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VA OIG Wait Time Report Summary

2016

Following the Department of Veterans Affairs' scandal in Phoenix in 2014, the VA inspector general launched more than 100 investigations at facilities in 31 states plus Puerto Rico. Newly released reports from the probes reveal supervisors instructed schedulers to falsify wait times at VA medical facilities in at least seven states, and employees at 40 medical facilities in 19 states and Puerto Rico regularly "zeroed out" veteran wait times, which masked growing demand as new waves of veterans returned from wars in Iraq and Afghanistan and as aging Vietnam veterans needed more care. Following is a summary of the results of the OIG investigations by state:

The Department of Veterans Affairs Headquarters in Washington D.C.

Alabama

Tuscaloosa, VA medical center. Investigators found that leadership at the facility determined in June 2014 that a scheduler had kept a paper list of veterans when transitioning patients from general mental health to a Post Traumatic Stress Disorder clinical team. Investigators concluded there did

not "appear to be any kind of guidance" from managers on scheduling policies and the supervisors "could not clearly articulate" scheduling directives. There was no evidence upper management knew about inappropriate scheduling. The center's director said supervisors had since undergone face-to-face and online training. Completed Sept. 28, 2015.

Arizona

Lake Havasu, outpatient clinic. Investigators found no violations, although one employee told investigators most patients ask to be seen on the next available appointment date, which then becomes their "desired date," a violation of scheduling directives that effectively zeros out wait times. Still, the inspector general concluded they were "clerical violations" due to a misunderstanding. Completed Feb. 26, 2015.

Arkansas

Little Rock, VA medical center. Investigators found supervisors directed employees to manipulate appointment dates, resulting in the appearance of lower wait times. One scheduler reported a supervisor instructed as recently as the morning of the investigators' interview to zero out wait times. Investigators concluded two supervisors displayed a "lack of candor" about their knowledge and participation in the manipulation. Completed Feb. 24, 2015.

California

Los Angeles, VA medical center. Investigators found schedulers were improperly zeroing out wait times, and a supervisor was intentionally canceling and rescheduling appointments in a way that showed no wait time. They found one manager sent an email to a "senior facility manager" in June 2013 noting the high rate of appointments showing no wait time and saying, "That's a glaring red flag" for improper zeroing out by schedulers. The senior manager did not follow up at the time. Investigators did not find evidence the improper scheduling was being done "specifically to manipulate data in order to artificially lower wait times." They said regional VA officials took corrective action. Completed Aug. 9, 2015.

Palo Alto, VA medical center. No improper scheduling found. Completed Aug. 9, 2015.

San Diego, VA medical center. A supervisor said scheduling was inconsistent so he would initiate refresher training. Completed Feb. 27, 2015.

San Diego, VA medical center and outpatient clinics. A veteran attempted suicide after the VA repeatedly canceled his mental health appointments in 2014. Investigators also found two supervisors directed schedulers to zero out wait times. Some schedulers said they were "hounded" so they did it. If they didn't, they said others or one of the supervisors would go in and do it anyway. Investigators also found evidence that appointments canceled by the clinic were rescheduled in a way that altered wait times. Completed March 18, 2015.

Colorado

Denver, VA medical center, dental clinic. Investigators found no improper scheduling. Completed Feb. 23, 2015.

Fort Collins outpatient clinic and associated VA Medical Center in Cheyenne, Wyo. A manager directed the canceling and rebooking of thousands of appointments so the system falsely showed veteran wait times shorter than the VA's 14-day goal. The manager conceded to investigators it was manipulation and "gaming" the system. Investigators did not conclude anyone received bonuses for the practices. Completed June 24, 2015.

Grand Junction, VA medical center. Investigators found no improprieties. Completed Sept. 2, 2014.

Delaware

Wilmington, VA medical center and outpatient clinics in Dover and Northfield, N.J. Investigators found schedulers had been zeroing out wait times by inputting the next available date as the "desired date." A manager lied to investigators but then conceded she had been untruthful and blamed "nervousness and anxiety." At the clinic in Dover, patients were listed in a book rather than the electronic scheduling system, and one doctor opined that was because "VA staff may have wanted good ratings," although investigators concluded the list was being kept for "no malevolent purposes." Schedulers at the clinics in Dover and Northfield also were inputting the next available date as the desired date. A supervisor directed schedulers in an email with a list of patients whose appointments showed long wait times, "I need everyone to make an exerted effort to keep these to 0 or 1 day," effectively ordering them to cook the books. Completed Sept. 29, 2014.

