



Testimony

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VA HEALTH CARE

Ongoing and Past Work Identified Access Problems That May Delay Needed Medical Care for Veterans

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GAO Highlights

Highlights of [GAO-14-509T](#), a testimony before the Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

Access to timely medical appointments is critical to ensuring that veterans obtain needed medical care. Over the past few years there have been numerous reports of VAMCs failing to provide timely care to patients, including specialty care, and in some cases, these delays have resulted in harm to patients.

In December 2012, GAO reported that improvements were needed in the reliability of VHA's reported medical appointment wait times, as well as oversight of the appointment scheduling process. Also in 2012, VHA found that systemwide consult data could not be adequately used to determine the extent to which veterans experienced delays in receiving outpatient specialty care. In May 2013, VHA launched the Consult Management Business Rules Initiative with the aim of standardizing aspects of the consults process.

This testimony highlights (1) preliminary observations from GAO's ongoing work related to VHA's management of outpatient specialty care consults, and (2) concerns GAO raised in its December 2012 report regarding VHA's outpatient medical appointment scheduling, and progress made implementing GAO's recommendations. To conduct this work, GAO reviewed documents and interviewed officials from VHA's central office. Additionally, GAO interviewed officials from five VAMCs for the consults work and four VAMCs for the scheduling work that varied based on size, complexity, and location. GAO shared the information it used to prepare this statement with VA and incorporated its comments as appropriate.

View [GAO-14-509T](#). For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

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What GAO Found

GAO's ongoing work examining VHA's management of outpatient specialty care consults identified examples of delays in veterans receiving outpatient specialty care, as well as limitations in the Department of Veterans Affairs' (VA), Veterans Health Administration's (VHA) implementation of new consult business rules designed to standardize aspects of the clinical consult process. For example, for 4 of the 10 physical therapy consults GAO reviewed for one VAMC, between 108 and 152 days elapsed with no apparent actions taken to schedule an appointment for the veteran. For 1 of these consults, several months passed before the veteran was referred for care to a non-VA health care facility. VA medical center (VAMC) officials cited increased demand for services, and patient no-shows and cancelled appointments among the factors that lead to delays and hinder their ability to meet VHA's guideline of completing consults within 90 days of being requested. GAO's ongoing work also identified variation in how the five VAMCs reviewed have implemented key aspects of VHA's business rules, such as strategies for managing future care consults—requests for specialty care appointments that are not clinically needed for more than 90 days. Such variation may limit the usefulness of VHA's data in monitoring and overseeing consults systemwide. Furthermore, oversight of the implementation of the business rules has been limited and did not include independent verification of VAMC actions. Because this work is ongoing, we are not making recommendations on VHA's consult process at this time.

In December 2012, GAO reported that VHA's outpatient medical appointment wait times were unreliable. The reliability of reported wait time performance measures was dependent in part on the consistency with which schedulers recorded desired date—defined as the date on which the patient or health care provider wants the patient to be seen—in the scheduling system. However, VHA's scheduling policy and training documents were unclear and did not ensure consistent use of the desired date. GAO also reported that inconsistent implementation of VHA's scheduling policy may have resulted in increased wait times or delays in scheduling timely medical appointments. For example, GAO identified clinics that did not use the electronic wait list to track new patients in need of medical appointments as required by VHA policy, putting these patients at risk for not receiving timely care. VA concurred with the four recommendations included in the report and, in April 2014, reported continued actions to address them. For example, in response to GAO's recommendation for VA to take actions to improve the reliability of its medical appointment wait time measures, officials stated the department has implemented new patient wait time measures that no longer rely on desired date recorded by a scheduler. VHA officials stated that the department also is continuing to address GAO's three additional recommendations. Although VA has initiated actions to address GAO's recommendations, continued work is needed to ensure these actions are fully implemented in a timely fashion. Ultimately, VHA's ability to ensure and accurately monitor access to timely medical appointments is critical to ensuring quality health care to veterans, who may have medical conditions that worsen if access is delayed.

