



Horror Stories From Obama's VA

As The VA Scandal Continues To Unfold, A Look At The Secret Lists And Poor Care That Is Endemic At Obama's VA

FLASHBACK: In July 2012, Obama Told Veterans: "I Promised To Strengthen The VA, And That Promise Has Been Kept." OBAMA: "This leads me to another promise I made four years ago -- upholding America's sacred trust with our veterans. I promised to strengthen the VA, and that promise has been kept. In my first year, we achieved the largest percentage increase in the VA budget in 30 years. And we're going to keep making historic investments in our veterans. When Richard came to the Oval Office, we talked about what those automatic budget cuts -- sequestration -- could mean for the VA. So my administration has made it clear: Your veteran's benefits are exempt from sequestration. They are exempt. And because advance appropriations is now the law of the land, veterans' health care is protected from the budget battles in Washington." (Barack Obama, [Remarks To The 113th National Convention Of The Veterans Of Foreign Wars](#), Reno, NV, 7/23/12)

- **Obama, 2013: "We Can't Just Promise Better Care, We've Actually Got To Deliver Better Care."** OBAMA: "Hundreds of medical and nursing schools have committed to improving research and care for our veterans and their families. And I've proposed more funding for mental health. We can't just promise better care, we've actually got to deliver better care." (Barack Obama, [Remarks At Disabled American Veterans Convention](#), Orlando, FL, 8/10/13)

WHILE OBAMA TALKS ABOUT DELIVERING BETTER CARE, VA FACILITIES ACROSS THE COUNTRY HAVE BEEN GAMING THE SYSTEM

26 VA Facilities Are Now Under Investigation For Manipulating Wait Times By The Inspector General, A Spokeswoman Announced Last Week. "A spokeswoman for the IG's office said 26 facilities were being investigated nationwide. Acting Inspector General Richard Griffin told a Senate committee last week that at least 10 new allegations about manipulated waiting times and other problems had surfaced since reports of problems at the Phoenix VA hospital came to light last month." (Matthew Daly, "VA Investigations Now Involve 26 Facilities, Says Inspector General," [Associated Press](#), 5/20/14)

- **National Journal Headline: "Obama, The VA, And 'Betrayal'"** (Major Garrett, "Obama, The VA, And 'Betrayal,'" [National Journal](#), 5/20/14)

And What's Worse—The VA Knew Of The Manipulation As Far Back As 2010

The Washington Post Headline: "This Memo Shows That The VA Knew Of Records Manipulation In 2010" (Josh Hicks, "This Memo Shows That The VA Knew Of Records Manipulation In 2010," [The Washington Post](#), 5/20/14)

“The Message Summarized At Least 17 Tactics That VA Hospitals Were Known To Have Used To Hide Treatment Delays And Give The Impression They Were Meeting The Department’s Goal Of Seeing Patients Within 14 To 30 Days.” (Josh Hicks, “This Memo Shows That The VA Knew Of Records Manipulation In 2010,” [The Washington Post](#), 5/20/14)

Phoenix, Arizona

CNN Headline: “A Fatal Wait: Veterans Languish And Die On VA Hospital’s Secret List” (Scott Bronstein And Drew Griffin, “A Fatal Wait: Veterans Languish And Die On VA Hospital’s Secret List,” [CNN](#), 4/30/14)

According To Whistleblower Reports, A VA Hospital In Phoenix “Developed A ‘Secret Waiting List’ To Hide Delays, Possibly Affecting Dozens Of Patients Who Died While Waiting For Care.” “The Legion’s action on Monday followed multiple reports of preventable deaths and attempts to cover up treatment delays at VA health clinics. At least two whistleblowers have said a Phoenix VA hospital developed a ‘secret waiting list’ to hide delays, possibly affecting dozens of patients who died while waiting for care.” (Josh Hicks, “American Legion Calls For Resignation Of VA Secretary Eric Shinseki,” [The Washington Post](#), 5/5/14)

- **The Secret List Was Designed By VA Officials “Who Were Trying To Hide That 1,400 To 1,600 Sick Veterans Were Forced To Wait Months To See A Doctor.”** “The secret list was part of an elaborate scheme designed by Veterans Affairs managers in Phoenix who were trying to hide that 1,400 to 1,600 sick veterans were forced to wait months to see a doctor, according to a recently retired top VA doctor and several high-level sources.” (Scott Bronstein And Drew Griffin, “A Fatal Wait: Veterans Languish And Die On VA Hospital’s Secret List,” [CNN](#), 4/30/14)

