United States Government Accountability Office

Testimony

Before the Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 7:30 p.m. ET
Monday, June 9, 2014

VA HEALTH CARE

Ongoing and Past Work Identified Access, Oversight, and Data Problems That Hinder Veterans' Ability to Obtain Timely Outpatient Medical Care

Statement of Debra A. Draper
Director, Health Care

June 9, 2014

VA HEALTH CARE

Ongoing and Past Work Identified Access, Oversight, and Data Problems That Hinder Veterans' Ability to Obtain Timely Outpatient Medical Care

GAO Highlights

Highlights of GAO-14-679T, a testimony before the Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

Access to timely medical appointments is critical to ensuring that veterans obtain needed medical care. Over the past few years, there have been numerous reports of VAMCs failing to provide timely care to veterans, and in some cases, these delays have reportedly resulted in harm to patients. As the number of these reports has grown, investigations have been launched by VA's Office of Inspector General and VA to examine VAMCs' medical appointment scheduling and other practices.

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 scheduling process. In May 2013, VHA launched the Consult Management Business Rules Initiative to standardize aspects of the consults process and develop system-wide consult data for monitoring.

This testimony is based on GAO's ongoing work to update information previously provided to the Committee on April 9, 2014, including information on VHA's (1) process for managing consults; (2) oversight of consults; and (3) progress made implementing GAO's December 2012 recommendations. To conduct this work, GAO has reviewed documents and interviewed VHA officials. Additionally, GAO has interviewed officials from five VAMCs for the consults work and four VAMCs for the scheduling work that varied based on size, complexity, and location. GAO shared the information it used to prepare this statement with VA and incorporated its comments as appropriate.

View GAO-14-679T. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

GAO's ongoing work examining the Department of Veterans Affairs' (VA) Veterans Health Administration's (VHA) process for managing outpatient specialty care consults has identified examples of delays in veterans receiving outpatient specialty care. GAO has found consults—requests for evaluation or management of a patient for a specific clinical concern—that were not processed in accordance with VHA timeliness guidelines. For example, consults were not reviewed within 7 days, or completed within 90 days. For 31 of the 150 consults GAO reviewed (21 percent), the consult records indicated that VA medical centers (VAMC) did not meet the 7-day review requirement. In addition, GAO found that veterans received care for 86 of the 150 consults (57 percent), but in only 28 of the consults (19 percent) was the care provided within 90 days. For the remaining 64 consults (43 percent), the patients did not receive the requested care. For 4 of the 10 physical therapy consults GAO reviewed for one VAMC, between 108 and 152 days elapsed with no apparent actions taken to schedule an appointment for the veteran. For 1 of these consults, several months passed before the veteran was referred for care to a non-VA health care facility. 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. VA officials indicated that they may refer veterans to non-VA providers to help mitigate delays in care.

GAO's ongoing work also has identified limitations in VHA's implementation and oversight of its new consult business rules designed to standardize aspects of the clinical consult process. Specifically, GAO has identified variation in how the five VAMCs reviewed have implemented key aspects of the 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. However, it is not clear the extent to which VHA is aware of the various strategies that VAMCs are using to comply with this task. Furthermore, oversight of the implementation of the business rules has been limited and does not include independent verification of VAMC actions. Because this work is ongoing, GAO is not making recommendations on VHA's consult process at this time.

In December 2012, GAO reported that VHA's outpatient medical appointment wait times were unreliable and recommended that VA take actions to: (1) improve the reliability of its outpatient medical appointment wait time measures; (2) ensure VAMCs consistently implement VHA's scheduling policy, including the staff training requirements; (3) require VAMCs to routinely assess scheduling needs and allocate staffing resources accordingly; and (4) ensure that VAMCs provide oversight of telephone access, and implement best practices. As of June 2014, VA has reported ongoing actions to address these recommendations, but GAO found that 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 is provided to veterans, who may have medical conditions that worsen if care is delayed.

