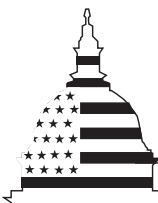


August 2001

VA HEALTH CARE

More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress



G A O

Accountability * Integrity * Reliability

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Abbreviations

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



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United States General Accounting Office
Washington, DC 20548

August 31, 2001

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

The Department of Veterans Affairs (VA) operates one of the nation's largest health care systems. In fiscal year 2000, roughly 4 million patients made about 39 million outpatient visits to more than 700 VA health care facilities nationwide. However, excessive waiting times for outpatient care have been a long-standing problem. For example, in October 1993, we found that veterans frequently waited 8 to 9 weeks to obtain appointments in specialty clinics.¹ To ensure timely access to care, in 1995, VA established a goal that all nonurgent primary and specialty care appointments be scheduled within 30 days of request and that clinics meet this goal by 1998.² Yet, 3 years later, reports of long waiting times persist.

Concerned about these delays in access to care, you asked us to (1) determine whether clinics in VA's medical centers are meeting the 30-day appointment standard for outpatient primary and specialty care, (2) describe clinics' approaches for meeting VA's waiting time standard, and (3) identify VA headquarter's efforts to help clinics meet this standard.

To conduct our work, we visited 17 primary care clinics and 54 clinics in five specialty areas—dermatology, gastroenterology, eye care (ophthalmology and optometry), orthopedics, and urology—within 10 VA medical centers. During these site visits, we spoke with center and clinic management and staff, including scheduling clerks and information resource management staff. We also spoke with VA headquarters officials.

¹See *VA Health Care: Restructuring Ambulatory Care System Would Improve Services to Veterans* (GAO/HRD-94-4, Oct. 15, 1993). A list of related GAO products is included in this report.

²VA's timeliness standard for urgent care requires that veterans have access to such care 24 hours a day.

In addition, we reviewed these clinics' and national waiting times data; however, we did not verify these data. Except for this, we conducted our work in accordance with generally accepted government auditing standards from August 2000 through July 2001. (See appendix I for more detail on our scope and methodology.)

Results in Brief

Waiting times at the clinics in the 10 medical centers we visited indicate that meeting VA's 30-day standard is a continuing challenge for many clinics. Although most of the primary care clinics we visited (15 of 17) reported meeting VA's standard for nonurgent, outpatient appointments, only one-third of the specialty care clinics we visited (18 of 54) met VA's 30-day standard. For the remaining two-thirds, waiting times ranged from 33 days at one urology clinic to 282 days at an optometry clinic. Many of these delays—both in primary and specialty care—were the result of poor scheduling procedures and inefficient use of staff. For example, some clinics automatically rescheduled patients who missed appointments without determining why the original appointment was missed or without notifying patients of their new appointment. In some clinics, patients also continued to be scheduled for specialty care appointments although they no longer needed such care. Clinics also reported that they had too few staff, such as technicians, scheduling clerks, and providers, to meet patient demand for care. However, given the inefficiencies that we found, it was difficult to determine the extent to which clinics would have benefited from additional staff.

While two-thirds of the specialty clinics we visited continued to have long waiting times, some were making noteworthy progress in reducing waiting times, primarily by improving their scheduling processes and making better use of their staff. These successes were often the result of medical centers and clinics working collaboratively with the Institute for Healthcare Improvement (IHI)—a private contractor VA retained in July 1999—to develop strategies to reduce patient waiting times. One medical center essentially restructured its health care delivery system, implementing multiple strategies facilitywide. Specifically, this medical center assigned all patients to a primary care provider for all routine, nonurgent care, established a triage system for walk-in patients, and implemented a centralized scheduling system for all of its clinics. As a result of these and other changes, the primary care clinics and all but one of the five specialty care clinics we reviewed at this medical center were meeting the 30-day standard.

Medical centers and clinics participating in VA's IHI project have received valuable information and strategies for successfully reducing waiting times. However, VA has not provided guidance to its medical centers on how to implement IHI's strategies, and has only recently contracted with IHI to disseminate best practices agencywide. VA also has not developed other national guidance to help clinics reduce waiting times. For example, half of the specialty clinics we visited had referral guidelines for primary care providers to follow when referring patients to specialists. These clinics' waiting times were 25 percent shorter than the half that did not have referral guidelines. While clinics that did not have guidelines could have benefited from headquarters assistance, VA has not established a national set of referral guidelines. Moreover, the Department lacks an analytic framework for its medical centers and clinics to use in determining the root causes of their long waiting times. Because VA is measuring patient waiting times for nearly 17,500 clinics nationally—and has recently determined that half of these clinics are not meeting its 30-day standard—it is especially important for headquarters to promote a more systematic way to determine the causes of long waiting times and address this problem quickly. As a result, we have recommended that VA create a national set of referral guidelines and take actions to strengthen its oversight of waiting times problems. In commenting on a draft of our report, VA agreed with our findings and concurred with our recommendations.