Chairman Miller, Ranking Member Michaud, and Members of the Committee:

I am pleased to be here today as you examine issues related to delays in medical care provided by the Department of Veterans Affairs' (VA), Veterans Health Administration (VHA). In fiscal year 2012, VHA provided nearly 84 million outpatient medical appointments to veterans through its primary and specialty care clinics, which are managed by VA medical centers (VAMC).¹ Although access to timely medical appointments is critical to ensuring that veterans obtain needed medical care, problems with VHA's scheduling and management of outpatient medical appointments may contribute to delays in care, or care not being provided at all. Over the past few years there have been numerous reports of VAMCs failing to provide timely care to patients, including specialty care, and in some cases, the delays have resulted in harm to patients.² Nonetheless, VHA has reported continued improvements in achieving timely patient access to medical appointments. For example, in fiscal year 2011, VA reported that VHA completed 89 percent of medical appointments for new patients within its goal; in fiscal year 2012, VA reported that VHA completed 90 percent of primary and specialty care new patient appointments within the goal.³ However, in December 2012, we reported that VHA's medical appointment wait times were unreliable and VHA's inadequate oversight of the outpatient medical appointment

¹Outpatient clinics offer services to patients that do not require a hospital stay. Primary care addresses patients' routine health needs, and specialty care is focused on a specific specialty service such as cardiology or gastroenterology.

²See, for example, Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina*, Report No. 12-04631-313. (Washington D.C.: September 6, 2013), and Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection Consultation Mismanagement and Care Delays Spokane VA Medical Center Spokane, Washington*, Report No. 12-01731-284. (Washington D.C.: September 25, 2012).

³In fiscal year 2012, VHA's appointment wait time goal for primary and specialty care appointments was 14 days from the patient's or provider's desired appointment date. According to VHA's scheduling policy, the desired appointment date, referred to as the "desired date," is the date on which the patient or provider wants the patient to be seen.

scheduling processes contributed to VHA's problems with scheduling timely medical appointments.⁴

When a physician or other provider determines that a veteran needs outpatient specialty care, the provider refers the veteran to a specialist for a clinical consult—a request for evaluation or management of a patient for a specific clinical concern, or for a specialty procedure such as a colonoscopy. VAMCs request and manage outpatient consults through an electronic system that retains information about each consult request and is part of VHA's Veterans Health Information Systems and Technology Architecture (VistA).⁵ Ideally, the consult system would contain timely and reliable information on the status and outcomes of consults, and would provide VHA information it needs to help effectively manage the process. In 2012, however, VHA found that systemwide consult data could not be adequately used to determine the extent to which veterans experienced delays in receiving outpatient specialty care. As a result, in May 2013, VHA launched an initiative to standardize aspects of the consult process, with the goal of developing consistent and reliable information on consults across all VAMCs.

Appointments resulting from outpatient consults, like other outpatient medical appointments, are subject to VHA's scheduling policy.⁶ This policy is designed to help VAMCs meet their commitment to scheduling medical appointments with no undue waits or delays for patients. It establishes processes and procedures for scheduling medical appointments and ensuring the competency of staff directly or indirectly involved in the scheduling process. Additionally, it includes several requirements that affect timely appointment scheduling, as well as accurate wait time measurement. For example, the policy requires schedulers to record appointments in VHA's VistA medical appointment scheduling system.

⁴GAO, *VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, [GAO-13-130](#) (Washington, D.C.: Dec. 21, 2012).

⁵VistA is the single integrated health information system used throughout VHA in all of its health care settings. It contains patients' electronic health records.

⁶VHA medical appointment scheduling policy is documented in VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010). We refer to the directive as "VHA's scheduling policy" from this point forward.

My statement today will draw from ongoing work examining the management of outpatient specialty care consult processes at five selected VAMCs, and our December 2012 report examining the reliability of VHA's reported outpatient medical appointment wait times data and scheduling oversight.⁷ In particular, this statement highlights (1) preliminary observations from our ongoing work, and (2) key findings and recommendations from our December 2012 report, as well as the progress VHA has made in implementing those recommendations.