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

I am pleased to be here today as you examine ongoing concerns related to the Department of Veterans Affairs' (VA) delivery of health care to our nation's veterans. In recent years, VA's Veterans Health Administration (VHA) has faced a growing demand for providing outpatient medical appointments. From fiscal years 2005 through 2012, the number of annual outpatient medical appointments VHA provided increased by approximately 45 percent, from 58 million to 84 million.[1] VHA provided this care through its primary and specialty care outpatient clinics, which are managed by VA's 151 medical centers (VAMC).[2] Although access to timely medical appointments is critical to ensuring that veterans obtain needed medical care, problems with VHA's scheduling and management of outpatient medical appointments may contribute to delays in care, or care not being provided at all. Over the past few years there have been numerous reports of VAMCs failing to provide timely care, including specialty care, and in some cases, the delays have reportedly resulted in harm to veterans.[3]

Nonetheless, VHA has reported continued improvements in achieving timely access to medical appointments. For example, in fiscal year 2011, VA reported that VHA completed 89 percent of medical appointments for new patients within its goal; in fiscal year 2012, VA reported that VHA completed 90 percent of primary and specialty care new patient

[1]In addition, the number of patients VHA served increased from fiscal years 2005 to 2012 by approximately 19 percent, from 5.3 million to 6.3 million patients.

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

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

appointments within the goal.[4] However, in December 2012, we reported that VHA's medical appointment wait times were unreliable and VHA's inadequate oversight of the outpatient medical appointment scheduling processes contributed to VHA's problems with scheduling timely medical appointments.[5] More recently, a report by VA's Office of Inspector General, as well as hearings on VA's delivery of medical care have discussed delays in care and improper scheduling practices resulting in lengthy wait times at VA facilities, and in some cases, care not being provided at all. Additionally, VA has initiated a system-wide audit to identify the scope and magnitude of these issues. Initial results of the audit confirmed questionable scheduling practices and other problems at many VA facilities.[6]

The problems that have been identified include VA's scheduling and delivery of outpatient specialty care. When a physician or other provider determines that a veteran needs outpatient specialty care, the provider refers the veteran to a specialist for a clinical consult—a request for evaluation or management of a patient for a specific clinical concern, or for a specialty procedure such as a colonoscopy. VAMCs request, review, and manage consults using VHA's clinical consult process and electronic consult system, which retains information about each consult request and is part of VHA's Veterans Health Information Systems and Technology Architecture (VistA).[7] VHA's timeliness guideline is that consults should be completed within 90 days of being requested.[8]

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

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

[6]U.S. Department of Veterans Affairs, *Access Audit Results Summary: Phase One Access Audit from 12 May 2014 – 16 May 2014*, accessed June 3, 2014, http://www.blogs.va.gov/VAntage/wp-content/uploads/2014/05/VHA-Access-Audit-Phase-1-Findings-Report-ExSum-05-30-2014.pdf.

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

[8]VHA officials noted that although VHA's guideline is for consults to be completed within 90 days; consults for urgent needs are completed sooner.

Appointments resulting from outpatient consults, like other outpatient medical appointments, are subject to VHA's scheduling policy.[9] This policy is designed to help VAMCs meet their commitment to scheduling medical appointments with no undue waits or delays for patients. It establishes processes and procedures for scheduling medical appointments and ensuring the competency of staff directly or indirectly involved in the scheduling process. Additionally, it includes several requirements that affect timely appointment scheduling, as well as accurate wait time measurement. For example, the policy requires schedulers to record appointments in VHA's VistA medical appointment scheduling system.

Ideally, the consult system would contain timely and reliable information on the status and outcomes of consults, and would provide VHA information it needs to help effectively manage the process. In 2012, however, VHA found that system-wide consult data could not be adequately used to determine the extent to which veterans experienced delays in receiving outpatient specialty care. VHA found that approximately 2 million consults were unresolved in its system for more than 90 days. Additionally, VHA determined that the data were inadequate to identify whether care had been provided for these consults, or provided in a timely manner. In response, in May 2013, VHA launched the Consult Management Business Rules Initiative (referred to as "consult business rules") to standardize aspects of the consult process, with the goal of developing consistent and reliable data on consults across all VAMCs.

My statement today will draw from our ongoing work examining the management of outpatient specialty care consult processes at five selected VAMCs, and our December 2012 report examining the reliability of VHA's reported outpatient medical appointment wait times data and scheduling oversight.[10] In particular, this statement updates information provided in our April 9, 2014 testimony before the Committee regarding (1) the extent to which VHA's process for conducting outpatient consults at five selected VAMCs ensured veterans timely access to specialty care,

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

[10]GAO-13-130.

