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May 2000

VETERANS' HEALTH CARE

VA Needs Better Data on Extent and Causes of Waiting Times

GAO
Accountability ★ Integrity ★ Reliability

Contents

Abbreviations

IHI	Institute for Healthcare Improvement
VA	Department of Veterans Affairs
VISN	Veterans Integrated Service Network
VISTA	Veterans Health Information Systems and Technology Architecture

B-284876

May 31, 2000

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
House of Representatives

Dear Congressman Evans:

Information on how long veterans must wait for outpatient health care—
and the locations and clinics where veterans must wait the longest—has
been largely anecdotal. While officials from the Department of Veterans
Affairs (VA) and representatives from veteran service organizations believe
these waiting times are often too long, VA lacks national data on the
number of days veterans must wait to get outpatient appointments at VA
health care facilities, as we have previously reported.[1] Nonetheless, data
gathered by one facility show that, in January 2000, veterans at the facility
had to wait as many as 118 days to see an ophthalmologist. Similarly, a
representative from one veteran service organization reported that, in May
1999, patients were waiting over 190 days for an appointment in another
facility's cardiology clinic. Concerned about such reports of waiting time
problems, you asked us to describe the initiatives VA has under way to (1)
improve its waiting time data and (2) address its waiting time problems.

Results in Brief

Although VA has begun to collect data systematically on waiting times for
outpatient care, it has yet to develop reliable national waiting time data.
Over the past 10 months, VA has initiated two separate efforts for gathering
comprehensive outpatient waiting time data from its facilities. The first
effort, initiated in June 1999, produced data that were incomplete and
inaccurate, in part because of the differences in facilities' scheduling of
appointments. VA's second effort, initiated in December 1999, was designed
to improve the data's reliability by measuring the average time taken to
schedule an appointment for an entire month. VA officials believe and we
agree that the new method is significantly better and should provide VA

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[1]See *VA Health Care: Progress and Challenges in Providing Care to Veterans* (GAO/T-HEHS-99-158, July 15, 1999).

with more complete and accurate data. To ensure this, however, VA will need to overcome some problems identified during implementation, such as inaccurate appointment codes being entered into the system.

In addition to taking steps to improve its waiting time data, VA has initiated actions to reduce the time veterans must wait for outpatient appointments. First, VA hired a private contractor to develop and implement techniques to reduce waiting times at selected clinics in VA facilities nationwide. In addition, VA plans to spend $400 million in fiscal year 2001 to make improvements in the timeliness of service, patient access to telephone care, and timely access to clinical information. However, VA's lack of reliable national waiting time data raises concerns about whether VA has an adequate basis upon which to design these initiatives. Specifically, without accurate data on the extent of waiting time problems and analyses of the causes of long waits, VA cannot assess whether its proposed expenditures would reduce waiting times or determine how best to allocate funds to reduce waiting times. Further, without reliable baseline waiting time data and a mechanism to track the funds used to improve timeliness of care, VA will not be able to objectively measure whether these funds have actually resulted in reduced waiting times. We recommended that VA take actions to identify the extent and causes of waiting time problems and to monitor and track expenditures for addressing these problems. VA agreed with our recommendations.

Background

VA operates one of the nation's largest health care systems, providing services in over 600 patient care facilities in all 50 states, Guam, and Puerto Rico. These facilities include 172 medical centers as well as numerous community-based outpatient clinics and domiciliaries.[2] Twenty-two regional Veterans Integrated Service Networks (VISN) manage the facilities and serve as the basic budgetary and decisionmaking units for determining how best to provide services to veterans within their geographic boundaries. Over the past several years, VA has begun to adopt managed care practices, treating more of its patients in outpatient settings and reducing its heavy reliance on inpatient care. VA reports that, during fiscal year 1999, it provided care to about 3.5 million veterans, resulting in almost 38 million outpatient visits.

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[2]Domiciliaries are residential rehabilitation and health maintenance centers for veterans who do not require hospital or nursing home care but are unable to live independently because of medical or psychiatric disabilities.