For our ongoing outpatient specialty care consults work,⁸ we reviewed documents and interviewed VHA central office officials about VHA's policies and guidance for VAMCs to send, receive, and complete consults, and VHA's procedures for VAMCs to schedule outpatient medical appointments, which include those for specialty care. We also reviewed documents and interviewed VHA central office officials about their efforts to oversee VAMCs' implementation of VHA's consult policies, including VHA's Consult Management Business Rules Initiative, launched in May 2013. Additionally, we interviewed officials from five VAMCs selected for variation in volume of outpatient consults, complexity,⁹ and location. These five VAMCs were located in Augusta, Maine; Denver, Colorado; Gainesville, Florida; Oklahoma City, Oklahoma; and Palo Alto, California. For each VAMC included in our review, we interviewed leadership about how VHA's consult policies and any local policies or procedures for managing consults are implemented at their facility. We also interviewed specialty care service chiefs, administrative staff, and providers of three high-volume specialty services—cardiology, gastroenterology, and physical therapy. Additionally, for each of the five medical centers, we reviewed the history of actions taken on a random sample of 30 outpatient consults (10 from each of the three specialties included in our review) that were requested during the period April 1, 2013, through September 30, 2013, that either took more than 90 days to complete or had been in process for more than 90 days. The results of our review of outpatient consults are not generalizable across all VAMCs.

⁷[GAO-13-130](#).

⁸The scope of our work is limited to outpatient consults; however, providers may also request consults for inpatient care and administrative needs, among other things.

⁹VHA categorizes VAMCs according to complexity level, which is determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions, and administrative complexity.

For our December 2012 report, we reviewed VHA's scheduling policy and methods for measuring medical appointment wait times, and interviewed VHA central office officials responsible for developing them. We also visited 23 high-volume outpatient clinics at four VAMCs selected for variation in size, complexity, and location. These four VAMCs were located in Dayton, Ohio; Fort Harrison, Montana; Los Angeles, California; and Washington, D.C. At each VAMC we interviewed leadership and other officials about how they managed and improved medical appointment timeliness, their oversight to ensure accuracy of scheduling data and compliance with VHA's scheduling policy, and problems staff experienced in scheduling timely appointments. Additionally, in April 2014, in preparation for this statement, we reviewed documentation and interviewed officials from VHA's central office about the extent to which they have addressed the recommendations we made in the 2012 report.

We are conducting our ongoing work on specialty care outpatient consults, which began in July 2013, in accordance with generally accepted government auditing standards. Because this work is ongoing, we are not making recommendations on VHA's consult process at this time. We conducted our prior work on VHA's outpatient appointment scheduling and oversight from February 2012 through December 2012, as well as an update on that work in April 2014, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We shared information we used to prepare this statement with VA. After reviewing this information, VA provided us with technical comments, which we incorporated as appropriate.

Background

When providers at VAMCs determine that a veteran needs outpatient specialty care, they request and manage consults using VHA's clinical consult process. Clinical consults include requests by physicians or other providers for both clinical consultations and procedures. A clinical consultation is a request seeking an opinion, advice, or expertise regarding evaluation or management of a patient's specific clinical concern, whereas a procedure is a request for a specialty procedure such as a colonoscopy. Clinical consults are typically requested by a veteran's primary care provider using VHA's electronic consult system. Once a

provider sends a request, VHA requires specialty care providers to review it within 7 days and determine whether to accept the consult. If the specialty care provider accepts the consult—determines the consult is needed and is appropriate—an appointment is made for the patient to receive the consultation or procedure.¹⁰ In some cases, a provider may discontinue a consult for several reasons, including that the care is not needed, the patient refuses care, or the patient is deceased.¹¹ In other cases the specialty care provider may determine that additional information is needed, and will send the consult back to the requesting provider, who can resubmit the consult with the needed information. Once the appointment is held, VHA's policy requires the specialty care provider to appropriately document the results of the consult, which would then close out the consult as completed in the electronic system.¹² VHA's current guideline is that consults should be completed within 90 days of the request.¹³ If an appointment is not held, staff are to document why they were unable to complete the consult.

In 2012, VHA created a database to capture all consults systemwide and, after reviewing these data, determined that the data were inadequate for monitoring consults. One issue identified was the lack of standard processes and uses of the electronic consult system across VHA. For example, in addition to requesting consults for clinical concerns, the system was also being used to request and manage a variety of administrative tasks, such as requesting patient travel to appointments. Additionally, VHA could not accurately determine whether patients actually received the care they needed or if they received the care in a timely fashion. According to VHA officials, approximately 2 million consults (both clinical and administrative consults) were unresolved for more than 90 days. Subsequently, VA's Under Secretary for Health convened a task force to address these and other issues regarding VHA's

¹⁰Some consults, referred to as "e-consults," do not require an in-person appointment with the patient and may be addressed electronically through the consult system.