(2) the extent to which VHA monitors and oversees consults to ensure veterans are receiving outpatient specialty care in accordance with its timeliness standards; and (3) key findings and recommendations from our December 2012 report, as well as the progress VHA has made in implementing those recommendations.[11]

For our ongoing outpatient specialty care consults work,[12] we have reviewed documents and interviewed VHA central office officials about VHA's policies and guidance for VAMCs to send, receive, and complete consults, and VHA's procedures for VAMCs to schedule outpatient medical appointments, which include those for specialty care. We also have reviewed documents and interviewed VHA central office officials about their efforts to oversee VAMCs' implementation of VHA's consult policies, including VHA's Consult Management Business Rules Initiative, launched in May 2013. Additionally, we have interviewed officials from five VAMCs selected for variation in volume of outpatient consults, complexity,[13] and location. These five VAMCs were located in Augusta, Maine; Denver, Colorado; Gainesville, Florida; Oklahoma City, Oklahoma; and Palo Alto, California. For each VAMC included in our ongoing work, we have interviewed leadership about how VHA's consult policies and any local policies or procedures for managing consults are implemented at their facility. We also have interviewed specialty care service chiefs, administrative staff, and providers of three high-volume specialty services—cardiology, gastroenterology, and physical therapy. Further, we have interviewed officials at the five regional Veterans Integrated Service Networks (VISN) responsible for overseeing consults for the VAMCs included in our review.[14]

[11]GAO, *VA Health Care: Ongoing and Past Work Identified Access Problems That May Delay Needed Medical Care for Veterans*, GAO-14-509T (Washington, D.C.: Apr. 9, 2014).

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

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

[14]VHA's health care system is divided into 21 areas called VISNs, each responsible for managing and overseeing medical facilities within a defined geographic area.

Additionally, for each of the five medical centers, we have reviewed the history of actions taken on a random sample of 30 outpatient consults (10 from each of the three specialties included in our review) that were requested during the period April 1, 2013, through September 30, 2013, that either took more than 90 days to complete or had been in process for more than 90 days. We also asked VHA to identify those consults that were requested during this time period for veterans who are now deceased. We randomly selected 50 of these consults (10 from each VAMC included in our review) to determine the extent to which these veterans may have experienced any delays in care. The preliminary findings from our ongoing review of outpatient consults are not generalizable across all VAMCs.

For our December 2012 report examining the reliability of VHA's reported outpatient medical appointment wait times and scheduling oversight,[15] we reviewed VHA's scheduling policy and methods for measuring medical appointment wait times and interviewed VHA central office officials responsible for developing them.[16] We also visited 23 high-volume outpatient clinics at four VAMCs selected for variation in size, complexity, and location; these four VAMCs were located in Dayton, Ohio; Fort Harrison, Montana; Los Angeles, California; and Washington, D.C. At each VAMC we interviewed leadership and other officials about how they managed and improved medical appointment timeliness, their oversight to ensure accuracy of scheduling data and compliance with scheduling policy, and problems staff experienced in scheduling timely medical appointments. We examined each VAMC's and clinic's implementation of elements of VHA's scheduling policy and obtained documentation of scheduler training completion. In addition, we interviewed schedulers from 19 of the 23 clinics visited, and also reviewed patient complaints about telephone responsiveness, which is integral to timely medical appointment scheduling. We interviewed the directors and relevant staff of the four regional VISNs for the VAMCs we visited. We also interviewed VHA central office officials and officials at the VAMCs we visited about selected initiatives to improve veterans' access to timely medical appointments. Additionally, in April and June 2014, we reviewed documentation and interviewed officials from VHA's central office about

[15]GAO-13-130.

[16]We did not include mental health appointments in the scope of our work, because this issue was already being reviewed by VA's Office of Inspector General.

the extent to which they have addressed the recommendations we made in the 2012 report.[17]

The work upon which this statement is based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We are not making recommendations on VHA's consult process at this time because some of this work is ongoing.

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

Background

When providers at VAMCs determine that a veteran needs outpatient specialty care, they request and manage consults using VHA's clinical consult process. Clinical consults include requests by physicians or other providers for both clinical consultations and procedures. A clinical consultation is a request seeking an opinion, advice, or expertise regarding evaluation or management of a patient's specific clinical concern, whereas a procedure is a request for a specialty procedure such as a colonoscopy. Clinical consults are typically requested by a veteran's primary care provider using VHA's electronic consult system. The consult process is governed by VHA's national consult policy.[18] The policy requires VAMCs to manage consults using a national electronic consult system,[19] and requires VAMC staff to provide timely and appropriate care to veterans.