Background

VA's health care system is divided into 22 regional Veterans Integrated Service Networks (VISN), which serve as the basic budgetary and decision-making units for determining how best to provide services to veterans at medical centers and community-based outpatient clinics located within their geographic boundaries. Spread throughout the 22 VISNs are 172 medical centers, each headed by a director who manages administrative functions, along with a chief of staff who manages clinical functions for the entire medical center. VA medical centers also have designated managers for each area of care, such as primary and specialty care. Within each area of care, there may be many clinics, which can vary in purpose and size.³ For example, VA has clinics that manage the care of patients who are taking prescription medication for blood clots, and, due

³VA defines a "clinic" as an entity for dividing provider workload and scheduling different types of patient care appointments. For example, the gastroenterology specialty in one medical center we visited had 28 individual clinics, such as colonoscopy, endoscopy, flexible sigmoidoscopy, hepatitis C, liver biopsy, and general gastroenterology.

to their more limited scope, these clinics might have a small number of providers and staff. On the other hand, VA's primary care clinics—where physicians are responsible for the routine health needs of a caseload of patients—tend to have a relatively larger number of providers and staff. In addition, specialty care clinics, such as gastroenterology and urology, could provide patients with specific care within that specialty, such as treatment for hepatitis C and prostate cancer.

In 1996, the Congress required VA to ensure that veterans enrolled in its health care system receive timely care.⁴ For outpatient care, VA established its “30-30-20” goals: routine primary care appointments are to be scheduled within 30 days from the date of request, as are specialty care appointments, and patients are to be seen within 20 minutes of their scheduled appointment time.⁵ Following reports of long waiting times from VA's medical centers and clinics, veterans' service organizations, veterans, the Inspector General, and us—VA began two initiatives to help identify and address waiting times problems.

First, VA contracted with IHI, a Boston-based contractor, to help develop strategies to reduce waiting times. As part of this project, 134 teams from VA medical centers across the nation worked on reducing waiting times for appointments in selected primary or specialty care clinics. Over half of these teams focused on primary care. Second, VA began collecting patient waiting times data from its outpatient scheduling system—the Veterans Health Information Systems and Technology Architecture (VISTA), one of VA's main computer systems for clinical, management, and administrative functions. Over the past few years, VA made several modifications to its appointment scheduling software to develop more reliable data on waiting times. In March 2001, VA began using these waiting times data to identify clinics that failed to meet its 30-day standard.

⁴Veterans' Health Care Eligibility Reform Act of 1996, P.L. 104-262, Sec. 104(b)(1).

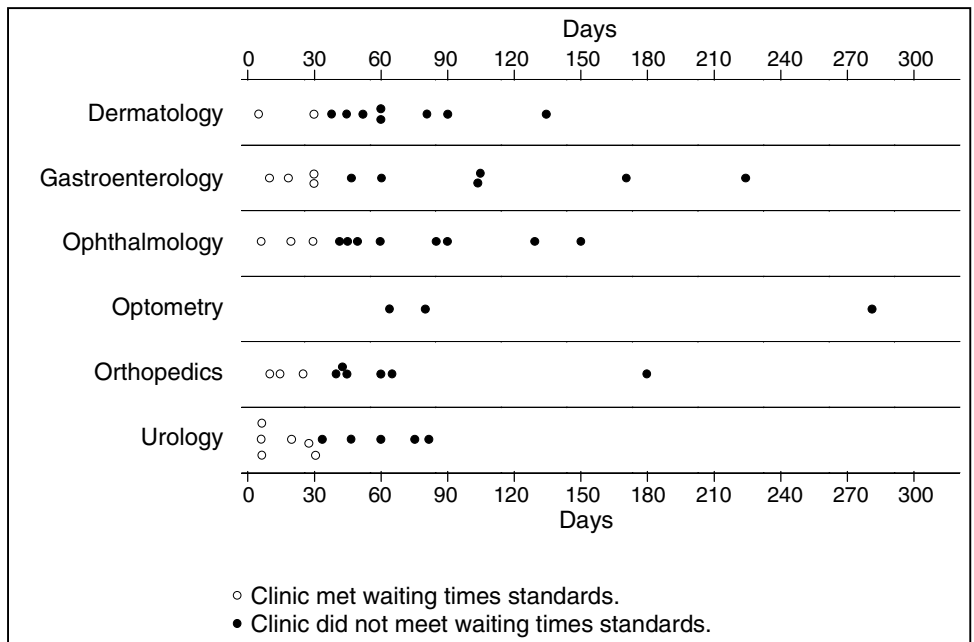
⁵VA's performance in meeting the 20-minute waiting time goal was beyond the scope of this review.

