Table 1: Geographic Location of Veterans Health Facilities Investigated for Wait-Time Problems, 2000-2014

Date	Type	Title		Report Summary	City	State	Sunbelt
September 5, 2000	VA-OIG	Healthcare Inspection Multiple Management and Patient Care Issues at the Department of Veterans Affairs Medical Center Omaha, Nebraska		The Inspector General report substantiated allegations concerning excessive delays in patient access to specialty care, and patient distrust and dissatisfaction	Omaha	NE	N
August 13, 2001	VA-OIG	Audit of the Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network (visn)		Inadequate capacity in some of the network's clinical services has restricted the availability of care to veterans. The Veterans Health Administration needs to revise its resource allocation strategies to ensure more effective network funding distributions and availability of services to veterans	FL	FL	Y
January 1, 2004	GAO	VA HEALTH CARE Access for Chattanooga-Area Veterans Needs Improvement		Almost all (99 percent) of the 16,379 enrolled veterans in the 18-county Chattanooga area, as of September 2001, faced travel times that exceeded VA's guidelines for accessing inpatient hospital care. During fiscal year 2002, only a few Chattanooga-area veterans were admitted to non-VA hospitals in Chattanooga—constituting about 5 percent of inpatient workload. In addition, over half (8,400) of Chattanooga-area enrolled veterans faced travel times that exceeded VA's 30-minute guideline for outpatient primary care. Also, waiting times for scheduling initial outpatient primary and specialty care	Chattanooga	FL	Y

				appointments frequently exceeded VA's 30-day guideline.			
March 19, 2004	VA-OIG	Interim Report - Patient Care and Administrative Issues at VA Medical Center Bay Pines, Florida		The Department of Veterans Affairs (VA) Office of Inspector General (OIG) is conducting an evaluation of clinical and administrative management issues at VA Medical Center (VAMC) Bay Pines, Florida	Bay Pines	FL	Y
July 1, 2004	GAO	VA HEALTH CARE VA Needs to Improve Accuracy of Reported Wait Times for Blind Rehabilitation Services		VA Needs to Improve Accuracy of Reported Wait Times for Blind Rehabilitation Services	American Lake	WA	N
					Hines	IL	N
					Tucson	AZ	Y
					West Palm Beach	FL	Y
March 3, 2005	VA-OIG	Healthcare Inspection Patient Care and Mismanagement Issues VA Medical Center West Palm Beach, Florida		This report had many allegation of mismanagement. While many were unsubstantiated. Some about diagnostic testing and other were at least in part true.	West Palm Beach	FL	Y

June 24, 2005	VA-OIG	Patient Care, Fraud, and Mismanagement Issues VA Medical Center San Juan, Puerto Rico		Increased physician responsibility for performing clerical work had the effect of prolonging clinic appointment times to over 30 minutes per patient, which lengthened the waiting times of hundreds of patients.	San Juan	PR	Y
July 8, 2005	VA-OIG	Audit of the Veterans Health Administration's Outpatient Scheduling Procedures		VHA medical facilities did not have effective procedures to ensure all veterans either had appointments within 4 months of the desired date of care or were identified on an electronic waiting list. At 5 of the 8 medical facilities, schedulers understated their electronic waiting lists by 856 veterans.	Atlanta	GA	Y
					Boston	MA	N
					Chicago	IL	N
					Kansas City	MO	N
					Los Angeles	CA	Y
					North Texas	TX	Y
					Puget Sound	WA	N
					Washington	DC	N
September 19, 2005	VA-OIG	Healthcare Inspection Quality of Care, Customer Service, and Environment of Care, VA Western New York Healthcare System, Buffalo, New York		The claims of delay were not strongly supported by evidence	Buffalo	NY	N
May 17, 2006	VA-OIG	Review of Access to Care in the Veterans Health Administration		Report reviewed the FY 2005 performance measure "Wait Times for Primary Care and New Patients Seen Within 30 Days" report and found that the facilities visited did not achieve a satisfactory rating in 9 of the 20 quarters.	Alaska	AK	N
					New York Harbor	NY	N
					Pacific Islands		N
					Portland	OR	N
					Tampa	FL	Y

June 12, 2006	VA-OIG	Follow-Up Evaluation of Clinical and Administrative Issues Bay Pines Health Care System Bay Pines, Florida		Ft. Myers SOC Managers Understated the Waiting List, although the problem had been fixed by the time this report came out.	Bay Pines	FL	Y
April 24, 2007	VA-OIG	Quality of Care Issue in Cardiology Bay Pines VA Healthcare System, Bay Pines, Florida		Waiting times for coronary artery bypass surgery often exceeded 3 months, especially when patients were referred within the VA healthcare system	Bay Pines	FL	Y
June 18, 2007	VA-OIG	Healthcare Inspection Appointment Scheduling and Administrative Issues Carl T. Hayden VA Medical Center Phoenix, Arizona		The OIG concluded that at the time of the allegations, the appointment scheduling system for	Phoenix	AR	Y
September 10, 2007	VA-OIG	Audit of the Veterans Health Administration's Outpatient Waiting Times		Found unexplained differences between the desired dates as shown in VistA and used by VHA to calculate waiting times and the desired dates shown in the related medical records. As a result, the accuracy of VHA's reported waiting times could not be relied on and the electronic waiting lists at those medical facilities were not complete.	Atlanta	GA	Y
					Chillicothe	OH	N
					Cincinnati	OH	N
					Dallas	TX	Y
					San Antonio	TX	Y
					Temple	TX	Y
May 19, 2008	VA-OIG	Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3		Differences in the Percent of Patients Seen in 30 Days or Less Between the OIG and the Facility	Bronx/NY Harbor	NY	N
					NJ	NJ	N