Once a provider sends a request, VHA requires specialty care providers to review it within 7 days and determine whether to accept the consult. If the specialty care provider accepts the consult—determines the consult is

[17]GAO-14-509T.

[18]VHA Directive 2008-056, VHA Consult Policy (Sept. 16, 2008).

[19]The electronic consult system retains information about each consult request and is part of VHA's VistA.

needed and is appropriate—an appointment is to be made for the patient to receive the consultation or procedure.[20] In some cases, a provider may discontinue a consult for reasons such as the care is not needed, the patient refuses care, or the patient is deceased.[21] In other cases the specialty care provider may determine that additional information is needed, and will send the consult back to the requesting provider, who can resubmit the consult with the needed information. Once the appointment is held, VHA's policy requires the specialty care provider to appropriately document the results of the consult, which would then close out the consult as completed in the electronic system.[22] VHA's current guideline is that consults should be completed within 90 days of the request. If an appointment is not held, staff are to document why they were unable to complete the consult.

According to VHA's consult policy, VHA central office officials have oversight responsibility for the consult process, including the measurement and monitoring of ongoing performance.[23] In 2012, VHA created a database to capture all consults system-wide and, after reviewing these data, determined that the data were inadequate for monitoring purposes. One issue identified was the lack of standard processes and uses of the electronic consult system across VHA. For example, in addition to requesting consults for clinical concerns, the system also was being used to request and manage a variety of administrative tasks, such as requesting patient travel to appointments. Additionally, VHA could not accurately determine whether patients actually received the care they needed, or if they received the care in a timely fashion. According to VHA officials, approximately 2 million consults (both clinical and administrative consults) were unresolved for more than 90 days. Subsequently, VA's Under Secretary for Health convened a task force to address these and other issues regarding VHA's

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

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

[22]The results of consults are documented in the consult system, and are contained in the patient's electronic health record.

[23]The policy also requires VISN leadership to oversee the consult processes for VAMCs in their networks.

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

- Review and properly assign codes to consistently record consult requests in the consult system;[24]
- Assign distinct identifiers in the electronic consult system to differentiate between clinical and administrative consults;
- Develop and implement strategies for requesting and managing requests for consults that are not needed within 90 days—known as "future care" consults;[25] and
- Conduct a clinical review as warranted, and as appropriate, close all unresolved consults—those open more than 90 days.

At the time of our December 2012 review, VHA measured outpatient medical appointment wait times as the number of days elapsed from the patient's or provider's desired date, as recorded in the VistA scheduling system by VAMCs' schedulers. In fiscal year 2012, VHA had a goal of completing new and established patient specialty care appointments within 14 days of the desired date. VHA established this goal based on its performance reported in previous years.[26] To facilitate accountability for achieving its wait time goals, VHA includes wait time measures—referred to as performance measures—in its budget submissions and

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

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

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

performance reports to Congress and stakeholders.[27] The performance measures, like wait time goals, have changed over time.

Officials at VHA's central office, VISNs, and VAMCs all have oversight responsibilities for the implementation of VHA's scheduling policy. For example, each VAMC director, or designee, is responsible for ensuring that clinics' scheduling of medical appointments complies with VHA's scheduling policy and for ensuring that all staff who can schedule medical appointments in the VistA scheduling system have completed the required VHA scheduler training.[28] In addition to the scheduling policy, VHA has a separate directive that establishes policy on the provision of telephone service related to clinical care, including facilitating telephone access for medical appointment management.

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

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

GAO's Ongoing Work Indicates That Veterans Did Not Always Receive Outpatient Specialty Care in Accordance with VHA Timeliness Standards, and in Some Cases, Did Not Receive Care at All

Our ongoing work has identified examples of delays in veterans receiving requested outpatient specialty care at the five VAMCs we reviewed. We found consults that were not processed in accordance with VHA timeliness guidelines—for example, consults were not reviewed within 7 days, or completed within 90 days. We also found consults for which veterans did not receive the requested outpatient specialty care, and those for which the requested specialty care was provided, but were not properly closed in the consult system.