Long Waits Are Often Due to Poor Scheduling Procedures and Inefficient Use of Staff

While most veterans using the primary care clinics we visited were able to get an appointment within 30 days, many seeking specialty care often had to wait longer than 30 days for a referral. Clinics with long waiting times often had poor scheduling procedures or did not use their staff efficiently.

The chiefs of primary care at the 10 VA medical centers we visited reported that 15 of their 17 primary care clinics—or about 88 percent—met VA’s 30-day timeliness standard. The other two clinics reported waiting times of 56 and 61 days.⁶ However, chiefs of specialty care at the clinics we visited reported that patients with nonurgent needs often wait in excess of VA’s 30-day standard (see fig. 1). The longest reported waiting times were in gastroenterology and optometry. At one location, veterans had to wait 282 days—more than 9 months—for an optometry appointment.

Figure 1: Range of Waiting Times for Patient Care at the 54 VA Specialty Clinics We Visited



Source: Clinic data provided by VA officials during site visits from November 2000 through March 2001.

⁶According to several clinic chiefs, some veterans continue to see specialists for primary care services—potentially decreasing the demand for primary care appointments.

These long waiting times were often the result of high percentages of patients not showing up for appointments, poor scheduling procedures, and inefficient use of staff. When veterans do not keep their appointments, some of the limited appointment slots are lost and are unavailable for other veterans. This could extend waiting times overall. Almost 60 percent of the 71 primary and specialty care clinics we visited had a no-show rate of 20 percent or greater. Gastroenterology had the highest average no-show rate at 29 percent. At one gastroenterology clinic, half of the scheduled patients did not show up for their appointments. Urology had the lowest average no-show rate at 18 percent. According to one clinic chief, patients failed to keep appointments because their health condition improved or they forgot about the appointment because it was scheduled so far into the future.

Some clinics' scheduling procedures may actually encourage no-shows. For example, some clinics schedule appointments several months in advance. Although most clinics remind patients of their appointments—by mail or telephone—we found that some reminder systems were not sufficient to ensure that patients kept their appointments. For example, over 30 percent of the clinics we visited automatically rescheduled no-shows, and some did not follow up with the veterans to determine why they had missed the original appointments. In addition, in one clinic, staff told us that the patient often was not informed of this new appointment, making it likely that the patient would miss the new appointment as well.

We found that inefficient use of staff could also limit the number of available appointment slots, contributing to long waiting times. For example, some specialists told us that they were treating patients who could be seen in primary care.⁷ Specifically, one chief of dermatology told us that she receives new patient referrals for conditions that could easily be treated in primary care, such as dry skin. In addition, several chiefs of orthopedics told us that they continue to see patients with conditions such as rheumatoid arthritis and back pain because the patients request appointments, even after their conditions have stabilized. Furthermore, shortages of nonprovider staff at some clinics also resulted in the inefficient use of physician time. For example, one orthopedic clinic did not have a cast technician, so an orthopedic surgeon had to apply and

⁷VA's "1998 Guidelines for Implementation of Primary Care" states that primary care providers should serve as the point of entry for nonemergency care and should refer patients to specialists only when appropriate.

remove patient casts. At another clinic, a shortage of clerks resulted in nurses' assuming clerical duties—such as scheduling, admitting, and discharging patients—and physicians' assuming tasks that nurses would otherwise have handled, such as escorting patients to the examination room. As physicians assumed duties that could more appropriately have been fulfilled by nonphysician personnel, the number of appointments that could have been scheduled each day might have been reduced.

When one appointment is linked to or dependent on another, scheduling and staffing problems can further compound delays. For example, two chiefs of orthopedics told us that patients who are scheduled for an x-ray prior to their orthopedic appointment sometimes arrive late to the orthopedic clinic or without an x-ray as a result of delays in the x-ray clinic. Because orthopedic surgeons typically must have x-rays to properly assess the severity of a patient's condition, patients who do not have x-rays often must reschedule their orthopedic appointments, wasting the original appointment and filling another future appointment slot on the schedule.

Some Clinics Have Made Progress in Their Efforts to Reduce Waiting Times

While most of the clinics we visited continue to experience waiting times problems, several have reported success in reducing their waiting times—primarily by improving their scheduling processes or making better use of staff. One VA medical center combined these and other strategies, and as a result, all but one of its clinics that we reviewed had reduced their waiting times to less than 30 days.

Improved Scheduling Helped Clinics Increase Their Available Appointments

According to the chiefs of several clinics we visited, their improved waiting times were, in part, the result of their increasing the number of available patient appointments. To make more appointments available, these clinics reduced the number of no-shows and reduced physician involvement in certain services. Some clinics also added more providers.