To serve veterans appropriately, the Veterans' Health Care Eligibility Reform Act of 1996 required VA to ensure that veterans enrolled in VA's health care system receive timely care. For outpatient care, VA's goals are that patients (1) receive an initial, nonurgent[3] appointments with their primary care or other appropriate provider within 30 days of requesting one; (2) receive specialty appointments within 30 days when referred by a primary care provider; and (3) be seen within 20 minutes of their scheduled appointments.[4] VA refers to these goals as the "30-30-20" goals.

To schedule outpatient appointments, VA relies on the Veterans Health Information Systems and Technology Architecture (VISTA). VISTA automates major clinical, management, and administrative functions and includes a scheduling component. The scheduling component has been upgraded several times since VA developed it about 2 decades.

VA Does Not Have Reliable Systemwide Waiting Time Data

In June 1999, VA began for the first time—in response to a congressional request for information on outpatient waiting times—to systematically collect data on the length of time veterans must wait for outpatient health care appointments.[5] According to VA officials, collecting these data required software modifications to VISTA's appointment-scheduling component because the system was not designed to collect information on waiting times. However, because VA clinics used this scheduling component in varying and often inconsistent ways, the data generated from the first data collection effort were not comparable from facility to facility. In an effort to address this problem, VA implemented in December 1999 a new data collection method that it plans to use to evaluate VISN directors' performance in improving waiting times, beginning in September 2000. Although VA officials told us they believe the new method is a better one, implementation problems—such as inaccurate appointment types being entered into the system—could reduce data reliability.

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[3]VA's timeliness standard for urgent care requires that veterans have access to such care 24 hours a day.

[4]For purposes of this review, we focused on how long it takes veterans to obtain a scheduled appointment for outpatient health care, not the length of time spent in the waiting room to see a provider.

[5]According to an official from VA's Office of Primary and Ambulatory Care, from 1993 to 1998, VA required facilities to self-report waiting time data for several specialty clinics. However, VA recognized that self-reported data were not reliable and that such data did not capture waiting time information on a national basis.

Initial Data Collection Effort Produced Unreliable Data

In its first attempt to collect outpatient waiting time information, VA designed a software program to extract data from VISTA's appointment-scheduling component once a month at every VA outpatient clinic nationwide. The program, run on the last day of each month, determined for each clinic the number of days veterans had to wait for a scheduled primary care appointment from that 1 day. For primary care appointments, the third available appointment was used because, according to VA, the first and second appointments are often held open for urgent care and would not be given to veterans calling for routine care. Waiting times for all clinics of the same type—such as orthopedics or primary care—were then averaged within a facility. For example, if a facility had 10 primary care clinics, the number of days to the third available appointment for each clinic was gathered, summed, and the total divided by 10 to establish the facility average waiting time for primary care appointments.

However, clinics varied in how they used the appointment-scheduling component, and data generated for the third available appointment could not be aggregated to obtain an overall picture of waiting times. Several other problems with this first data collection effort resulted in VA not being able to determine whether waiting times in a given clinic were understated or overstated.

- Some clinics showed a higher number of available appointment slots than could actually be staffed and relied on the scheduling clerks to know which slots were available and which slots should not be filled—a distinction the software program could not make. Therefore, by averaging "available" slots, the software program probably understated the time a veteran would wait for an appointment.
- Conversely, some clinics scheduled more patients than the number of appointment slots shown in the scheduling component—perhaps to account for patients who fail to appear for their appointments or because the number of appointment slots shown were fewer than the number of patients that the clinic could actually accommodate during that time. In such cases, the software program probably overstated waiting times.
- Finally, the software program only extracted information on clinic availability on the last day of the month for which it was run. Because of day-to-day variations in scheduling, the data collected for that 1 day might not have been representative of general clinic availability on the other days of the month.

We attempted to validate VISTA's automated data by comparing it with data collected manually at one location in VISN 2—Syracuse, New York. To measure adherence to VA's 30-day waiting time standard, scheduling clerks at facilities in VISN 2 check appointment availability for 1 day during the second week of every month, counting the number of days to the third available appointment using VISTA scheduling package information. Although this technique parallels that used by VA's software program, the manual collection of waiting time data allows clerks in VISN 2 facilities to identify nuances associated with a particular location or clinic. For example, one doctor out of several in a clinic may not be accepting new patients, so when a new patient asks for an appointment, the clerk would not check that doctor's availability for appointments but instead would check the availability of others. In this situation, VISTA's count of available appointments would be overstated because it would count all doctors.