VHA requires specialty care providers to review consults within 7 days and determine whether to accept the consult. Of the 150 consults we reviewed, the consult records indicated that VAMCs did not meet the 7-day requirement for 31 consults (21 percent). For one VAMC, nearly half the consults were not reviewed and triaged within 7 days. Officials at this VAMC cited a shortage of providers needed to review and triage the consults in a timely manner.

Our ongoing work also has identified that for the majority of the 150 consults we reviewed, VAMCs did not meet VHA's timeliness guideline that care be provided and consults completed within 90 days. We found that veterans received care for 86 of the 150 consults we reviewed (57 percent), but in only 28 of the consults (19 percent) veterans received care within 90 days of the date the consult was requested. For the remaining 64 consults (43 percent), the patients did not receive the requested care. Specific examples of consults that were not completed in 90 days, or were closed without the patients being seen, include:

- For 3 of 10 gastroenterology consults we reviewed for one VAMC, we found that between 140 and 210 days elapsed from the dates the consults were requested to when the patients received care. For the consult that took 210 days, an appointment was not available within 90 days and the patient was placed on a waiting list before having a screening colonoscopy.
- For 4 of the 10 physical therapy consults we reviewed for one VAMC, we found that between 108 and 152 days elapsed, with no apparent actions taken to schedule an appointment for the veteran. The patients' files indicated that due to resource constraints, the clinic was not accepting consults for non-service-connected physical therapy

evaluations.[29] In 1 of these cases, several months passed before the veteran was referred to non-VA care, and he was seen 252 days after the initial consult request. In the other 3 cases, the physical therapy clinic sent the consults back to the requesting provider, and the veterans did not receive care for that consult.

- For all 10 of the cardiology consults we reviewed for one VAMC, we found that staff initially scheduled patients for appointments between 33 and 90 days after the request, but medical files indicated that patients either cancelled or did not show for their initial appointments. In several instances patients cancelled multiple times. In 4 of the cases VAMC staff closed the consults without the patients being seen; in the other 6 cases VAMC staff rescheduled the appointments for times that exceeded the 90-day timeframe.[30]

VAMC officials cited increased demand for services, patient no-shows, and cancelled appointments, among the factors that hinder their ability to meet VHA's guideline for completing consults within 90 days. Several VAMC officials also noted a growing demand for both gastroenterology procedures, such as colonoscopies, as well as consultations for physical therapy evaluations, combined with a difficulty in hiring and retaining specialists for these two clinical areas, as causes of periodic backlogs in providing these services. Officials at these facilities indicated that they try to mitigate backlogs by referring veterans to non-VA providers for care.

While officials indicated that use of non-VA care can help mitigate backlogs, several officials indicated that non-VA care requires more coordination between the VAMC, the patient, and the non-VA provider; can require additional approvals for the care; and also may delay obtaining the results of medical appointments or procedures. In addition, wait times are generally not tracked for non-VA care. As such, officials acknowledged that this strategy does not always prevent delays in veterans receiving timely care or in completing consults.

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

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

Our ongoing review also has identified one consult for which the patient experienced delays in obtaining non-VA care and died prior to obtaining needed care. In this case, the patient needed endovascular surgery to repair two aneurysms – abdominal aortic and an iliac. According to the patient's medical record, the timeline of events surrounding this consult was as follows:

- September 2013 – Patient was diagnosed with two aneurysms.
- October 2013 – VAMC scheduled patient for surgery in November, but subsequently cancelled the scheduled surgery due to staffing issues.[31]
- December 2013 – VAMC approved non-VA care and referred the patient to a local hospital for surgery.
- Late December 2013 – After the patient followed up with the VAMC, it was discovered that the non-VA provider lost the patient's information. The VAMC resubmitted the patient's information to the non-VA provider.
- February 2014 – The consult was closed because the patient died prior to the surgery scheduled by the non-VA provider.[32]

According to VAMC officials, they conducted an investigation of this case. They found that the non-VA provider planned to perform the surgery on February 14, 2014, but the patient died the previous day. Additionally, they stated that according to the coroner, the patient died of cardiac disease and hypertension and that the aneurysms remained intact.