To increase the likelihood that patients would show up for their appointments, the clinics we visited used various strategies, such as the following.

- One ophthalmology and optometry clinic reduced its no-show rate from 45 percent to 22 percent by having scheduling clerks call patients a few days in advance to remind them of their appointments. When making these calls, clerks found that some patients had forgotten their appointments and would likely have missed them had they not received the reminder

call. Some patients, however, said that they did not plan to keep the appointments. In these cases, clerks were typically able to schedule another patient into the time slot and thus increase the number of patients that the provider could see each day and thereby reduce the number of days it took veterans to get appointments.

- A primary care clinic at another medical center reduced its no-show rate from 22 percent to about 12 percent through two actions. First, it changed its medical resident rotation rate to once every 3 years, allowing patients to develop relationships with the residents assigned to their care. The chief of this clinic told us that she believes that the patients are more comfortable knowing that they will see the same provider on each visit and so are more likely to keep their appointments. Second, this primary care clinic also used open access scheduling—an IHI technique—to reduce its no-show rate.⁸ The basic premise of open access scheduling is to schedule nonurgent appointments within 30 days to reduce the likelihood that patients would miss their appointments. For those patients needing appointments past the 30-day time frame, the center sends reminder notices near the time the patient needs to call in to schedule the appointment. According to this center’s director of ambulatory care, lower no-show rates have helped to reduce patient waiting times for primary care. Further, to accommodate urgent patients who need same-day appointments, the medical center holds open the last two appointment slots for each provider in each clinic day.

Clinics also freed up appointments by reducing provider involvement in services that do not require one-on-one physician-patient interaction.

- Providers in one medical center’s primary care clinic now use an automated telephone system to convey the results of blood and other lab tests to patients when the test results are normal. The system automatically calls patients and instructs them to call the system back and enter a preassigned password to retrieve messages from their providers about the results of their tests—which patients can access at any time.
- The gastroenterology clinic at another medical center initiated group education classes for patients diagnosed with hepatitis C. In these classes, patients can receive information and ask questions about the virus. A

⁸Open access scheduling typically can only occur in health care systems that have eliminated or greatly reduced the backlog of patients who are waiting for nonurgent appointments. Under the open access system at this medical center, clinics are encouraged to use a reminder system to contact patients within 30 days of the time they need to make appointments.

primary care clinic at another medical center developed an innovative approach to educating patients newly diagnosed with chronic diseases, such as diabetes. Once diagnosed, each patient is given a “prescription” to take to the clinic’s medical library, where the patient receives medical literature and other media on the disease. Providers at this clinic told us that patients who fill their library prescriptions know more about managing their own conditions and thus need less time with a physician.

Chiefs of 12 clinics told us that they hired more providers—both physician and nonphysician—to increase the number of available appointments, thereby reducing waiting times.

- A urology clinic at one medical center hired a full-time urologist, and, according to the clinic’s chief, this action—along with others such as providing education seminars for primary care physicians—helped reduce the clinic’s waiting time from over 1 year to 30 days, over a period of several years.
- Another urology clinic hired a full-time physician’s assistant to help in its general and procedure clinic. According to the chief of the clinic, clinic efficiency and the number of patients seen each day have increased because the physician’s assistant can independently see patients.
- One eye care clinic hired a part-time optometrist, which helped to reduce the waiting times for patients requiring nonurgent appointments.

Use of Referral Guidelines Helped Some Clinics Make Better Use of Staff

Some clinic chiefs told us that, through the use of referral guidelines, they were able to increase the number of available specialty appointments by reducing the number of scheduled patients whose medical needs could more appropriately be met by a primary care provider.⁹ Some clinics have computerized their referral guidelines, which provides easy access to the guidelines, expedites referrals, and helps ensure that needed tests and exams are completed in advance. Efficiencies such as these enable clinics to increase the number of daily appointments available and help reduce waiting times.

Half of the 54 specialty care clinics we visited had referral guidelines for primary care providers to use when determining whether to refer a patient to a specialist. For example, an orthopedics clinic at one medical center

⁹The use of referral guidelines is supported by the IHI.

we visited implemented referral guidelines in September 1999 to encourage orthopedists to refer patients back to primary care after their orthopedic needs have been met. Seventeen months after the guidelines were implemented, the clinic's waiting times dropped from 200 days to 54 days. Referral guidelines also often indicate which laboratory tests need to be ordered by the primary care provider before a patient is referred to the specialist. According to the director of ambulatory care at another medical center—which established facilitywide referral guidelines—before the guidelines were implemented, primary care providers would notify specialists that patients were being referred. However, these referrals often did not include the primary care provider's assessment of the patient's condition. As a result, the specialists were required to spend time performing routine tests to assess patients' conditions.