¹¹When a provider discontinues a consult, action on the consult is stopped, and a new consult request must be initiated by the requesting provider for the veteran to obtain the specialty care—whether that care is for a clinical consultation or procedure.

¹²The results of consults are documented in the consult system and are contained in the patient's electronic health record.

¹³VHA officials noted that although VHA's guideline is for consults to be completed within 90 days, consults for urgent needs are completed sooner.

consult system, among other things. In response to task force recommendations, in May 2013, VHA launched the Consult Management Business Rules Initiative to standardize aspects of the consult process, with the goal of developing consistent and reliable information on consults across all VAMCs. This initiative requires VAMCs to complete four specific tasks between July 1, 2013, and May 1, 2014:

- Review and properly assign codes to consistently record consult requests in the consult system;¹⁴
- Assign distinct identifiers in the electronic consult system to differentiate between clinical and administrative consults;
- Develop and implement strategies for requesting and managing requests for consults that are not needed within 90 days—known as “future care” consults;¹⁵ and
- Conduct a clinical review as warranted, and as appropriate, close all unresolved consults—those open more than 90 days.

At the time of our December 2012 review, VHA measured outpatient medical appointment wait times as the number of days elapsed from the patient’s or provider’s desired date, as recorded in the VistA scheduling system by VAMCs’ schedulers. In fiscal year 2012, VHA had a goal of completing new and established patient specialty care appointments within 14 days of the desired date. VHA established this goal based on its performance reported in previous years.¹⁶ To facilitate accountability for achieving its wait time goals, VHA includes wait time measures—referred to as performance measures—in its Veterans Integrated Service Network

¹⁴These codes identify the type of care requested in the consult (e.g., dermatology or cardiology) and are used by VHA to run reports that assist with managing its services.

¹⁵According to VHA guidance, the consult system should only be used for services needed within 90 days. VAMCs were given the option to track future care consults either by developing markers so they could be identified in the consult system, or using existing mechanisms outside of the consult system such as electronic wait lists. The electronic wait list is a type of computer software application designed for recording, tracking, and reporting veterans waiting for medical appointments.

¹⁶In 1995, VHA established a goal of scheduling primary and specialty care medical appointments within 30 days to ensure veterans’ timely access to care. VA’s reported wait times for fiscal year 2010 showed that nearly all primary and specialty care medical appointments were scheduled within 30 days of desired date. In fiscal year 2011, VHA shortened the wait time goal to 14 days for both primary and specialty care medical appointments.

(VISN)¹⁷ directors' and VAMC directors' performance contracts, and VA includes measures in its budget submissions and performance reports to Congress and stakeholders.¹⁸ The performance measures, like wait time goals, have changed over time.

Officials at VHA's central office, VISNs, and VAMCs all have oversight responsibilities for the implementation of VHA's scheduling policy. For example, each VAMC director, or designee, is responsible for ensuring that clinics' scheduling of medical appointments complies with VHA's scheduling policy and for ensuring that any staff who can schedule medical appointments in the VistA scheduling system have completed the required VHA scheduler training.¹⁹ In addition to the scheduling policy, VHA has a separate directive that establishes policy on the provision of telephone service related to clinical care, including facilitating telephone access for medical appointment management.

¹⁷VHA's health care system is divided into 21 areas called VISNs. Each of VA's 21 VISNs is responsible for managing and overseeing medical facilities within a defined geographic area.

¹⁸VA prepares a congressional budget justification that provides details supporting the policy and funding decisions in the President's budget request submitted to Congress prior to the beginning of each fiscal year. The budget justification articulates what VA plans to achieve with the resources requested; it includes performance measures by program area. VA also publishes an annual performance report—the performance and accountability report—which contains performance targets and results achieved compared with those targets in the previous year.

¹⁹Specifically, VAMCs are required to maintain a list of all staff who can schedule medical appointments in the VistA scheduling system and VAMC directors are required to ensure successful completion of required training by all staff on the list. Schedulers are not to be allowed to schedule medical appointments in the VistA scheduling system without proof of their successful completion of this training.