Comparing data from both approaches for 12 clinics located at the Syracuse VA medical center, we noted large differences between waiting time data reported by clerks and data extracted from VISTA. For five clinics, clerks reported waiting times ranging from 17 to 56 days shorter than the computer-extracted data; for seven clinics, waiting times reported by clerks ranged from 2 to 47 days longer. Waiting times were closest for neurology and farthest apart for orthopedics and cardiology (see table 1).

Table 1: Comparison of Scheduling Clerk Data and VISTA Data on Number of Days Patients Wait for an Appointment at Syracuse VA Medical Center Clinics, October 1999

Clinic	Days as reported by clerks	Days as extracted by software program	Difference in days reported
Cardiology	10	66	-56
Ear, nose, and throat	47	69	-22
Gastroenterology	3	30	-27
General surgery	56	22	+34
Gynecology	38	10	+28
Neurology	15	13	+2
Ophthalmology	70	41	+29
Optometry	99	61	+38
Orthopedics	81	34	+47
Podiatry	37	54	-17
Primary care	5	36	-31
Urology	44	29	+15

Some variations may be attributable to the data's being collected on different days in October. However, even in the unlikely event that all variations could be attributed to different collection days, the variations still serve to illustrate the problems inherent in collecting data for only 1 day of the month.

Second Data Collection Effort Designed to Overcome Earlier Problems

Recognizing the shortcomings of its initial data collection effort, VA introduced in December 1999 a new method of collecting data on outpatient appointment waiting times. While this new method also uses information from the VISTA scheduling package, it measures the average number of days between the date that an appointment was requested and the scheduled date of the appointment. These data are collected on a monthly basis for every patient, not just for 1 day. VA most recently extracted data on the average time from request to appointment for the entire month of April 2000. VA now has 4 months of data to monitor waiting times for the next available appointment—January, February, March, and April—since the new software program was initiated in December 1999.

The amount of time between the day an appointment was requested and the date for which it was scheduled is then summed for all patients and a per-patient average is calculated. This calculation is performed once a

month for all clinics within each VA facility, then summed for all clinics of the same type in each facility. By examining only actual scheduled appointments, the new method is designed to overcome the problems posed by the variations in clinic scheduling practices. Similarly, obtaining data on all appointments scheduled in a month provides VA with complete information.

This second approach also takes into account the possibility that patients may not want or need the next available appointment. For example, some patients may schedule a follow-up visit in 6 months at their physicians' direction or may choose an appointment further in the future rather than the next available appointment because of their work or personal demands. VA has chosen to omit scheduled appointments such as these from its calculations because it is interested only in determining the time that patients have no choice but to wait for the next available appointment.

To exclude these types of appointments from its calculations, VA introduced with this second effort a procedure under which scheduling clerks must enter in a particular field on the computer whether an appointment is (1) the next available (indicated by an "N"), (2) other than the next available at the request of the clinician (indicated by a "C"), or (3) other than the next available at the request of the patient (indicated by a "P"). In calculating the average time to appointment, only those appointments marked with an "N" are considered.

VA field officials, who have oversight responsibilities for appointment scheduling, told us that the new data collection method is conceptually superior to VA's initial approach because the data collected is more accurate. However, these officials raised concerns that early problems in implementing the method could reduce the data's reliability. For example, if a patient initially requests the next available appointment but then decides to select an appointment further in the future, the clerk must exit and then reenter the system and rekey all of the appointment information— simply to change the appointment code from "N" to "P." According to these field officials, requiring scheduling clerks to exit and then reenter the scheduling system in such events is cumbersome and may cause busy clerks to leave the "N" they initially entered rather than changing it to a "P." As a result, the appointment would be inappropriately included in the clinic's waiting time data and would overstate the actual waiting time at the clinic.