This same medical center requires its primary care providers to use a computerized checklist program, which prompts them to complete specific steps for each referral to a specialist. The referral is then reviewed for completeness and accuracy by a medical center team, and, if it meets the criteria, is sent forward to the specialist within a 24-hour period or less. According to medical center officials, this process has greatly reduced the number of unnecessary patient referrals and has helped to make the time that specialists spend with patients more productive.

While the use of patient referral guidelines at the sites we visited varied from clinic to clinic and from one medical center to another, many officials told us that clearly defined and strictly adhered-to guidelines would help reduce the number of specialty referrals for conditions that could more appropriately be handled by a primary care provider and would maximize the time that specialists spend with patients. Yet half of the 54 specialty clinics we visited did not have any form of referral guidelines, and waiting times at these clinics were 25 percent longer than those clinics that had referral guidelines. Some chiefs of specialty and primary care told us that while they believe that referral guidelines could help them better manage their workload and increase the number of available appointment slots, they did not have time to establish such guidelines.

One VA Medical Center Used Multiple Strategies to Reduce Waiting Times

One medical center significantly reduced its waiting times by using multiple strategies, phased in over a 4-year period, that completely restructured its health care delivery system. According to the medical center's director of ambulatory care, because of these changes, along with the hiring of a modest number of primary care providers,¹⁰ waiting times for primary care appointments have been reduced from an average of 35 days to an average of 20 days. In addition, waiting times for specialty care met the 30-day standard in all but one of the specialties we reviewed.¹¹ For example, waiting times in urology were reduced from 3 months to 7 days, and waiting times in ophthalmology were reduced from more than a year to about 7 days.

Before these strategies were implemented, the medical center operated under a "traditional" health care delivery model within VA—screening new patients in the emergency room and compensating for high no-show rates by overbooking appointments and allowing patients to walk in for care, regardless of the level of urgency. Based on information received during the VA-sponsored national collaborative with IHI, the medical center adopted several strategies to more effectively manage its patient workload. In addition to increasing available appointments and implementing referral guidelines,¹² the medical center adopted three key features: the primary care model, walk-in triage, and centralized appointment scheduling.

- **The primary care model.** Almost all of the medical center's nonurgent patient care workload was shifted into primary care. Until 4 years ago, none of the veterans seeking care at this medical center were assigned to a primary care provider; now, about 97 percent are. Primary care providers are now expected to provide comprehensive, ongoing medical care and preventive health measures. They are also expected to coordinate patients' other health care needs, doing more diagnosis and treatment themselves before referring patients to specialists. For example, if a patient makes a request to see an orthopedist for a knee problem or a urologist for suspected prostate cancer, the primary care provider is expected to review the patient's records, order and review the results of needed tests, refer

¹⁰Over the past 4 years, the medical center has hired three full-time primary care providers and now has a total of 15 full-time equivalent primary care physicians.

¹¹At the time of our visit, dermatology had a waiting time of 45 days.

¹²The facility's guidelines are based on those developed by InterQual, a private medical consulting firm.

the patient to a specialist only when needed, and oversee and coordinate the patient's care.

- **Walk-in triage.** According to officials at the medical center, delivering nonurgent care on a walk-in basis (without a scheduled appointment)—a practice common at many VA medical centers—limits the number of appointments that can be scheduled because providers spend time on unscheduled walk-in patients instead of scheduled patients. They also said that treating walk-in patients is not in the best interest of the patients or providers because the treatment is episodic and lacks continuity of care; consequently, providers do not get to know the patients and are less involved in their overall health.¹³ The medical center now triages walk-in patients, with a nurse assessing them to determine whether they need emergency, urgent, or nonurgent care. If their conditions require care in the emergency room or urgent care clinic, they are seen immediately. However, if their conditions require nonurgent care, they are referred to a scheduling clerk, who schedules an appointment for them within 30 days. According to the medical center's director of ambulatory care, this approach helps to better ensure that patients are seen in the appropriate setting, maximizing the delivery of primary care and ensuring that patients with urgent symptoms, such as blurred vision, loss of breath, or acute pain, still receive the most timely care possible.
- **Centralized appointment scheduling.** Prior to centralized scheduling, clerks in each of the medical center's clinics scheduled patient appointments, resulting in a wide variety of scheduling practices. With centralized scheduling, patient appointments for all clinics are now scheduled from one administrative office. According to the center's director of ambulatory care, implementing a centralized scheduling system also allowed the individual clinic clerks more time to focus on other functions, including patient intake at appointment time and patient discharge activities such as recording patient visit information into encounter forms.

According to the center's director of ambulatory care, implementing any of these strategies could result in reduced waiting times, but she believed that combining all of the strategies had the most significant effect.