Florida

Bay Pines, VA medical center. A former administrative manager told investigators that at a meeting with regional VA officials "it was identified that Bay Pines was bringing the (regional) metrics down"' and a regional official suggested more than 200 appointments should be rescheduled "in an effort to make the metrics look better." Investigators found that schedulers were entering the next available date as the veterans' desired dates, effectively zeroing out wait times. Completed Sept. 8, 2014.

Gainesville, VA medical center. Investigators found some schedulers were entering the next available date as the "desired date," a violation that zeros out wait times. Schedulers also were keeping lists outside the scheduling system, including a paper list of 219 veterans who needed appointments months in the future, because they didn't know about software allowing them to do that. Investigators found a supervisor had certified that they did and failed to make sure they were trained and had access to the software. They found no patients were harmed and the clerks have since been trained. Completed Sept. 8, 2014.

Jacksonville, outpatient clinic. Managers in prosthetics instructed employees to create new referral requests for eyeglass prescriptions if the veterans hadn't acted on them for 30 days, which made it look like the timeliness of service was shorter. "The reason for this change was that their system's Prosthetics departments continually had very low percentages" on a timeliness report from VA Central Office, the investigation found. Completed Sept. 8, 2014.

Lake City, VA medical center. Investigators found no improper scheduling. Staffers had been keeping a list of patients, but they also were entered in the scheduling system, which accurately reflected their wait times. Completed Sept. 8, 2014.

Marianna, outpatient clinic. Investigators concluded a doctor was using a paper list to make notes and a nurse was using a list to contact patients to see whether they wanted additional services. The lists were discontinued, staff were trained, and investigators determined no patient care was denied or wait times masked because of the practice. Completed Sept. 8, 2014.

Miami, VA medical center. Investigators found schedulers used next available date as the desired date to show wait times under the 14-day benchmark, masking actual wait times in violation of policy. They reviewed emails and found no direction from managers that schedulers manipulate the system. Completed Oct. 28, 2014.

Orlando, VA medical center and Daytona Beach, outpatient clinic. Investigators found it was common practice at the clinic in Daytona Beach for clerks to determine next available date, then back out of the system and go back in using the next available as the veterans' desired dates, masking actual wait times. A doctor at the clinic reported three patients he believed had substandard or delayed care, two of whom died, but investigators "did not identify any harm to patients." At the Orlando medical center, they found employees were manipulating the electronic wait list to show reduced wait times. They did not find evidence managers had directed the manipulation. Completed Sept. 8, 2014.

St. Augustine, outpatient clinic. Investigators did not find improper scheduling. They found an employee keeping a list of patients interested in a support group, not awaiting appointments. Completed Sept. 8, 2014.

Tallahassee, outpatient clinic. Schedulers were entering the next available appointment dates as veterans' desired dates, a violation that hides wait times. Managers corrected the issues through meetings and training. Investigators concluded this effort was misunderstood by employees as an attempt to cover up the previous practices. One scheduler said that before the investigators arrived, clerks were given a handout and coaching telling them how to answer questions about scheduling and another suggested managers "alluded to the fact they wished her to go along with the story that the new method had been the normal course of business all along. ... However, there was no evidence to support this belief," investigators concluded. Completed Sept. 8, 2014.

West Palm Beach, VA medical center. Investigators found schedulers deliberately used next available date as the desired date to show wait times under the 14-day benchmark. The medical center director hailed the short wait times and thanked clerks for their work in an email reviewed by

investigators, but they concluded the director did not order the manipulation. Any bonus the director received was not "solely" tied to the short wait times. Completed Sept. 29, 2014.

Georgia

Dublin, VA medical center. The medical center's director ordered an employee to cancel 1,546 referrals to non-VA care without contacting the patients in an effort to meet VA goals of reducing open referrals. The director omitted key information when speaking with investigators showing "a lack of candor." Completed Sept. 8, 2014.

Hawaii

Honolulu, VA medical center. Three schedulers told investigators that veterans asked for the next available date so that became their desired date, effectively zeroing out wait times. One used the next available date as the desired date to get veterans off an electronic wait list. Investigators found no evidence that managers instructed employees to manipulate wait times. Completed Jan. 19, 2015.

Idaho

Boise, VA medical center. Investigators found no improper scheduling practices. Completed Feb. 3, 2015.