In addition, VA's ability to collect comparable waiting time data for all facilities may be limited because some clinics schedule appointments only 2 months into the future. In such cases, patients would be asked to call back if no appointments were available during that 2-month time period. As a result, data collected from these clinics would always show average waiting times of 2 months or less. To the extent patients in the clinics must wait longer than 2 months to obtain an appointment, data collected from these clinics would understate waiting times.

Believing its new approach will provide adequate and accurate data on waiting times, VA intends to use this information to evaluate VISN directors' performance in their efforts to reach waiting time goals, beginning in September 2000. According to VA's "Fiscal Year 2000 Network Performance Plan," VISN directors' performance will be measured on their ability to provide patient appointments within 30 and 45 days for six clinics: audiology, cardiology, ophthalmology, orthopedics, primary care, and urology. According to an official in VA's Chief Network Office, VA identified these six clinics by asking clinical managers from each of the 22 VISNs to survey their facilities on what clinics had the most problems with waiting times. VA plans to collect waiting time data for all clinics and might replace one or more of the six clinics with different clinics if the data show that their waiting times are worse.

VA Has Waiting Time Initiatives Under Way, but More Data Are Needed

VA has begun several initiatives to reduce its waiting times. For example, in June 1999, VA retained a private contractor to help it develop and implement techniques to reduce waiting times in selected VA clinics nationwide. Recognizing that this project will not completely solve its waiting time problems, VA plans to spend $400 million in fiscal year 2001 to help it achieve its timeliness goals. However, VA currently has little detailed knowledge of the extent or causes of outpatient waiting times systemwide. Further, without baseline waiting time data and a method for tracking and monitoring funds, VA will not be able to objectively measure whether any funds spent to reduce waiting times have produced the desired improvements. Given VA's lack of reliable national waiting time data and lack of detailed plans specifying which facilities or clinics would implement the improvements, we cannot assess whether VA's proposed expenditures would reduce waiting times.

VA Launches Project to Reduce Waiting Times

In July 1999, VA contracted with the Boston-based Institute for Healthcare Improvement (IHI) to develop ways to reduce waiting times in specific clinics selected by VA facilities nationwide. As part of this project, 134 teams from VA facilities across the nation developed strategies to reduce waiting times for appointments in 160 primary or specialty care clinics. While some teams worked to reduce waiting times in only one clinic, several chose two or more clinics. Table 2 summarizes the clinics that the VA teams chose for their IHI projects.

Table 2: Clinics Chosen by VA Teams Participating in the IHI Project

Clinic	Number of clinics
Primary care	88
Orthopedics	11
Eye (including ophthalmology and optometry)	9
Urology	9
Gastrointestinal	8
General medicine/surgery	6
Neurology	5
Cardiology	3
Dermatology	3
Mental health/psychiatry	3
Rheumatology	3
Endocrinology	2
Physical therapy	1
Women's health	1
Other specialty care (specialty not identified)	8
Total	**160**

Source: Institute for Healthcare Improvement.

Since the project began in July 1999, some VA clinics have reported notable successes in reducing waiting times, often by increasing provider availability and office efficiency. One VA facility, for example, reports that it has reduced the number of days veterans must wait for a primary care appointment from 240 days to about 14 days—that is, veterans who once had to wait almost 8 months for primary care are now able to obtain appointments within 2 weeks. VA staff attribute this success, in part, to scheduling changes, such as reducing the number of unnecessary return

visits scheduled for veterans and no longer automatically rescheduling new patients who do not show up for their appointment.

Other improvements reported to us include an orthopedic clinic's having reduced its waiting time for consultations from 130 days to 7 days, and an eye clinic's having reduced its waiting time from 120 days to 50 days. Some teams, however, have struggled with reducing waiting times, citing barriers such as physician and team member resistance to the changes and difficulties in sustaining improvements made to reduce waiting times.

The IHI project ended in March 2000, and the final report summarizing the results of this project is due in July 2000. According to VA officials, reduced waiting times in other clinics could be expected to follow from the success of these initial projects as VA facilities implement the techniques they learned by participating in IHI.

