	36.9	36.7	36.7	36.7
Q18: Wait time includes time spent in the waiting room and exam room. In the last 12 months, how often did you see this provider within 15 minutes of your appointment time?	29.7	30.3	30	30	30

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IV. DISCUSSION

Through this research and data analysis it was discovered that the VA has made tremendous strides to try to improve veterans wait times through systematically researching, collecting evidence and making changes to how wait times are calculated to ensure new and established patients are tracked equally. The ultimate goals of these changes are to allow veterans to have access to shorter wait times which is presumed to improve healthcare outcomes. A limitation of these changes still includes whether or not an increased wait time is a major contributing factor to people dying.

Through this research and data analysis it is not possible to state unequivocally if VA is regaining its trust with veterans regarding their wait times. The statistics show that more veterans are being serviced after VACAA. However, it cannot be determined if this is a result of more veterans having access to what VA offers or if prior statistics were not providing all of the information regarding how well VA was performing prior to the whistleblowing incident in Phoenix.

The research does show that VA has made systematic changes to make things more transparent for veterans, the media and the public. All patients are tracked exactly alike, not like prior VACAA when established and new patients had a different system. VA provides surveys for veterans to fill out and the results are published publicly so everyone can observe how well VA is doing in regards to the wait times of their patients. The lessons learned from VA whistleblowing incident and the systematic changes that have occurred so far can be applied to the public healthcare sector in hopes that public hospitals and their patients will not be subjected to extremely long wait times, which could affect the level of care provided to help patients sustain a long livelihood.

While these are initial phases toward improvement, some areas that were not explicitly researched include specific dates of when data were tracked; there were only examples of 30-day intervals. The wait times would be easier to decipher if the data would give a start and end date as opposed to just stating a “through” date. The surveys should also ask veterans how they feel about the services that they are receiving and if they believe

VA is providing a better service now than in the past. VA's changes have not had much time to take effect and, especially since past reforms did not persist, this study should be replicated in a few years.

As VA continues to be honest, transparent, track wait times, survey veteran's satisfaction, hire trained professionals and ensure that all VA employees honor President Lincoln's promise, it will continue to regain the trust of the veterans, the media and the public.

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