GAO's Ongoing Work Identified Examples of Delays in Specialty Care, and Limitations in VHA's Implementation of Its Business Rules Impede Its Ability to Assess Delays

Our ongoing work identified examples of delays in veterans receiving requested outpatient specialty care at the five VAMCs we reviewed. VAMC officials cited increased demand for services, and patient no-shows and cancelled appointments, among the factors that hinder their ability to meet VHA's guideline for completing consults within 90 days. Specifically, several VAMC officials discussed a growing demand for both gastroenterology procedures, such as colonoscopies, as well as consultations for physical therapy evaluations. Additionally, officials noted that due to difficulty in hiring and retaining specialists for these two clinical areas, they have developed periodic backlogs in providing services. Officials at these facilities indicated that they try to mitigate backlogs by referring veterans for care with non-VA providers. However, this strategy does not always prevent delays in veterans receiving timely care. For example, officials from two VAMCs told us that non-VA providers are not always available. Examples of consults that were not completed in 90 days include:

- For 3 of 10 gastroenterology consults we reviewed for one VAMC, we found that between 140 and 210 days elapsed from the dates the consults were requested to when the patient received care. For the consult that took 210 days, an appointment was not available and the patient was placed on a waiting list before having a screening colonoscopy.
- For 4 of the 10 physical therapy consults we reviewed for one VAMC, we found that between 108 and 152 days elapsed, with no apparent actions taken to schedule an appointment for the veteran. The patients' files indicated that due to resource constraints, the clinic was not accepting consults for non-service-connected physical therapy evaluations.²⁰ In 1 of these cases, several months passed before the veteran was referred to non-VA care, and he was seen 252 days after the initial consult request. In the other 3 cases, the physical therapy clinic sent the consults back to the requesting provider, and the veterans did not receive care for that consult.
- For all 10 of the cardiology consults we reviewed for one VAMC, we found that staff initially scheduled patients for appointments between 33 and 90 days after the request, but medical files indicated that patients either cancelled or did not show for their initial appointments.

²⁰A non-service-connected disability is an injury or illness that was not incurred or aggravated during active military service.

In several instances patients cancelled multiple times. In 4 of the cases VAMC staff closed the consults without the patients being seen; in the other 6 cases VAMC staff rescheduled the appointments for times that exceeded the 90-day timeframe.²¹

Our ongoing work also identified variation in how the five VAMCs we reviewed have implemented key aspects of VHA's business rules, which limits the usefulness of the data in monitoring and overseeing consults systemwide. As previously noted, VHA's business rules were designed to standardize aspects of the consult process, thus creating consistency in VAMCs' management of consults. However, VAMCs have reported variation in how they are implementing certain tasks required by the business rules. For example, VAMCs have developed different strategies for managing future care consults—requests for specialty care appointments that are not clinically needed for more than 90 days.

- At one VAMC, officials reported that specialty care providers have been instructed to discontinue consults for appointments that are not needed within 90 days and requesting providers are to track these consults outside of the electronic consult system and resubmit them closer to the date the appointment is needed. These consults would not appear in VHA's systemwide data once they have been discontinued.
- At another VAMC, officials stated that appointments for specialty care consults are scheduled regardless of whether the appointments are needed beyond 90 days. These future care consults would appear in VHA consult data and would eventually appear on a timeliness report as consults open greater than 90 days. Officials from this VAMC stated that they continually have to explain to VISN officials who monitor the VAMC's consult timeliness that these open consults do not necessarily mean that care has been delayed.
- Officials from another VAMC reported piloting a strategy in its gastroenterology clinic where future care consults are entered in an electronic system separate from the consult and appointment scheduling systems. Approximately 30 to 60 days before the care is needed the requesting provider is notified to enter the consult request

²¹According to VHA consult policy, when a patient fails to keep a scheduled appointment, the specialty care provider must reassess the need for service and either reschedule the appointment or cancel the consult request, as appropriate. VHA Directive 2008-056, *VHA Consult Policy* (Sept. 16, 2008).

in the electronic consult system for the specialty care provider to complete.

In addition, oversight of the implementation of VHA's business rules has been limited and has not included independent verification of VAMC actions. VAMCs were required to self-certify completion of each of the four tasks outlined in the business rules. VISNs were not required to independently verify that VAMCs appropriately completed the tasks. Without independent verification, VHA cannot be assured that VAMCs implemented the tasks correctly.