Concerns About Basis for Waiting Time Initiatives

In its fiscal year 2001 budget submission to the Congress, VA is proposing to spend $400 million toward meeting its 30-30-20 timeliness goal (that is, appointments within 30 days for initial primary care and specialty care referrals and patients seen by providers within 20 minutes of scheduled appointments). VA plans to spend these funds to improve the timeliness of service, patient access to telephone care, and timely access to clinical information.[6] VA expects that these improvements will help it achieve its 30-30-20 goal by fiscal year 2003. Table 3 shows the fiscal year 2001 funds VA plans to spend on each of these improvements.[7]

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[6]According to VA's Acting Director for Resource Formulation, VA identified these initiatives by summarizing and reviewing proposals from each of VA's 22 VISNs and from headquarters program officials. Although the estimated funding needed to accomplish these goals by fiscal year 2003 exceeds the $400 million, VA determined that it was a reasonable investment in fiscal year 2001 to help reach this future goal.

[7]Of this $400 million, VA plans to obtain $77 million through new appropriated dollars from the Congress. The remaining $323 million is expected to come from fiscal year 2000 activities. Specifically, $200 million is expected to come from management savings and $123 million is expected to be available as a result of a reduction in staff through retirement incentives.

Table 3: VA's Proposed Initiatives and Funds Requested to Help Achieve Its 30-30-20 Timeliness Goals

Proposed initiative	Projected expenditure (in millions)
Timeliness of service	$223
Patient access to telephone care	21
Timely access to clinical information	156
Total	**$400**

Source: VA Acting Director for Resource Formulation.

To meet its timeliness of service initiative, VA plans to spend a total of $223 million to implement the following three efforts:

- Scheduling package: VA plans to spend $34.7 million to redesign or replace its outpatient appointment-scheduling package. VA believes that difficulties with the current system reduce both access to and timeliness of service because it does not allow flexibility in appointment length or scheduling across different facilities. VA officials told us that they recently formed a team to review whether it should redesign or replace the scheduling package. After its review, the team is expected to provide a detailed proposal of project costs, time frames, and implementation strategies. VA anticipates this project to be a multiyear effort and expects the $34.7 million to help fund the project for about 2 years.

- Contract physicians: VA plans to use additional contract specialist physicians to reduce the backlog of patients waiting for specialty care and, as a result, reduce the amount of time patients must wait to receive such care. According to VA budget officials, VA has not yet determined how much of the fiscal year 2001 funds it will use for this purpose, nor which facilities will receive additional specialists. VA hopes to contract for specialists based on patient needs and facility capabilities. Because VA does not know at this time which facilities or clinics will contract with physicians, what specialties are experiencing the longest waiting times, and how much it intends to spend on this initiative, it is unclear to what extent using contract physicians will reduce patient waiting times.

- Outpatient clinics: VA plans to improve timeliness by establishing 63 additional community-based outpatient clinics. VA believes that by offering patients more convenient access to care—and possibly alleviating workload at other clinics—these patients might receive more timely initial and subsequent appointments for their primary care.[8] However, VA has not yet determined the cost or locations of these new clinics or to what extent they would reduce waiting times. Further, it is unclear whether this initiative would reduce waiting times at all. Specifically, in 1999, 12 of the 22 VISN directors we surveyed told us that by increasing veterans' access to VA health care, community-based outpatient clinics could stimulate demand. If this occurs, waiting times could actually lengthen. VA is currently studying whether existing community-based outpatient clinics have resulted in shorter waiting times.

VA also believes that telephone care will help it achieve its timeliness goals. Specifically, VA officials cited studies that found that a significant percentage of visits to emergency departments, urgent care, and doctors' offices bring no medical benefits, and a percentage of unnecessary visits could be avoided by providing patients the option to speak to a nurse over the telephone. To improve patient access to telephone care, VA plans to spend $21 million to begin providing nurse advice lines nationwide, 24 hours a day, 7 days a week. According to an official in VA's Office of Primary and Ambulatory Care, VA plans to identify basic systemwide standards and measures as part of this nationwide initiative. To ensure that the advice provided over the phone is standardized at all locations, for example, this official explained that VA will need to purchase a license for automated medical and legal protocols. Along with this telephone care program, VA is also considering using a portion of the $21 million to purchase self-care manuals to provide to patients to improve their medical knowledge and possibly reduce unnecessary visits. VA expects the program to be fully implemented at the end of fiscal year 2002.