¹³VA's primary care directive, dated April 1998, requires that VA provide continuity of care to its patients, which it defines as follows: the primary care provider must be backed by a team that knows the patient well and effective and appropriate communication will facilitate continuity of care and ensure that the primary care provider is notified of patient encounters other than scheduled visits.

VA Lacks A Systemwide Approach to Reducing Waiting Times

Although VA has set a performance goal for network directors and has contracted with IHI, it has generally relied on its medical centers nationwide to develop and implement strategies to reduce their own waiting times. However, clinic officials we talked to noted that more guidance and direction from VA on implementing and using referral guidelines could help them in their efforts to reduce waiting times. In addition, some chiefs of specialty and primary care clinics were unaware of the successes that other medical centers have had in reducing waiting times and told us that they would find such information useful in developing their own strategies. However, VA has not provided clinics with referral guidelines, nor has it assessed or disseminated ways to improve patient waiting times that have worked at some clinics. VA also lacks a systematic process for determining the causes of long waiting times, for monitoring clinics' progress in reducing waiting times, and for helping those centers and clinics that continue to have long waiting times.

Referral Guidelines and Information on Best Practices Could Help

Clinic officials told us that while IHI's strategies for reducing waiting times have been useful, they could benefit from more guidance and direction from VA—including referral guidelines and information on best practices—to help them implement these strategies.

In April 1998, VA established a requirement that all medical centers and community-based outpatient clinics adopt a primary care model—a system in which patients use primary care providers to manage their care. In implementing a primary care model, VA strongly suggested that its health care facilities establish guidelines for primary care providers to follow in deciding when to refer patients to specialty care. According to the chief of primary care at one medical center we visited, the center's guidelines for referrals to urology and gastroenterology have resulted in improved communication between these specialists and primary care providers, fewer inappropriate referrals, more complete information on patients who have been referred, and ultimately shorter waiting times for patients in these two specialty clinics.

However, the chief of primary care also told us that the medical center had not developed referral guidelines for the three other specialty care areas that we reviewed. Overall, we found that half of the 54 specialty care clinics we visited have implemented referral guidelines. Further, the existence and use of referral guidelines varied within a medical center and even within a specialty. For example, in one medical center, only the urology clinic had developed referral guidelines. In another medical center, referral guidelines were not available for two of the five specialty

care areas that we reviewed. Several of the chiefs of primary and specialty care we spoke to indicated that implementing referral guidelines would help reduce the number of inappropriate referrals and the time specialists spend with patients, but they did not have the time to develop such guidelines and would like headquarters to do so. Although headquarters officials told us that they believe that providing minimum guidelines could serve as a framework for medical centers and clinics to build on and could help standardize the referral process, VA has not yet developed a national set of referral guidelines for its medical centers and clinics to use.

Clinic officials also told us that they could benefit from learning about other clinics' successes—especially those achieved through VA's initial project with IHI. In July 1999, IHI began working with 134 teams from various medical centers across the nation, representing 160 different clinics. Nine of the 10 medical centers we visited had teams that participated in the IHI project—including the medical center that had reduced waiting times by implementing a primary care model, referral guidelines, centralized appointment scheduling, and a system for triaging walk-ins. However, as of July 2001, none of the 134 teams' findings have been summarized and publicized, leaving the medical centers and clinics nationwide to independently determine how to implement IHI's strategies for reducing waiting times. In March 2001, VA entered into a second contract with IHI to identify and disseminate information on clinics' best practices for reducing waiting times. According to an official from VA headquarters, this second contract should help VA communicate and share, nationwide, the results of medical centers and clinics that have had success in reducing waiting times.

VA Has Identified Clinics With Excessive Waiting Times but Has Not Developed a Process to Analyze Their Root Causes

When VA established its 30-day waiting times standard for primary and specialty care over 5 years ago, it also established the objective that clinics meet this standard by 1998. However, until several months ago, VA had problems collecting accurate and reliable patient waiting times data. The deficiencies in the data limited its ability to identify clinics that were not meeting its 30-day timeliness standard. After several modifications to its national data collection software package, VA can now identify those clinics that exceed the 30-day standard systemwide. In September 1999, VA began holding its network directors responsible for meeting the 30-day

waiting times standard for six clinic types.¹⁴ As of March 2001, VA data showed that about half of VA's nearly 17,500 clinics for these six clinic types were meeting VA's 30-day standard (see table 1).