Internal Emails “Show That Top Management At The VA Hospital In Arizona Knew About The Practice And Even Defended It.” “Internal e-mails obtained by CNN show that top management at the VA hospital in Arizona knew about the practice and even defended it.” (Scott Bronstein And Drew Griffin, “A Fatal Wait: Veterans Languish And Die On VA Hospital’s Secret List,” [CNN](#), 4/30/14)

Fort Collins, Colorado

According To An Inspector’s Report, A VA Clinic In Colorado “Falsified Appointment Records To Give The Impression That Staff Doctors Had Seen Patients Within The Agency’s Goal Of 14 Days.” “Similarly, a new report from the VA’s Office of the Medical Inspector said a department clinic in Fort Collins, Colo., falsified appointment records to give the impression that staff doctors had seen patients within the agency’s goal of 14 days. USA Today first revealed the findings in an article on Sunday.” (Josh Hicks, “American Legion Calls For Resignation Of VA Secretary Eric Shinseki,” [The Washington Post](#), 5/5/14)

- **“The Whistleblower Behind The Federal Investigation Of The Fort Collins Veterans Affairs Clinic Said She Was Put On Two-Week Unpaid Leave For Not ‘Cooking The Books’ When Scheduling Appointments.”** (Nick Coltrain, “Whistleblower: VA Punished Me For Not Falsifying Records,” [The Coloradan](#), 5/19/14)

“Many Of The 6,300 Veterans Treated At The Outpatient Clinic Waited Months To Be Seen.” (Gregg Zoroya, “VA Treatment Records Falsified, Probe Finds,” [USA Today](#), 5/4/14)

Austin And San Antonio, Texas

A VA Scheduling Clerk Said Officials In San Antonio And Austin Manipulated Appointment Data To Conceal Long Wait Times. “A Department of Veterans Affairs scheduling clerk has accused VA officials in Austin and San Antonio of manipulating medical appointment data in an attempt to hide long wait times to see doctors and psychiatrists, the American-Statesman has learned.” (Jeremy Schwartz, “VA Employee: Wait List Data Was Manipulated In Austin, San Antonio,” [Austin American-Statesman](#), 5/6/14)

- **The Staffer Said Employees Were “Verbally Directed By Lead Clerks, Supervisors, And During Training” To Ensure Wait Times Were “As Close To Zero Days As Possible.”** “In communications with the U.S. Office of Special Counsel, a federal investigative body that protects government whistleblowers, the 40-year-old VA employee said he and others were ‘verbally directed by lead clerks, supervisors, and during training’ to ensure that wait times at the Austin VA Outpatient Clinic and the North Central Federal Clinic in San Antonio were ‘as close to zero days as possible.’” (Jeremy Schwartz, “VA Employee: Wait List Data Was Manipulated In Austin, San Antonio,” [Austin American-Statesman](#), 5/6/14)

Hines, Illinois

The Hines VA Medical Center Used A Secret Waiting List To Hide Appointment Delays So Managers Could Receive Bonuses And Recognition. WYATT ANDREWS: “Germaine Clarno is a VA social worker and employee representative in Chicago. She alleges there are multiple secret waiting lists of veterans kept here at the Hines VA Medical Center. Which divisions of the hospital kept these secret waiting lists?” GERMAINE CLARNO: “Well, employees are coming to me from all over the hospital, from out-patient, in-patient, surgery, radiology.” ANDREWS: “Clarno says veterans were put on secret waiting lists when they called for an appointment but wouldn't formally get an appointment booked in the computer until one came up within the VA's goal of 14 days. The purpose of the list, she says, was to hide how often veterans were not being seen on time. Is it too strong to call this fraud?” CLARNO: “No.” ANDREWS: “To what purpose?” CLARNO: “To make the numbers look better for their own recognition and for bonuses.” ([CBS Evening News](#), 5/13/14)

Gainesville, Florida

Three Administrators Have Been Placed On Administrative Leave After A “Secret” Waiting List Of Over 200 Patients Was Discovered At A Gainesville Facility. “Three mental health administrators at the Malcom Randall VA Medical Center in Gainesville have been placed on administrative leave after U.S. Department of Veterans Affairs officials found a ‘secret’ waiting list of more than 200 patients, a local union president said Thursday.” (Morgan Watkins, “Source: 3 Suspended At Gainesville VA Over Mental Health Waiting List,” [Ocala Star Banner](#), 5/15/14)