Illinois

Hines, VA medical center. Schedulers throughout the medical center zeroed out wait times at the direction of supervisors who said they were under direction from a manager. The manager regularly sent out lists, known as the "Priscilla report," to supervisors showing appointments beyond 14 days, and they told subordinates to go in and "fix" the errors. Schedulers then changed the desired date to match the actual appointment dates on the list, hiding the wait times. The manager conceded he directed employees to look at the next available appointment, then "back out" of the system and then get the patient to agree to next available, making it their desired date and zeroing out wait time. This is in direct violation of VA policy, which he said was too restrictive. The manager said he was "in the process" of changing this as it was not in line with directives. Even though he found out weeks before investigators visited that schedulers had been changing dates due to the Priscilla reports, "he did nothing to stop this," the investigators concluded. He denied instructing supervisors to have dates changed as a result of the reports. Investigators also found employees had been keeping a log book outside of the scheduling system to track patients needing pain treatment. They would be scheduled for appointments once they became available. This method effectively hid their waiting time, though investigators said it wasn't a "secret" wait list. Completed Jan. 26, 2015.

Danville, VA medical center. Investigators found a supervisor sent a list weekly to schedulers showing appointments with wait times longer than 14 days. One scheduler without direction then changed dates to zero out the wait times, another said she was instructed to do so and a third said a

supervisor told her always to input the next available date as the desired date, which would show no wait time. But the investigators could not determine who one of the supervisors was and a second denied the charge. Completed Jan. 19, 2015.

Iowa

Des Moines, VA medical center. Investigators did not find any scheduling improprieties. They found a spreadsheet was used to track wait times but it was not a "secret list" designed to hide wait times. Completed Jan. 30, 2015.

Kansas

Leavenworth and Topeka, VA medical centers. Investigators found no improper scheduling practices. Completed Jan. 1, 2015.

Wichita VA medical center and outpatient clinics in Parsons and Salina. Investigators found two lists of patients waiting for home-based care at the VA Medical Center Wichita. Managers entered them into the system, and investigators concluded there was "nothing indicative of intentional and/or malicious falsification of wait time data." They found another list to track consults being kept at the Parsons clinic was not used to manipulate wait times. Schedulers at the Salina clinic were entering the next available appointment as the desired date, effectively zeroing out wait times. When they fell outside the 14-day benchmark, a supervisor would send schedulers a list and ask them to make corrections. While schedulers then went in and zeroed out the wait times in those cases, investigators concluded the supervisor was not telling them to do that and therefore not instructing them to game the system. Completed Jan. 1, 2015.

Kentucky

Louisville, outpatient clinic. No improper scheduling found. Completed June 28, 2015.

Louisville, VA medical center. No improper scheduling found. Completed June 23, 2015.

Louisiana

New Orleans and Baton Rouge, outpatient clinics. Investigators found schedulers at both clinics were using next available date as desired date, which hid true wait times. But they found this was due to a lack of training, not pressure from managers to mask actual wait times. Completed April 17, 2015.

Shreveport, VA medical center. Employees told investigators there was a spreadsheet of 2,700 mental health patients needing assignment to a provider, but they were not awaiting appointments. A list of patients from the spreadsheet was labeled "appointments needed" and one employee told investigators the patients listed needed appointments, but investigators concluded that was not the case and there was no evidence it was used to hide wait times. Investigators found some non-mental health schedulers inputting appointments in a way that manipulated wait times, but they did not find

evidence this was deliberate. A supervisor notified schedulers when appointments were outside the 14-day benchmark. The supervisor reported the 14-day standard was "drilled in your head" by facility leadership and regional VA officials. Investigators concluded past culture may have promoted wait time manipulation but no evidence that the culture existed currently and no evidence of patient harm. Completed June 26, 2015.

Massachusetts

Northampton, VA medical center. Schedulers were using a fake desired date to see available appointments or using the next available as the desired date, masking wait times, which meant the mental health clinic data showed 93.97% of patients were seen within 14 days (The target was 70%). A confidential source provided records showing one veteran seeking primary care services didn't get an appointment for more than seven months because it was reportedly "lost in the system." The medical center also did not use electronic wait lists when it could have. Investigators did not identify any "schemes or gaming of the system" and found no "specific patient harm." Completed Oct. 31, 2014.