Furthermore, VHA did not require that VAMCs document how they addressed unresolved consults that were open greater than 90 days, and none of the five VAMCs in our review were able to provide us with specific documentation in this regard. VHA officials estimated that as of April 2014, about 450,000 of the approximately 2 million consults (both clinical and administrative consults) remained unresolved systemwide. VAMC officials noted several reasons that consults were either completed or discontinued in this process of addressing unresolved consults, including improper recording of consult notes, patient cancellations, and patient deaths. At one of the VAMCs we reviewed, a specialty care clinic discontinued 18 consults the same day that a task for addressing unresolved consults was due. Three of these 18 consults were part of our random sample, and our review found no indication that a clinical review was conducted prior to the consults being discontinued. Ultimately, the lack of independent verification and documentation of how VAMCs addressed these unresolved consults may have resulted in VHA consult data that inaccurately reflected whether patients received the care needed or received it in a timely manner.

Although VHA's business rules were intended to create consistency in VAMCs' consult data, our preliminary observations identified variation in managing key aspects of consult management that are not addressed by the business rules. For example, there are no detailed systemwide VHA policies on how to handle patient no-shows and cancelled appointments, particularly when patients repeatedly miss appointments, which may make VAMCs' consult data difficult to assess.²² For example, if a patient

²²As we previously reported, scheduling practices at some VAMCs could result in miscommunication with patients and cause them not to make medical appointments. In addition, outdated or incorrect patient contact information may also affect patient no-shows and cancelled appointments. See [GAO-13-130](#).

cancels multiple specialty care appointments, the associated consult would remain open and could inappropriately suggest delays in care. To manage this type of situation, one VAMC developed a local consult policy referred to as the “1-1-30” rule. The rule states that a patient must receive at least 1 letter and 1 phone call, and be granted 30 days to contact the VAMC to schedule a specialty care appointment.²³ If the patient fails to do so within this time frame, the specialty care provider may discontinue the consult. According to VAMC officials, several of the consults we reviewed would have been discontinued before reaching the 90-day threshold if the 1-1-30 rule had been in place at the time.²⁴ Three VAMCs included in our review also noted some type of policy addressing patient no-shows and cancelled appointments, each of which varied in its requirements.²⁵ Without a standard policy across VHA addressing patient no-shows and cancelled appointments, VHA consult data may reflect numerous variations of how VAMCs handle patient no-shows and cancelled appointments.

²³According to VAMC officials, the 1-1-30 rule provides a minimum standard for specialty care providers to follow in scheduling patient appointments.

²⁴The VAMC issued its updated consult policy, which included the 1-1-30 rule, in December 2013 after our request for consults data.

²⁵One of the VAMCs allowed for a maximum number of two no-shows for all specialty appointments, with consideration given to the patient’s medical needs. The other two VAMCs policies stated that specialty providers should reassess the patient’s needs after one no-show and may or may not reschedule the appointment.

Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement, and VA Has Initiated Actions to Address Related GAO Recommendations

In December 2012, we reported that VHA's reported outpatient medical appointment wait times were unreliable and that inconsistent implementation of VHA's scheduling policy may have resulted in increased wait times or delays in scheduling timely outpatient medical appointments. Specifically, we found that VHA's reported wait times were unreliable because of problems with recording the appointment desired date in the scheduling system. Since, at the time of our review, VHA measured medical appointment wait times as the number of days elapsed from the desired date, the reliability of reported wait time performance was dependent on the consistency with which VAMC schedulers recorded the desired date in the VistA scheduling system. However, VHA's scheduling policy and training documents were unclear and did not ensure consistent use of the desired date. Some schedulers at VAMCs that we visited did not record the desired date correctly. For example, the desired date was recorded based on appointment availability, which would have resulted in a reported wait time that was shorter than the patient actually experienced.

At each of the four VAMCs we visited, we also found inconsistent implementation of VHA's scheduling policy, which impeded scheduling of timely medical appointments. For example, we found the electronic wait list was not always used to track new patients that needed medical appointments as required by VHA scheduling policy, putting these patients at risk for delays in care. Furthermore, VAMCs' oversight of compliance with VHA's scheduling policy, such as ensuring the completion of required scheduler training, was inconsistent across facilities. VAMCs also described other problems with scheduling timely medical appointments, including VHA's outdated and inefficient scheduling system, gaps in scheduler and provider staffing, and issues with telephone access. For example, officials at all VAMCs we visited reported that high call volumes and a lack of staff dedicated to answering the telephones affected their ability to schedule timely medical appointments.