February 2, 2009	VA-OIG	Mammography, Cardiology, and Colonoscopy Management		Report concluded waiting times for scheduling colonoscopies were excessive.	Muskogee	OK	N
August 17, 2010		Veterans Health Administration Review of Alleged Use of Unauthorized Wait Lists at the Portland VA Medical Center		Approximately 2,500 of the patients who were contacted experienced an average delay of 128 days in receiving care because of the recall system's failure	Portland	OR	N
July 12, 2011	VA-OIG	Healthcare Inspection Electronic Waiting List Management for Mental Health Clinics Atlanta VA Medical Center Atlanta, Georgia		They substantiated that several MH clinics had significantly high numbers of patients on their Electronic Waitlists (EWL) over a period of months in fiscal year (FY) 2010, and we substantiated that facility managers were aware of the EWLs but were slow in taking actions to address the condition. We are unaware of any completed suicides; however, we did find evidence of MH EWL patients who attempted suicide, were hospitalized, or presented to the emergency department.	Atlanta	GA	Y
June 29, 2011	VA-OIG	Delays in Cancer Care West Palm Beach VA Medical Center West Palm Beach, Florida		The report substantiated the allegation that renal cancer patients faced delays in treatment. For those patients who were referred to another VA Medical Center for care, there was no mechanism in place to follow their progress and verify that treatment was provided. These patients faced significantly longer wait times for treatment than those patients whose treatment option was available at the West Palm Beach VA Medical Center	West Palm Beach	FL	Y

January 6, 2012	VA-OIG	Healthcare Inspection Select Patient Care Delays and Reusable Medical Equipment Review Central Texas Veterans Health Care System Temple, Texas		The report substantiated that there are hundreds of fee-basis GI, mammogram, radiation oncology, and breast biopsy consults requiring action; however, we did not find evidence of patient harm due to delays in follow-up actions. We substantiated that there are GI wait times in excess of VHA requirements following initial positive screenings.	Temple	TX	Y
April 23, 2012	VA-OIG	Veterans Health Administration Review of Veterans' Access to Mental Health Care		Delay's: On average, a patient had to wait 41 days	Denver	CO	Y
					Milwaukee	WI	N
					Salisbury	NC	Y
					Spokane	WA	N
September 25, 2012	VA-OIG	Healthcare Inspection Consultation Mismanagement and Care Delays Spokane VA Medical Center, Spokane, Washington		We substantiated that requests for consultations were inappropriately cancelled or discontinued, and that patients consequently had unnecessary delays in the amelioration of symptoms. We found that the facility did not have a comprehensive policy or process in place for consult management	Spokane	WA	N
August 22, 2012	VA-OIG	Healthcare Inspection Access and Coordination of Care at Harlingen Community Based Outpatient Clinic VA Texas Valley Coastal Bend Health Care System Harlingen, Texas		The reports demonstrated that requests for consultations were inappropriately cancelled or discontinued, and that patients consequently had unnecessary delays in the amelioration of symptoms. We found that the facility did not have a comprehensive policy or process in place for consult management	Harlingen	TX	Y

October 23, 2012	VA-OIG	Healthcare Inspection Delays for Outpatient Specialty Procedures VA North Texas Health Care System Dallas, Texas		The reports explained that these and other patients experienced excessive wait times. For 5 recent referrals for vascular access, the time from referral to completion of a procedure was 89–138 days. For 213 patients scheduled for ambulatory cardiac monitoring, the average wait time was 68 days.	Dallas	TX	Y
March 14, 2013	VA-OIG	VA HEALTH CARE Appointment Scheduling Oversight and Wait Time Measures Need Improvement		The reports showed that appointment were unreliable, that there implementation was inconsistent and there were issue with VistA records systems and dates	Dayton	OH	N
					Fort Harrison	MT	N
					Los Angeles	CA	Y
					Washington	DC	N
April 17, 2013	VA-OIG	Healthcare Inspection Patient Care Issues and Contract Mental Health Program Mismanagement Atlanta VA Medical Center Decatur, Georgia		Seventy-four percent of CSB referred patients had wait times greater than 14 days, with a wait time average of 92 days and a median of 56 days (range from 5 to 432 days).	Decatur	GA	Y
				Located In Sunbelt:	**Y-21**	**N-22**	
				Note: The Sunbelt total does not include repeats. Thus, if Los Angeles appeared in more than one report, it is only counted once in the Sunbelt total.			