Table 1: National Waiting Times for Patients for VA Clinics in Areas Measured for Network Performance Goals

Clinic	Total clinics	Percentage of clinics with waiting times of 30 days or less	Percentage of clinics with waiting times of 31 to 45 days	Percentage of clinics with waiting times of 46 to 90 days	Percentage of clinics with waiting times of 91 to 120 days	Percentage of clinics with waiting times of more than 120 days
Primary care	11,586	49	16	24	6	5
Audiology	920	66	15	11	5	3
Cardiology	1,440	49	16	23	7	5
Eye care	1,961	42	14	24	9	11
Orthopedics	717	59	12	21	4	4
Urology	854	51	16	21	6	6
Total^a	17,478	50	15	23	6	5

^aDue to rounding, percentages do not add to 100.

Source: GAO calculations using VA March 2001 VISTA waiting times data.

According to a headquarters' official, VA is planning to notify, in several phases, clinics whose waiting times have not met the 30-day standard. VA has begun by notifying clinics whose waiting times exceed 120 days and, in the next phase, plans to notify clinics whose waiting times exceed 90 days. In March 2001, VA reported that 948 of its clinics had waiting times of 120 days or more in the six medical care areas that VA is using to measure VISN director performance. VA has also developed new waiting time performance objectives to be met by 2003: 90 percent of nonurgent primary care patients and 90 percent of patients with nonurgent specialty care referrals are to be seen within 30 days.

However, VA has not developed an analytic framework for identifying root causes and tracking progress for solving these clinics' waiting times problems. Consequently, over 8,700 clinics for the six areas in which waiting times are longer than 30 days are left to independently develop a process for identifying these root causes. Moreover, while VA distributed a report showing waiting times data to each of its networks, it did not

¹⁴VA identified the six specialties to measure VISN director performance by asking clinical managers from the 22 VISNs to survey their facilities on what clinics had the most problems with waiting times.

require networks to develop corrective actions for medical centers and clinics that failed to meet the 30-day waiting times standard. As a result, VA cannot be sure that medical center management is making progress to meet this standard.

Conclusions

Some of the 71 clinics in the 10 medical centers we visited have successfully begun to address their waiting times problems for patients—often by implementing IHI’s strategies—and several are meeting VA’s 30-day goal to provide nonurgent, outpatient primary and specialty care. However, many veterans continue to experience long waits for appointments, especially for certain types of care—despite VA’s initial objective to have its medical centers and clinics meet the 30-day standard by 1998.

While VA’s two contracts with IHI are important first steps needed to expedite solving its waiting times problems systemwide, the Department could provide more guidance and direction to medical centers and clinics to reduce patient waiting times. In particular, VA has not established national referral guidelines—with local discretion, as appropriate—even though many centers and clinics told us that they need such guidelines but do not have the time to develop them. In addition, VA has not provided medical centers and clinics with an analytic framework for identifying the root causes of their long waiting times. Such a framework could greatly help those centers and clinics that need assistance. Until VA develops a systematic approach for identifying, analyzing, and monitoring waiting times problems, veterans will continue to be at risk of experiencing long waits in their access to nonurgent primary and specialty care.

Recommendations for Executive Action

To help ensure that clinics meet VA’s 30-day waiting times standard, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following actions:

- Create a national set of referral guidelines for medical centers to use when referring patients from primary care to specialty care as well as guidelines for specialty clinics to follow in returning patients to primary care when they no longer need specialty care.
- Strengthen oversight by developing an agencywide process for determining the causes of waiting times problems; implementing corrective actions, where needed; and requiring periodic progress reports from clinics with long waiting times until they meet VA’s national standards.

Agency Comments

We provided VA a draft of our report for its review. In its comments, VA agreed with our findings and concurred with both of our recommendations (see appendix II). In response to our first recommendation, VA acknowledged the need to develop national referral guidelines for specialty care and has charged its newly formed National Waiting Time Steering Committee to address this issue. In response to our second recommendation, VA stated that its ongoing collaboration with IHI should provide an analytic roadmap for facilities to use in analyzing their waiting time problems. In addition, VA is working with IHI to develop a reporting instrument for clinics to use in monitoring waiting time progress.

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

Please contact me at (202) 512-7101 if you or your staffs have any questions. Another contact and key contributors to this report are listed in appendix III.



Cynthia A. Bascetta
Director, Health Care—Veterans'
Health and Benefits Issues

Appendix I: Scope and Methodology

To determine the extent to which clinics are meeting VA's 30-day appointment standard for outpatient primary and specialty care and to learn about approaches some clinics have used to improve waiting times, we visited 10 medical centers¹ selected to include a variety of different-size medical centers, with relatively high, medium, and low numbers of patient visits, located across the United States.² The results of the site selection are reflected in figure 2.