VA concurred with the four recommendations included in our December 2012 report and reported continuing actions to address them.

- First, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to improve the reliability of its outpatient medical appointment wait time measures. In response, VHA officials stated that they implemented more reliable measures of patient wait times for primary and specialty care. In fiscal years 2013 and 2014, primary and specialty care appointments for new patients

have been measured using time stamps from the VistA scheduling system to report the time elapsed between the date the appointment was created—instead of the desired date—and the date the appointment was completed. VHA officials stated that they made the change from using desired date to creation date based on a study that showed a significant association between new patient wait times using the date the appointment was created and self-reported patient satisfaction with the timeliness of VHA appointments.²⁶ VA, in its *FY 2013 Performance and Accountability Report*, reported that VHA completed 40 percent of new patient specialty care appointments within 14 days of the date the appointment was created in fiscal year 2013; in contrast, VHA completed 90 percent of new patient specialty care appointments within 14 days of the desired date in fiscal year 2012. VHA also modified its measurement of wait times for established patients, keeping the appointment desired date as the starting point, and using the date of the pending scheduled appointment, instead of the date of the completed appointment, as the end date for both primary and specialty care. VHA officials stated that they decided to use the pending appointment date instead of the completed appointment date because the pending appointment date does not include the time accrued by patient no-shows and cancelled appointments.

- Second, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to ensure VAMCs consistently implement VHA's scheduling policy and ensure that all staff complete required training. In response, VHA officials stated that the department is in the process of revising the VHA scheduling policy to include changes, such as the new methodology for measuring wait times, and improvements and standardization of the use of the electronic wait list. In the interim, VHA distributed guidance, via memo, to VAMCs in March 2013 describing this information and also offered webinars to VHA staff on eight dates in April and May of 2013. To assist VISNs and VAMCs in the task of verifying that all staff have completed required scheduler training, VHA has developed a database that will allow a VAMC to identify all staff that have scheduled appointments and the volume of appointments scheduled

²⁶Prentice, Julia C., Michael L. Davies, and Steven D. Pizer, "Which Outpatient Wait-Time Measures Are Related to Patient Satisfaction?" *American Journal of Medical Quality*, (Aug. 12, 2013), accessed April 4, 2014, <http://ajm.sagepub.com/content/early/2013/07/31/1062860613494750.abstract>.

by each; VAMC staff can then compare this information to the list of staff that have completed the required training. However, VHA officials have not established a target date for when this database would be made available for use by VAMCs.

- Third, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to require VAMCs to routinely assess scheduling needs for purposes of allocation of staffing resources. VHA officials stated that they are continuing to work on identifying the best methodology to carry out this recommendation, but stated that the database that tracks the volume of appointments scheduled by individual staff also may prove to be a viable tool to assess staffing needs and the allocation of resources. VHA officials stated that they needed to discuss further how VAMCs could use this tool, and that they had not established a targeted completion date for actions to address this recommendation.
- Finally, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to ensure that VAMCs provide oversight of telephone access, and implement best practices to improve telephone access for clinical care. In response, VHA required each VISN director to require VAMCs to assess their current telephone service against the VHA telephone improvement guide and to electronically post an improvement plan with quarterly updates. VAMCs are required to routinely update progress on the improvement plan. VHA officials cited improvement in telephone response and call abandonment rates since VAMCs were required to implement improvement plans. Additionally, VHA officials said that the department has also contracted with an outside vendor to assess VHA's telephone infrastructure and business process. VHA expects to receive the first report in approximately 2 months.

Although VA has initiated actions to address our recommendations, we believe that continued work is needed to ensure these actions are fully implemented in a timely fashion. Furthermore, it is important that VA assess the extent to which these actions are achieving improvements in medical appointment wait times and scheduling oversight as intended. Ultimately, VHA's ability to ensure and accurately monitor access to timely medical appointments is critical to ensuring quality health care to veterans, who may have medical conditions that worsen if access is delayed.

Chairman Miller, Ranking Member Michaud, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions you may have.

GAO Contact and Staff Acknowledgments

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