(March 14, 2016)

In order to further improve the lines of communication and to respond to the concerns between the National VA Council and you our members, I have established a National VA Council Briefing. This NVAC Briefing will bring you the latest news and developments within DVA and provide you with the current status of issues this Council is currently addressing. I believe that this NVAC Briefing will greatly enhance the way in which we communicate and the way in which we share new information, keeping you better informed.

Alma L. Lee
National VA Council, President

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In This Briefing: VA wait-times still manipulated, whistleblowers say

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WASHINGTON — Employees at the Department of Veterans Affairs who blew the whistle on the manipulation of scheduling data to falsely reflect shorter wait times are blasting investigations of their complaints, saying they were not thorough enough and the practice is still continuing in some VA facilities.

“My office has just been crazy busy with providers, schedulers, coming to me and saying, ‘Hey, we’re still manipulating, and the intimidation is still active,’ ” said Germaine Clarno, a social worker and union representative at a suburban Chicago VA Medical Center.

“I can promise you that it is still going on at facilities across this country,” said Shea Wilkes, co-director with Clarno of a group of more than 40 whistleblowers from VA medical facilities in more than a dozen states.

The VA’s inspector general last week began releasing the findings of 77 wait-time investigations following a Freedom of Information request from USA TODAY. In the 38 cases released so far, investigators found improper scheduling in 21 of them.

The problems included schedulers entering the next available date as a veteran’s desired date, thereby reflecting no wait time. In some cases, they found managers directing them to do it. In others, VA staff had lists of patients outside the system, which meant their actual wait time was unknown.

In most cases, however, the investigators concluded the practices were due to confusion and a lack of training rather than deliberate manipulation to mask wait times.

The whistleblowers say they didn't go far enough, including to look more broadly at whether veterans died or were harmed awaiting care.

"The investigations they're doing continue to be half-a---- and shoddy," said Wilkes, a social worker at the Shreveport, La., VA who blew the whistle on wait-time problems there. "I mean, it's sad because veterans are still getting poor care."

VA whistleblower Germaine Clarno confronts Secretary Bob McDonald after a Senate hearing March 10. She says wait times still are being manipulated.

In the Phoenix VA scandal, staffers had been keeping secret wait lists rather than entering veterans into the scheduling system, hiding their actual wait times, and at least 40 veterans died while they waited.

The whistleblowers are not alone in criticizing some of the findings released in recent days. The Office of Special Counsel, which is responsible for investigating whistleblower complaints, has written a letter to President Obama complaining that probes were inadequate at VA medical centers in Hines, Ill., and Shreveport, where Clarno and Wilkes had reported problems.

"The OIG investigations found evidence to support the whistleblowers' allegations that employees were using separate spreadsheets outside of the VA's electronic scheduling and patient records systems," Special Counsel Carolyn Lerner wrote. "However, the OIG largely limited its review to determining whether these separate spreadsheets were 'secret.' "

A spokeswoman for acting Inspector General Linda Halliday did not respond to messages Thursday seeking comment.

VA Secretary Bob McDonald said at a Senate hearing Thursday the agency is reviewing the inspector general's probes. He noted that Lerner wrote that new leadership in the inspector general's office will "steer inquiries in a more appropriate and comprehensive direction." He urged Senate confirmation of Michael Missal, a Washington lawyer nominated last fall to lead the office.

"During a time of change like we're having … that can create challenges for us, and so we want the IG to be vigilant on where those challenges are," he said.

Sen. Mark Kirk, R-Ill., who was chairing the appropriations subcommittee hearing, tried to drive home that lengthy wait times cost lives. He said one of his constituents, Army Spc. Tom Young, afflicted with post-traumatic stress disorder after two tours in Iraq, went to the Hines VA for help but was turned away.

"Tom laid down on the metro tracks near Prospect Heights in July 2015," he said. Kirk said two days after the suicide, the VA said no further investigation of wait-time problems at the Hines VA was needed because the inspector general already had investigated and addressed the problems.