The Director Of The North Florida/South Georgia Veterans Health System Claimed “Officials Found Was A Paper List Of Patients Who Needed Appointment Callbacks.” “The director of the North Florida/South Georgia Veterans Health System, Thomas Wisnieski, however, said what officials found was a paper list of patients who needed appointment callbacks. That list isn't considered proper protocol, Wisnieski said. Wisnieski said the list was not a secret waiting list, but he also said he did not know about it until a VA team discovered it while visiting the hospital Tuesday for a review.” (Morgan Watkins, “Source: 3 Suspended At Gainesville VA Over Mental Health Waiting List,” [Ocala Star Banner](#), 5/15/14)

Cheyenne, Wyoming

An Employee At A Wyoming VA Facility Has Been Placed On Administrative Leave Over The Growing Scandal Of Appointment Manipulations. “A growing scandal over the manipulation of health care appointments resulted in an employee at a Wyoming clinic of the Department of Veterans Affairs being placed on administrative leave, VA Secretary Eric Shinseki said Friday.” (Drew Griffin, Scott Bronstein, Nelli Black, And Ray Sanchez, “VA Clinic Employee On Leave After E-Mail About Manipulating Appointments,” [CNN](#), 5/10/14)

- **Email By A Cheyenne VA Employee: “Yes, It Is Gaming The System A Bit. But You Have To Know The Rules Of The Game You Are Playing, And When We Exceed The 14-Day Measure, The Front Office Gets Very Upset, Which Doesn't Help Us.”** “An e-mail allegedly written by an

employee in Cheyenne, obtained by CNN, says: ‘Yes, it is gaming the system a bit. But you have to know the rules of the game you are playing, and when we exceed the 14-day measure, the front office gets very upset, which doesn’t help us. Let me know if this doesn’t make sense.’” (Drew Griffin, Scott Bronstein, Nelli Black, And Ray Sanchez, “VA Clinic Employee On Leave After E-Mail About Manipulating Appointments,” [CNN](#), 5/10/14)

Albuquerque, New Mexico

An Albuquerque VA Hospital Has Been Accused Of Keeping A Secret Waiting List. “Add Albuquerque, New Mexico’s to the growing list of VA hospitals accused of keeping secret waiting lists to hide delays for veterans seeking medical care. And it may already be too late to get to the truth and find out what harm, if any, was done to veterans there—VA officials are already destroying records to cover their tracks, a whistleblower inside the hospital tells The Daily Beast.” (Jacob Siegel, “Exclusive: VA Scandal Hits New Scandal,” [The Daily Beast](#), 5/18/14)

- **According To A Whistleblower Inside The Facility, “VA Officials Are Already Destroying Records To Cover Their Tracks.”** (Jacob Siegel, “Exclusive: VA Scandal Hits New Scandal,” [The Daily Beast](#), 5/18/14)

VA Physician: “There Is An Eight-Month Waiting List For Patients To Get Ultrasounds Of Their Hearts. Some Patients Have Died Before They Got Their Studies.” (Jacob Siegel, “Exclusive: VA Scandal Hits New Scandal,” [The Daily Beast](#), 5/18/14)

- **“[T]he Doctor Says It’s Quite Possible That Some Veterans Would Still Be Alive If They Hadn’t Been Pushed Through A Record-Keeping Trap Door That Buried Their Requests For Medical Care.”** “There’s no proof yet that veterans died while waiting for treatment, like what allegedly happened in Phoenix. But the doctor says it’s quite possible that some veterans would still be alive if they hadn’t been pushed through a record-keeping trap door that buried their requests for medical care.” (Jacob Siegel, “Exclusive: VA Scandal Hits New Scandal,” [The Daily Beast](#), 5/18/14)

EVEN WHEN VETERANS GET SERVICE, THE VA HAS A LONG RECORD OF IMPROPER CARE LEADING TO DEATH AND ILLNESS

The VA In Pittsburgh Knew Of A Legionnaires Disease Outbreak, But Failed To Inform Patients And Families