Michigan

Battle Creek, VA medical center. No scheduling irregularities found. Completed June 28, 2015.

Minnesota

Minneapolis, VA medical center. No improper scheduling found. Completed Feb. 23, 2015.

Minneapolis, VA medical center. In the gastroenterology clinic, investigators found no improper scheduling and a database of patients was used for tracking their care, not as a wait list outside the scheduling system. Completed June 26, 2015.

Minneapolis and St. Cloud, VA medical centers. A veteran patient suffering from a seizure disorder arrived at St. Cloud VA Medical Center for an appointment but the center canceled the appointment because his doctor was unavailable. At the rescheduled appointment six days later he was referred to a specialty clinic at the Minneapolis VA. He called the clinic, a scheduler responded to him seven days later and gave him an appointment two months later, though he wanted to be seen in two weeks. The scheduler did not triage or prioritize appointments. The veteran died three weeks before the appointment. Records showed that before his death he had called VA to cancel his appointment, but schedulers didn't cancel it until four days later, giving the appearance he had canceled it after he died. No wrongdoing found. Completed June 4, 2015.

Missouri

Kansas City, VA medical center. A cardiology clinic clerk had kept 1,032 paper records locked in a drawer rather than processing them, and at least 37 of those represented patients whose care had

been delayed. Those were immediately scheduled. A review by facility clinical staff identified no specific harm to patients. Completed Sept. 2, 2014.

New Hampshire

Manchester, VA medical center. Investigators found it was a "routine and well-known" practice for schedulers to effectively zero out wait times through early 2012. They also found that as recently as early 2014, cardiology clinic staffers canceled referrals and asked that they be re-entered within the 14-day VA target time frame. A senior management physician conceded to instructing the clinic to do it to meet the 14-day access goal and said meeting the goal affected the amount of bonuses he awarded. A review of cardiology data in 2012 showed 100 % of new patients were seen within 14 days in 11 of 12 months. Investigators did not identify patient harm. Completed Jan. 29, 2015.

Manchester, VA medical center. Investigators found excessive wait times of up to several months but did not find improper scheduling. Completed Feb. 24, 2015.

New Jersey

Northfield, outpatient clinic. Schedulers were entering next available date as desired date, effectively zeroing out wait times. A supervisor directed schedulers in an email with a list of patients whose appointments showed long wait times, "I need everyone to make an exerted effort to keep these to 0 or 1 day," effectively ordering them to cook the books. Completed Sept. 29, 2014.

New York

Brooklyn, VA medical center, radiology department. Investigators found no improper scheduling. Completed Aug. 22, 2014.

Rochester, outpatient clinic. Multiple schedulers were using the first available date as the desired date, which showed no wait time in the system. Supervisors had told them to do it that way, and a manager for the supervisors told investigators she should have been more specific and thorough in training them on the correct policy. No malicious intent found. Completed Aug. 22, 2014.

Rochester, outpatient clinic. A scheduler lied to investigators about contacting veterans and he changed desired dates to actual appointment dates for nine veterans because of "misunderstanding" a supervisor's instructions, investigators concluded. Completed June 3, 2015.

North Carolina

Durham, VA medical center. Investigators found supervisors routinely directed schedulers to hide actual veteran wait times by changing them in the system in a way that falsely showed they met VA performance targets. They concluded this practice was "greatly diminished" after 2010, training on proper scheduling had been instituted and supervisors were now identifying and correcting schedulers. A supervisor told investigators she found three schedulers zeroing out wait times just a week before investigators arrived. Completed Aug. 9, 2015.

Oregon

Portland, VA medical center neurosurgery clinic. Investigators found non-neurosurgery schedulers were booking appointments without consulting the clinic, causing problems with booking appointments appropriately so the neurosurgery schedulers were using a placeholder code to make sure slots were held open for clinic patients. Using placeholders for future appointment slots is not allowed, but the VA Medical Center stopped the practice and retrained schedulers before the investigation. Completed Feb. 3, 2015.

Pennsylvania

Horsham, outpatient clinic. Schedulers were entering the next available date as the desired date, falsely reflecting zero wait time. Supervisors sent out "error lists" of appointments where desired dates "drastically differed" from actual appointment dates — reflecting long wait times but said they meant for schedulers to check and see if there were errors. Investigators blamed "misunderstandings" for schedulers then going in and zeroing out the wait times and found managers "failed to adequately follow up" to make sure any corrections were done properly. Completed Oct. 31, 2014.

