

GAO Highlights

Highlights of [GAO-14-620T](#), a testimony before the Committee on Veterans' Affairs, U.S. Senate

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 statement highlights (1) preliminary observations GAO made in an April 9, 2014, testimony statement regarding 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.

View [GAO-14-620T](#). For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

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VA HEALTH CARE

VA Lacks Accurate Information about Outpatient Medical Appointment Wait Times, Including Specialty Care Consults

What GAO Found

As GAO previously reported in its testimony on April 9, 2014, its preliminary work examining the Department of Veterans Affairs' (VA), Veterans Health Administration's (VHA) management of outpatient specialty care consults identified examples of delays in veterans receiving outpatient specialty care, as well as limitations in the 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 VA medical center (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. 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 preliminary 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 has not included independent verification of VAMC actions. Because of the preliminary nature of this work, GAO is not making recommendations on VHA's consult process at this time.

In its December 2012 report, GAO found 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 found 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.