The VA Hospital Knew For Over A Year It Had An Outbreak Of Legionnaires’ disease But Didn’t Warn Patients While Placing Blame On An Old Water System. “In January 2013, CBS News reported that a Veterans Affairs hospital in Pittsburgh knew for more than a year it had an outbreak of Legionnaires’ disease, but failed to warn patients. VA officials testified before Congress on February 5, 2013, blaming the facilities’ old water system for the outbreak.” (Jennifer Janisch, “VA Hospital Knew Human Error Caused Legionnaires’ Outbreak,” [CBS News](#), 3/13/14)

- **Emails Show Employees At The Clinic Knew Human Error Was Responsible For The Outbreak.** “Now, emails and internal memos obtained by CBS News indicate top employees at the Pittsburgh VA knew human error was behind the outbreak, and not an equipment failure as officials suggested to Congress.” (Jennifer Janisch, “VA Hospital Knew Human Error Caused Legionnaires’ Outbreak,” [CBS News](#), 3/13/14)

After Reports Surfaced That A VA Center “Failed To Prevent The Outbreak,” The Facility’s Head Received A \$62,895 Bonus. “After the CBS News investigation, the VA’s inspector general found the Pittsburgh VA failed to prevent the outbreak. The man who oversees that hospital is Regional Director Michael Moreland. Just days after that finding, the department gave him a \$62,895 service award for

saving the government money on a hospital construction project, and for starting a new infection prevention program.” (Elaine Quijano, “Officials At Troubled VA Hospitals Received Big Bonuses,” [CBS News](#), 8/27/13)

Improper Treatment At A VA Hospital In Memphis Led To The Death Of Three Patients

At A VA Hospital In Memphis, “A Failure To Guard Against An Allergic Reaction, An Over-Medication Of Sedatives And Poor Monitoring Of High-Blood Pressure Led To The Deaths Of Three Patients.” “A failure to guard against an allergic reaction, an over-medication of sedatives and poor monitoring of high-blood pressure led to the deaths of three patients last year at a VA hospital in Memphis, Tenn., according to inspector general report issued Wednesday.” (Gregg Zoroya, “IG: 3 Deaths At A VA Medical Center Linked To Poor Care,” [USA Today](#), 10/24/13)

Financial Mismanagement, Poor Staffing, And Long ER Wait Times Are What You’ll Find In Dallas

A Dallas VA Hospital’s Former Chief Of Medicine “Testified About Financial Mismanagement, Staffing Problems And Unacceptable Emergency Room Wait Times.” “A former high-ranking doctor at the VA Hospital in Dallas is joining the parade of critics claiming area veterans are getting substandard care. The hospital’s former Chief of Medicine recently testified about financial mismanagement, staffing problems and unacceptable emergency room wait times.” (Brett Shipp, “Insiders Raise Care Concerns At Dallas VA Hospital,” [WFAA](#), 1/14/14)

- **The Former Official Highlighted “Long Wait Times, ‘Unanswered Communications,’ And A Constant ‘Turnover Of Doctors’ Making Him And Other Veterans Feel Like ‘Guinea Pigs.’”** “In a series of complaints to hospital administrators dating back to 2011, Johansen documents long wait times, ‘unanswered communications,’ and a constant ‘turnover of doctors’ making him and other veterans feel like ‘guinea pigs.’” (Brett Shipp, “Insiders Raise Care Concerns At Dallas VA Hospital,” [WFAA](#), 1/14/14)

Poor Management At An Atlanta VA Led To Three Deaths—But That Didn’t Stop Managers From Receiving Bonuses

According To An Inspectors General Report, The Center “Was Not Sufficiently Addressing Patient Safety” With Three Deaths Blamed On Mismanagement “Dellinger mentioned other issues on Monday, including a deadly Legionnaires’ disease outbreak at a Pittsburgh VA hospital in 2012 and claims that mismanagement led to three deaths at an Atlanta clinic. An inspectors general report said the Atlanta center was not sufficiently addressing patient safety.” (Josh Hicks, “American Legion Calls For Resignation Of VA Secretary Eric Shinseki,” [The Washington Post](#), 5/5/14)

The Former Top Official Of The Atlanta VA Center Received \$65,000 In Bonuses Even As It Was Revealed Mismanagement Led To Three Deaths. “The former top administrator at the Atlanta VA Medical Center received \$65,000 in performance bonuses over a four-year span as internal audits revealed lengthy wait times for mental health care and mismanagement that led to three deaths.” (Daniel Malloy, “Atlanta VA Exec Scored Bonuses While Audits Found Lapses,” [The Atlanta Journal-Constitution](#), 4/26/14)