Philadelphia, VA medical center. The investigation found a former manager had previously used a spreadsheet of referrals outside the VA scheduling system to private care at the Pennsylvania Eye Institute. The institute identified 900 patients who weren't in the VA system. Two employees said the former medical center director wanted to reduce the number of patients on wait lists and said he stated that the VA Medical Center lost a patient care award and he "didn't want to be in that position again." So referrals were being closed in the VA system once they went to PEI. A former manager said wait lists were mentioned in his 2012 performance evaluation and there was "moderate pressure" to reduce the wait lists but he wasn't instructed to violate policy. The former director didn't recall making these statements and said his performance awards were not based solely on wait times. Management corrected the issues, contacting the 900 patients, and the spreadsheet was no longer in use. Completed Jan. 28, 2015.

Puerto Rico

San Juan, VA medical center. Schedulers routinely used the next available as the desired dates and changed appointments that fell outside the 14-day policy, and the practice was done "under pressure" that was "clearly evident" from first line supervisors to meet the agency’s goal. Investigators found no evidence of senior management direction or knowledge of the manipulation. A current manager said schedulers were being trained on the proper policies. Completed Sept. 29, 2014.

Tennessee

Chattanooga, outpatient clinic. Schedulers told investigators they were using the next available date as the desired date, zeroing out wait times. One said a former manager directed her to take around a list of appointments and have schedulers initial it if wait times did not show zero. Another said the former manager instructed them in emails to change desired dates to actual dates, zeroing out wait time. Investigators interpreted the emails as an attempt to follow scheduling directives and they found no evidence the manager was trying to "game the system." Investigators identified a need for more training, which the medical center's director had already initiated. Completed April 17, 2015.

Chattanooga, outpatient clinic. Investigators were unable to substantiate allegations that a VA employee took home any VA records to conceal them from a VHA inspection team. Completed June 4, 2015.

Memphis, VA medical center. Investigators found no improper scheduling practices at the time of their visit. They found that previously for a few months in 2011 and 2012 a scheduler used the actual dates as the desired dates, zeroing out wait time, but stopped the practice, and a list of patients needing mammograms had been improperly kept outside the system 18 months prior to the investigation but was addressed. Completed Feb. 25, 2015.

Murfreesboro, VA medical center. Investigators found schedulers were going in to the scheduling system to find next available and then backing out and re-entering and using that as the next available, a process VA officials have called "gaming" the system. They were also zeroing out wait times after being flagged on an "error list," but investigators found no evidence the violations were a deliberate attempt to game the system. They noted that management had already instituted corrective training. Completed June 4, 2015.

Texas

Amarillo, VA medical center, and outpatient clinic in Lubbock. Investigators did not find unauthorized paper wait lists were being used in Amarillo. They found one scheduler at the Lubbock clinic had previously used the next available date as the desired date, reflecting no wait time and a violation of policy. They determined that had affected a small percentage of appointments and it was discontinued. Completed Aug. 9, 2015.

Dallas, VA medical center. Investigators found misleading training led schedulers to input next available as the desired date, zeroing out wait times. New training was initiated. Completed Nov. 20, 2014.

El Paso, VA health care system. Investigators found most of the schedulers were negotiating dates with veterans based on what was available and then using that as the veterans' desired date, which would show no wait time for appointments and was in violation of VA policy. They did not find it was at the direction of management or an intentional manipulation to stay within the 14-day VA benchmark. Completed June 28, 2015.

Fort Worth, outpatient clinic. Investigators found it was common practice at the clinic to use next available as desired date, thereby zeroing out wait times in violation of VA policy, but they did not

conclude it was done intentionally or at the direction of management to meet performance standards. Completed Sept. 27, 2015.

Harlingen, Texas Valley Coastal Health Care System, including a health care center in Harlingen and outpatient clinics in McAllen and Harlingen. Investigators found routine manipulation of scheduling and that employees felt pressure from a management official that led to the cooking of the books. They used next available dates as desired dates, which showed zero wait times. Schedulers whose bookings showed longer than 14-day wait times reported being berated at morning meetings by the official. One said it was "not pretty." Investigators did not find evidence that the official explicitly ordered the manipulation. Completed June 28, 2015.

Houston, VA medical center. Investigators found that from at least 2010 through 2014, primary care, mental health and dental schedulers zeroed out wait times by using the next available appointments as veterans' desired ones. "This was done pervasively in almost all cases and by all schedulers," they concluded. Investigators found they were trained to do it, in violation of policy. Completed April 16, 2015.