Figure 2: VA Medical Centers Visited



At these locations, we visited in total 71 clinics—17 primary care clinics and 54 clinics in five specialty areas: dermatology, gastroenterology, eye care (ophthalmology and optometry), orthopedics, and urology—within 10 VA medical centers. We selected these specialties, using data from VA's national VISTA database for April, May and June 2000, because the data showed that these areas had some of the highest waiting times for scheduled outpatient clinic appointments compared to other VA specialty

¹These 10 medical centers were Cheyenne, WY; Chicago, IL; Clarksburg, WV; Dallas, TX; Los Angeles, CA; Minneapolis, MN; New Orleans, LA; Seattle, WA; Tampa, FL; and Washington, DC.

²VA also has a goal for patients to be seen within 20 minutes of their scheduled appointment, but this goal was beyond the scope of our review.

areas. During these site visits, we interviewed the medical center directors and chiefs of staff, when available, and clinic management and staff, including scheduling clerks and information resource managers. We also reviewed documents that these medical centers and clinics provided, such as examples of referral guidelines that primary care providers use before referring patients to specialists. We also spoke with VA headquarters officials.

To identify VA's efforts to help medical centers and clinics deliver timely care, we interviewed VA headquarters, medical center, and clinic officials and reviewed documents relating to VA's past and current projects with IHI. We also reviewed VA's *Annual Performance Report Fiscal Year 2000* and other documents detailing VA's goals to reduce its waiting times for appointments. To assess VA's progress in improving the accuracy of waiting times data, we reviewed VA's VISTA waiting time data for July 2000 through March 2001 and reviewed documentation of VA's changes to the VISTA scheduling software, but we did not verify these data. We also interviewed chiefs of primary and specialty care clinics at the 10 medical centers we visited and obtained clinic waiting times data from these officials.

Apart from data verification, we conducted our work from August 2000 through July 2001 in accordance with generally accepted government auditing standards.

Appendix II: Comments From The Department of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

August 14, 2001

Ms. Cynthia Bascetta
Director, Health Care—Veterans'
Health and Benefits Issues
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Bascetta:

This is in response to your draft report, ***VA HEALTH CARE: More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress*** (GAO-01-953). As your report recognizes, the unavailability of reliable national data has significantly restricted the Department of Veterans Affairs' (VA) efforts to develop waiting time reduction strategies on a systematic basis.

I agree with your findings and concur with both of your recommendations. Regarding your first recommendation, VA recognizes the need to develop national referral guidelines for specialty care, since facilities have not consistently adhered to VA's primary care model in establishing these recommended guidelines. The Veterans Health Administration (VHA) recognizes, however, that there will always be circumstances that are not covered under guidelines, or are inconsistent with a guideline. We will support clinical flexibility in meeting the best interests of individual patients. The newly formed National Waiting Time Steering Committee will address this issue. We will provide detailed planned actions in the Department's response to GAO's final report.

With respect to your second recommendation, our ongoing collaboration with the Institute for Healthcare Improvement (IHI) is also yielding important national waiting time program initiatives. We were pleased that GAO was able to identify concrete scheduling improvements in some of the clinics the evaluators visited that were directly linked to application of IHI techniques. Our current goal in this second phase of our VHA/IHI national strategy is to spread those recognized best practices throughout the entire system. We are working with IHI representatives to develop a reporting instrument for each clinic site to use in monitoring waiting time progress. The reporting format is based on 10 key items that IHI has identified as being critical for reducing waiting times. In fact, we are incorporating all the recommended changes addressed in GAO's report into the developing systems. We anticipate that this initiative will provide an analytic roadmap for facilities to analyze their wait time problems.

Thank you for the opportunity to comment on your draft report.

Sincerely yours,

A handwritten signature in black ink that reads "Anthony J. Principi".

Anthony J. Principi

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Ronald J. Guthrie, (303) 572-7332

Acknowledgments

In addition to the contact named above, James Espinoza, Lisa Gardner, Sigrid McGinty, Karen Sloan, Bradley Terry, and Alan Wernz made key contributions to this report.

Related GAO Products

Major Management Challenges and Program Risks: Department of Veterans Affairs ([GAO-01-255](#), Jan. 1, 2001).

Veterans' Health Care: VA Needs Better Data on Extent and Causes of Waiting Times ([GAO/HEHS-00-90](#), May 31, 2000).

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

Veterans' Affairs: Progress and Challenges in Transforming Health Care ([GAO/T-HEHS-99-109](#), Apr. 15, 1999).

VA Health Care: More Veterans Are Being Served, but Better Oversight Is Needed ([GAO/HEHS-98-226](#), Aug. 28, 1998).

VA Health Care: Status of Efforts to Improve Efficiency and Access ([GAO/HEHS-98-48](#), Feb. 6, 1998).

Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Care Reform ([GAO/HEHS-95-14](#), Dec. 23, 1994).

VA Health Care: Restructuring Ambulatory Care System Would Improve Services to Veterans ([GAO/HRD-94-4](#), Oct. 15, 1993).

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