To improve timely access to clinical information, VA plans to spend $156 million to primarily provide the information technology support it believes is necessary to ensure timely and quality care. VA officials believe that

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[8]According to VA, it determines the need for community-based outpatient clinics based on a demographic analysis that includes an evaluation of the proposed area, its proximity to the parent facility, the existing and projected veteran population, and the characteristics of the population to be served.

improvements such as access to clinical information across sites of care will help ensure prompt service and improve continuity of quality care. For example, to improve access to clinical information across sites of care, VA plans to improve software capabilities so that facilities can access and exchange patient health summary information across sites of care. In addition, VA also plans to expand several national telemedicine pilot programs and study the results of these programs to establish best practices for new telemedicine programs. Further, VA plans to purchase software and hardware—such as personal computers, network servers, and X-ray equipment—and hire additional technical staff to support these functions. VA has not yet determined how much of the $156 million it will spend on each of these initiatives or which locations will receive these improvements. According to VA's Acting Director for Resource Formulation, these determinations will be based on individual needs and the capabilities of the facilities within the 22 VISNs.

Given VA's lack of reliable national waiting time data, VA cannot reasonably allocate its proposed $400 million to facilities that have the worst problems. VA also cannot measure program progress, as it currently does not have a baseline of reliable national data from which to measure such progress. Moreover, without a thorough, data-driven analysis of the cause of the long waits and a method for tracking and monitoring funds, VA cannot objectively measure whether funds appropriated to reduce waiting times would produce these desired reductions.

VA's lack of reliable national waiting time data not only limits its ability to identify which facilities and clinics have the longest waiting times but also limits VA's ability to know whether waiting time problems are systemwide or isolated to particular facilities. VA officials explained that they hope to collect more reliable appointment waiting time data in the near future but, in the interim, are encouraging VISN directors to monitor their facilities' waiting times by reviewing the data extracted from the VISTA software program for the facilities within their VISN. According to a VA official, VISN directors are also encouraged to take appropriate actions to reduce waiting times, including implementing techniques learned through the IHI project, such as targeting resources to clinics where they are most needed and improving office efficiencies.

Although VA has budgeted funds expressly to help it achieve its timeliness goals, it does not plan to track these funds by project and thus will be unable to monitor whether the funds have contributed to reduced waiting times. Specifically, VISN directors have the authority to allocate funds to

the facilities within their VISNs. VA officials told us that, for this reason, VA does not have detailed spending plans for much of the $400 million of planned obligations. For example, while VA has proposed spending $223 million on three initiatives to improve the timeliness of service, it could only provide funding estimates for one: the $34.7 million to redesign or replace its scheduling package.

Because VA will not be designating the exact uses for most of the $400 million, each VISN director has discretion over how the funds will be used. Consequently, VA will not be able to track whether these funds were actually spent on improving timeliness or whether their use had the intended effect on reducing waiting times.

Conclusions

Anecdotal information has led to the perception that VA is not meeting its 30-30-20 timeliness goals and that veterans in different locations do not have equal access to timely care. In order to correct these perceived problems, VA managers must make decisions about where and how to apply the agency's finite resources in order to have the greatest effect. To make such decisions, we believe that VA managers must have reliable data on the extent and causes of waiting times in different locations and in different clinics.

Although VA has made significant strides in collecting waiting time data systemwide, some problems must be overcome before the data can be reliably used. Once improvements are made, we believe the data can be used to give VA managers an estimate of national waiting times and those for every individual VA clinic. However, VA has not analyzed the causes of waiting times and is still waiting for final data from the IHI project. Consequently, it does not have an adequate basis for determining which initiatives could best improve the timeliness of care. Further, VA does not plan to ensure that its initiatives for improving timeliness will result in decreased waiting times or even if these funds will be spent on timeliness initiatives.