San Antonio, VA medical center, sleep clinic. Investigators found from 2011 to 2013, zeroing out wait times was "pervasive" and done "in almost all cases by all schedulers" and in violation of policy. They found a supervisor canceled and rescheduled appointments, which eliminated wait times, and the supervisor instructed other employees to do the same thing. They did not find it was done at the direction of management in an effort to secure bonuses. Completed April 17, 2015.

San Antonio, VA medical center. A former employee reported using a spreadsheet outside the scheduling system after she was told to decrease the number of veterans on an electronic wait list, but the employee did not provide evidence and no one corroborated any improper practices. Completed April 17, 2015.

San Antonio, VA medical center, an outpatient clinic in Austin, and a consolidated outpatient appointment center in Kerrville. Investigators found "systemic" zeroing out of wait times. Some schedulers were backing out and going back in — a practice called "gaming" in a 2010 VA memo. They were using the next available appointment as the desired one, eliminating wait times. One former scheduler said if wait times did not equal zero, schedulers would show up on a "hit list" and would have to go back in and zero out the wait time. The investigation did not find evidence that any employee received a bonus or award "specifically related to wait times." Completed May 6, 2015.

San Antonio, outpatient clinic. The inspector general launched an investigation of a leak to local media of a list of 161 veterans who were late to be recalled for appointments. Investigators could not determine who leaked the information. Completed Jan. 30, 2015.

Temple, VA medical center, orthotics & prosthetics lab. Investigators found no inappropriate cancellation of referrals to lessen a backlog of orthotics or prosthetics orders. Completed Nov. 16, 2015.

Temple, VA medical center, radiology service. Investigators found that an imaging supervisor had previously sent out emails notifying doctors of the next available opening and asking them to use

certain desired dates, thereby lessening wait times in the system. But they concluded it did not violate VA policy because the providers still set the desired dates. The practice stopped after the chief of staff sent the supervisor an email saying, "You cannot do this!!!! This is essentially fraud." Completed Nov. 16, 2015.

Vermont

White River Junction, VA medical center. Supervisors routinely directed schedulers to zero out wait times, investigators concluded. Data showed more than half of schedulers — 152 out of 293 — had zero wait times for 100 % of appointments booked during a two-year period before the investigation. One scheduler said if they didn't, they would get "called on the carpet." Another said they would come up on a "naughty list." Others said they were told if that happened three times, it would affect their performance reviews negatively. As part of a "14-day-rule," specialty and surgical care services were holding on to referrals — not putting them into the scheduling system until they could be seen within 14 days, thereby falsely showing the wait times met the VA target. Investigators also found employees used "ad-hoc methods" including a spreadsheet to track patients needing appointments, a practice that hid actual wait times. A physician told investigators that since starting work at the center three months prior she had found cancer in at least 10 patients that had been missed during earlier VA visits and that number was "conservative." She said the pressure to see more patients and show higher productivity forced previous providers to schedule 15- to 20-minute appointments that didn't allow for adequate exams. This was not due to wait-time manipulation as the system accurately showed long wait times for her department. Completed Dec. 16, 2014.

Washington

Chehalis, outpatient clinic. On less than 10 occasions between 2012 and 2015, schedulers changed desired dates in the system. Investigators found no evidence this was done at the direction of supervisors. Completed Aug. 10, 2015.

American Lake, VA medical center. Investigators found no evidence of improperly altered records. Completed Sept. 4, 2015.

Spokane, VA medical center. The mental health clinic canceled 14,076 appointments — 36 % of all appointments — between January 2012 and May 2014 due to provider absence. Schedulers also used paper slips to track patients needing providers, a violation of policy. New software allowed them to stop this practice in late 2014. Completed Sept. 24, 2015.

West Virginia

Huntington, VA medical center. Investigators found a report of delays in providing psychiatric care unfounded. Completed June 2, 2015.

Wyoming

Cheyenne, VA medical center and associated outpatient clinic in Fort Collins, Colo. A manager directed the canceling and rebooking of thousands of appointments so the system falsely showed veteran wait times shorter than the VA's 14-day goal. The manager conceded to investigators it was manipulation and "gaming" the system. Investigators did not conclude anyone received bonuses for the practices. Completed June 24, 2015.