Written by **Raven Clabough** on July 21, 2014

Obama Administration Had Been Briefed on VA Problems in 2008

As if the Obama administration is not in enough hot water over the disastrous Department of Veterans' Affairs, reports now reveal that the administration had been warned about waiting times and fraud immediately after the president was first elected in 2008.

The Veterans Administration has been under harsh scrutiny after reports exposed that the Phoenix facility had been altering its scheduling books and that at least 40 veterans had died while awaiting care. Senator John McCain, an Arizona Republican, said though the scandal began in his home state, it has since become a national crisis. "Altogether, similar reports of lengthy waiting lists and other issues have surfaced in at least 10 states," according to the *Washington Times*.

What's worse is that the Obama administration had been briefed on the weaknesses of the VA and did nothing to address them.

On Sunday, the *Washington Times* reported that officials had briefed Obama's transition team on the need to decrease excessive wait times through the development of a new system. According to that report, development on the new system had been in progress since 2002.

The *Washington Times* wrote, "The briefing materials, obtained by the *Washington Times* through the Freedom of Information Act, make clear that the problems existed well before Mr. Obama took office, dating back at least to the Bush administration. But the materials raise questions about what actions the department took since 2009 to remedy the problems."

It is typical for briefing reports to be prepared when a power change is set to take place, allowing new administrations to have detailed insights into the operations of various agencies. The VA briefing report indicates that officials have been well aware of the problems plaguing the agency for a long time but had been unable to correct them. "Although VHA has recognized the need to improve scheduling practices and the accuracy of wait times data, no meaningful action has been taken to achieve this goal today," officials wrote.

Perhaps most damning is that the 2008 transition report cites a VA inspector general recommendation to test the accuracy of reported waiting times. The report observes that those tests could compel officials to take action if the results reveal "questionable differences" between the dates shown in medical records and those in the Veterans Health Administration's scheduling system.

"Audits of outpatient scheduling and patient waiting times completed since 2005 have identified noncompliance with the policies and procedures for scheduling, inaccurate reporting of patient waiting times and errors in [electronic waiting lists]," the briefing papers state. "This report and prior reports indicate that the problems and causes associated with scheduling, waiting times and wait lists are systemic throughout the VHA," officials wrote for the incoming administration.

Of course the briefing papers are just one of many ways the Obama administration had been informed of the VA's issues. Though former White House Press Secretary Jay Carney said that President Obama only found about the VA wait-list scandal from watching the news, the Obama administration reportedly knew that an internal VA investigation into secret "paper" waiting lists was conducted in 2010 under then-VA Secretary Eric Shinseki.

"We conducted this review to determine the validity of an allegation that senior officials in Veterans Integrated Service Network 20 (VISN) instructed employees at the Portland VA Medical Center to use unauthorized wait lists to hide access and scheduling problems," according to an August 17, 2010 VA Office of Inspector General (OIG) report entitled "Review of Alleged Use of Unauthorized Wait Lists at the Portland VA Medical Center," which was obtained by the online Daily Caller.

"OIG has reported problems since 2005 with schedulers not following established procedures for making or recording medical appointments. This practice has resulted in data integrity weaknesses that impacted the reliability of patient waiting times and facility waiting lists," the report continued.

"The OIG received an anonymous e-mail alleging the use of unauthorized paper wait lists, and that the eye clinics had over 3,500 patients waiting more than 30 days for appointments," according to the report.

But the briefing papers obtained by the *Washington Times* further illustrate the ineptitude of the Department of Veterans' Affairs. "VA has been trying — and failing — to replace its outpatient scheduling system since 2000, wasting nearly $130 million in the process," Rep. Jeff Miller, R-Fla., the chairman of the House Veterans' Affairs Committee, told the paper. "Because VA acquisition officials have proven time and again they are simply too inept to guide the development of a new proprietary appointment-scheduling system in an expedient and cost-effective manner, department leaders need to look at adopting commercial technologies that are being used in the private sector."

The Obama administration was not alone in ignoring the warnings. Reports also indicate that various whistleblowers at VA hospitals brought concerns to VA staff and were ultimately ignored. "The recent revelations from Phoenix are the latest and most serious in the years-long pattern of disclosures from VA whistleblowers and their struggle to overcome a culture of nonresponsiveness," according to a letter from the special counsel's office. "Too frequently, the VA has failed to use information from whistle blowers to identify and address systemic concerns that impact patient care."

And those whistleblowers are now facing retribution for their actions. In a press release issued earlier this month, the U.S. Office of the Special Counsel (OSC) indicated that it has received numerous complaints of retaliation from employees at VA facilities in 19 states — Arkansas, Arizona, California, Colorado, Delaware, Florida, Georgia, Iowa, Kentucky, Michigan, North Carolina, New York, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Texas, Utah, Wyoming — but did not identify the facilities. The Special Counsel's office has instituted an ongoing investigation.

Nick Schwellenbach, a spokesman for the OSC, told NBC News that the VA has "one of the highest reprisal case rates in the federal government. We're concerned by what we're seeing…. The frequency

of retaliation complaints has given us a lot of pause."

The VA scandal has critics calling for the resignation of VA undersecretary for benefits Allison Hickey. Secretary Eric K. Shinseki has already resigned.

"They are both part of VA's leadership problem," American Legion Commander Daniel Dellinger said in a statement Friday. "This isn't personal. VA needs a fundamental shift in leadership if it is to defeat its systematic lack of accountability."