Recommendations

We recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to first determine the extent of waiting times and their causes and then develop a spending plan that will result in solving the identified waiting time problems. In addition, VA should develop a

mechanism for monitoring and tracking expenditures for improving timeliness to evaluate how well targeted funds have reduced waiting times.

Agency Comments and Our Evaluation

We provided VA a draft copy of our report for its review and comment. Overall, VA agreed with the report's conclusions and recommendations and indicated that it will use it as a guide for developing a national plan for addressing waiting time issues. As a result of our report, VA is also planning to require VISNs to develop systematic spending plans for waiting time expenditures and is planning to track projected goals for each waiting time initiative, including a description of anticipated and measurable benefits in meeting its goals.

VA said that it believes its February 2000 clinic appointment waiting time data are adequate for use as a baseline to measure progress. While the February 2000 data are better than that previously available, VA has not yet tested the validity of each clinic's data and, thus, cannot be assured that these data can be used as an adequate baseline. As noted in the report, we found errors at some locations—specifically, inaccurate appointment types being entered into the system—that indicate the data may not be reliable. Moreover, VA points out that it is continuing to collect and improve upon its monthly data and that its understanding will increase as the data are refined.

VA also noted that it is developing a systematic spending plan for addressing identified waiting time problems. It also intends to integrate existing and proposed initiatives—which have been fragmented—into a cohesive national plan. VA appears to be committed to carrying out these and other initiatives aimed at achieving its waiting time goals. However, we cannot assess the effectiveness of these actions until they are completed. The full text of VA's comments is presented in appendix II.

As arranged with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after the date of this letter. At that time, we will send copies to the Honorable Togo D. West, Jr., Secretary of Veterans Affairs; appropriate congressional committees; and other interested parties. We will also make copies available to others upon request.

Please contact me at (202) 512-7101 or Ronald J. Guthrie at (303) 572-7332 if you or your staff have any questions. Other key contributors to this report are listed in appendix III.

Sincerely,

Cynthia Bascetta, Associate Director
Veterans' Affairs and Military
   Health Care Issues

Scope and Methodology

To determine what initiatives VA has under way to improve its waiting time data, we reviewed and analyzed VA data extracted under both of its recent approaches and VA supporting documentation for these approaches. We interviewed VA headquarters and field officials to gain their perspectives on these data extracts and whether they could be used as a reliable measure of waiting times systemwide.

To determine what initiatives VA has under way to address its waiting time problems, we reviewed VA's fiscal year 2001 budget submission to the Congress, VA's Fiscal Year 2000 Network Performance Plan, and other documents detailing VA's goals to reduce its waiting times for appointments. In addition, we interviewed VA headquarters and field officials and IHI officials and faculty to gain their perspectives on the project to reduce waiting times. To learn more about the VA/IHI project, we also attended two of the three learning sessions and reviewed and analyzed relevant documents obtained from these sessions. Finally, we interviewed veteran service organization representatives and obtained data related to their reports of waiting times in several clinics.

We conducted our work between January 2000 and May 2000 in accordance with generally accepted government auditing standards.

Comments From the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

MAY   9 2000

Ms. Cynthia A. Bascetta
Associate Director, Veterans' Affairs and Military
 Health Care Issues
Health Education and Human Services Division
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Bascetta,

 We have reviewed your draft report, **VETERANS' HEALTH CARE: VA
Needs Better Data on Extent and Causes of Waiting Times** (GAO/HEHS-00-
90) and concur in its findings and recommendations. This report coincides with
the beginning phase of VA's multi-faceted approach to analyze and implement
strategies to reduce outpatient appointment waiting times. Your report describes
many of the different waiting time initiatives VA has undertaken at various
organizational levels, including its proposal to re-design a new outpatient
appointment scheduling package. While the groundwork was being laid to
establish data-based monitoring and oversight mechanisms at the Headquarters
level, VHA also encouraged individual Network Offices and facilities to address
improvement opportunities in waiting time management immediately. VHA took
these preliminary steps prior to developing its proposed nation-wide master plan
or national wait time reporting data to systematically guide the process.
Significant variations exist in the extent and causes of waiting time and delays
among VA facilities. In many instances, unique locally devised solutions will be
critical to the success of the VHA-wide plan. VHA took these steps in the belief
that had they waited until all systems were in place for each action interval,
worthwhile improvement opportunities might have been overlooked or
unnecessarily delayed.