“Health And Leadership Problems” At A St. Louis Facility Led To At Least One Death

According To A 2012 Report, A VA Center In St. Louis Was “Cited For Health And Leadership Problems After A Nurse Failed To Monitor A Patient Who Died” Following A 2010 Kidney Dialysis Treatment. “John Cochran VA Medical Center in St. Louis has again been cited for health and leadership problems after a nurse failed to monitor a patient who died following kidney dialysis. The nurse did not recognize or report that a man, 58, became unresponsive at some point during a five-hour dialysis

treatment in December 2010, according to a report released Monday by the Veterans Affairs Office of Inspector General.” (Blithe Bernhard, “St. Louis Hospital Again Gets Critical Report,” [St. Louis Post-Dispatch](#), 6/13/12)

“The Former Director Of The St. Louis VA Medical Center Received Nearly \$25,000 In Extra Pay Even Though 1,800 Patients May Have Been Exposed To HIV And Hepatitis As A Result Of Unsanitary Dental Equipment.” (Ledyard King, “Lawmakers Demand Greater Accountability At VA,” [USA Today](#), 4/3/14)

20 Veterans Tested Positive For Hepatitis In Buffalo After Nurses Reused Insulin Pens On Multiple Patients

20 Veterans Treated At A Buffalo VA Hospital Have Tested Positive For Hepatitis “In The Wake Of Revelations That Nurses Improperly Reused Insulin Pens On Multiple Patients.” “Twenty veterans treated at the Buffalo Veterans Affairs Medical Center have tested positive for hepatitis in the wake of revelations that nurses improperly reused insulin pens on multiple patients, but all but two have cleared the virus, the hospital said Thursday.” (Jerry Zremski, “20 Buffalo VA Patients Test Positive For Hepatitis,” [The Buffalo News](#), 5/9/13)

Six Veteran Deaths Have Been Linked To Cancer Screening Delays At A VA Hospital In Columbia, South Carolina

The William Jennings Bryan Dorn VA Hospital In Columbia Had 20 Cases Of Cancer Screening Delays, Linked To Six Deaths. “Delays in endoscopy screenings for potential gastrointestinal cancer in 76 veterans treated at Department of Veterans Affairs hospitals are linked to 23 deaths, most of them three to four years ago, according to the VA. The delays occurred at 27 VA hospitals with deaths at 13 of the facilities. The worst record was at the William Jennings Bryan Dorn veterans hospital in Columbia, S.C., where there were 20 cases of delays and six deaths, according to a VA report. Other deaths occurred at VA hospitals in Hampton, Va.; Augusta, Ga.; Charleston, S.C.; Miami; West Palm Beach, Fla.; Huntington, W.Va.; Cleveland; Prescott, Ariz.; Tucson; Grand Junction, Colo.; and Iowa City, Iowa, the report says.” (Gregg Zoroya, “VA: Delayed Treatment Led To Cancer Deaths,” [USA Today](#), 4/8/14)

MEANWHILE, OBAMA’S RESPONSE HAS FAILED TO SATISFY ANYONE, PARTICULARLY VETERANS

CNN’s Drew Griffin: We Are Five Years Into Obama’s Presidency And The “Problem Seems To Be Certainly Not Better And Perhaps Even Worse.” DREW GRIFFIN: “I was a little confused by the president’s remarks today. At the same time, he was saying he’s known about this problem for years and years and years and it goes back decades far past into other people’s presidencies and yet we’re five years into his presidency and the problem seems to be certainly not better and perhaps even worse.” (CNN’s “@This Hour,” 5/21/14)

Paul Rieckhoff, CEO And Founder Of The Iraq And Afghanistan Veterans Of America: Obama’s Comments On The Growing VA Scandal Were “A Tremendous Disappointment.” “Paul Rieckhoff, the CEO and founder of the Iraq and Afghanistan Veterans of America, called the president’s comments on the growing scandal ‘a tremendous disappointment’ and said those impacted by mismanagement at health centers across the country shouldn’t have to wait as the government investigated allegations of misconduct.” (Justin Sink, “Veterans Groups Slam Obama Comments On VA,” [The Hill](#), 5/21/14)