 VHA's collaborative project with the Institute for Healthcare Improvement
has already resulted in reduced waiting times for many of the 134 facilities that
participated in the project. Further, it assisted VA in being able to systematically
identify key causes of access delays. Over the course of this joint venture, the
median wait for an appointment for both primary and specialty clinics decreased
from 48 to 22 days, an improvement of 54 percent. These data were obtained
from the monthly reports submitted by 94 of the participating teams that
measured their wait time for an appointment as the "time to the third next
available appointment." This past March, the third learning session of the
collaborative project revealed some of the most outstanding "success stories."

 Based on these outcomes, and using the IHI-provided methodology to
assess waiting times, each Network has recently developed plans to analyze

2. Ms. Cynthia A. Bascetta

collected waiting time data, and to identify best practices their facilities used that might be applied nationwide. The plans also include specific steps the Networks will take to sustain and enhance the improvements that were accomplished during this successful collaborative effort. Subsequent to your evaluation, Network Directors submitted their plans to the Chief Network Office where they are being reviewed.

GAO aptly pointed out that accurate national waiting time data are essential. GAO reviewers believe VA's new data collection methodology has the potential for providing good information for study, strategic planning, and action implementation. Contrary to GAO's conclusion, however, we believe that VA does have an adequate baseline (February 2000 clinic appointment wait time) from which to measure progress. VHA will continue to collect monthly data, improve upon it, and analyze it over time, not only at the national level, but at the VISN and facility levels, as well. Even now, it is possible to identify which facilities have the worst problems and where the problems exist, and our understanding will continue to increase as we refine the data. We will also make efforts on an ongoing basis to validate the data, perhaps through veteran surveys to assess patient perceptions of wait times.

In accordance with GAO's recommendation, VA commits to maintaining accountability for resource expenditures targeted for waiting time/access improvement. Access and service delivery improvement represents one of our priority goals, and specific waiting times performance goals are included in the performance contracts of all Network Directors. VHA has not previously tracked these funds by project at the national level or systematically monitored project effectiveness. It is now committed to developing a systematic spending plan approach as a component of the existing Network planning process. As an addendum to existing national planning guidance, VHA is proposing to include specific access/service delivery guidance. VHA's Office of Finance is developing the guidance, which is still in the early draft stage. We anticipate that as part of the process, each Network will complete a comprehensive financial planning worksheet. These worksheets will track projected goals for each designated initiative (through FY 2003), including actual performance levels for each goal. The required initiative justification documentation will include a description of anticipated and measurable benefits in meeting the goals.

We expect that these and other waiting time initiatives will continue to assist in achieving our access and service delivery goals. While some activities thus far have been somewhat fragmented, our objective is to develop a process to systematically integrate existing and proposed initiatives into a cohesive national plan. We will also identify ways to use collected data as more effective management decision-making tools. As a beginning step in this direction, the Deputy Under Secretary for Health has requested that the VA/IHI Steering Committee use GAO's report to guide it in identifying priority actions that will be

3. Ms. Cynthia A. Bascetta

required to establish a foundation to develop the plan. This will be a complex
challenge, given the diverse variables that must be considered. The Steering
Committee has already discussed such issues during their May 2, 2000, meeting,
and will provide feedback about their initial deliberations and recommendations
for future action. We will be happy to share any decisions we make with GAO.

We appreciate the opportunity to comment on your draft report and
believe that GAO's perceptions will assist us in our continuing efforts.

Sincerely,

(for) Dennis Duffy
Assistant Secretary for
Planning and Analysis

Enclosure

Staff Acknowledgments

James Espinoza, Lisa Gardner, Steve Gaty, George Lorenzen, Karen Sloan, and Alan Wernz also made key contributions to this report.

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