Furthermore, our ongoing work shows that for nearly all of the consults where care had been provided within 90 days, an extended amount of time elapsed before specialty care providers completed them in the consult system.[33] Specifically, for 28 of the 29 consults, even though care was provided, the consult remained open in the system, making it appear as though the requested care was not provided within 90 days. For one

[31]Officials indicated that in October 2013, the VAMC temporarily suspended the endovascular surgeon that conducts these surgeries.

[32]We have referred this case to VA's Office of Inspector General for further review.

[33]According to VAMC officials, in order to successfully complete a consult, the specialty care provider must select a specific note title that links the results to the consult.

VAMC, we found that for all 10 cardiology consults we reviewed, specialty care providers did not properly document the results of the consults in order to close them in the system. In some cases, it took over 100 days from the time care was provided until the consults were completed in the system.

Officials from several VAMCs told us that often specialty care providers do not choose the correct notes needed to document that the consults are complete. Officials attributed this ongoing issue in part to the use of residents, who rotate in and out of specialty care clinics after a few months and lack experience with completing consults. Officials from one VAMC told us that this requires VAMC leadership to continually train new residents on how to properly complete consults. To ensure that specialty care providers consistently choose the correct notes, this VAMC activated a prompt in its consult system asking each provider if the note the provider is entering is in response to a consult. Officials stated that this has resulted in providers more frequently choosing the correct note title to complete consults.

Limitations in VHA's Implementation of the Consult Business Rules Impedes Its Ability to Assess Delays in Care

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

One task of the consult business rules required VAMCs to develop and implement strategies for requesting and managing requests for future care consults.[34] Based on our ongoing work, we have identified that VAMCs are adopting various strategies when implementing this task,[35]

[34]VHA provided VAMCs with options for managing future care consults—namely that they could develop markers to identify them in the consult system, or use existing mechanisms outside of the consult system such as electronic wait lists.

[35]Information on the strategies used by VAMCs to implement this consult business rule task was included in our April 2014 testimony. See GAO-14-509T.

such as piloting an electronic system for providers to manage future care consults outside of the consult system and entering the consult regardless of whether the care was needed beyond 90 days.[36] However, during the course of our ongoing work, several VAMCs told us they are changing their strategies for requesting and managing future care consults. For example, officials from a VAMC that was piloting an electronic system stated that, after evaluating the pilot, they decided not to use this approach, and are instead planning to implement markers to identify future care consults. These consults will appear in the consult data, but will be identified as future care consults and remain appropriately open until care is provided. Officials from two other VAMCs that were entering consults regardless of whether the care was needed beyond 90 days told us they are no longer doing this. According to officials, instead they are implementing a separate electronic system to track needed future care outside of the consult system, and these future care needs will not appear in consult data until they are entered in the consult system closer to the date the care is needed. Based on our discussions with VHA officials, it is not clear the extent to which they are aware of the various strategies that VAMCs are using to comply with this task. According to VHA officials, they have not conducted a system-wide review of the future care strategies and did not have detailed information on the various strategies specific VAMCs have implemented.

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

Furthermore, our ongoing work shows that VHA did not require that VAMCs document how they addressed unresolved consults that were open greater than 90 days, and none of the five VAMCs in our ongoing review were able to provide us with specific documentation in this regard.

[36]Two VAMCs included in our review reported entering the consults regardless of whether the care was needed beyond 90 days. One of these VAMCs further stated that providers discontinued consults for future care appointments when the 90-day threshold was reached.

VHA officials estimated that as of June 2014, about 278,000 consults (both clinical and administrative consults) remained unresolved system-wide. VAMC officials noted several reasons that consults were either completed or discontinued in this process of addressing unresolved consults, including improper recording of consult notes, patient cancellations, and patient deaths. At one of the VAMCs we reviewed, a specialty care clinic discontinued 18 consults the same day that a task for addressing unresolved consults was due. Three of these 18 consults were part of our random sample, and ongoing review has found no indication that a clinical review was conducted prior to the consults being discontinued. Ultimately, the lack of independent verification and documentation of how VAMCs addressed these unresolved consults may have resulted in VHA consult data that inaccurately reflected whether patients received the care needed or received it in a timely manner.

Although VHA's consult business rules were intended to create consistency in VAMCs' consult data, our preliminary work has identified variation in managing key aspects of the consult process that are not addressed by the business rules. For example, there are no detailed system-wide VHA policies on how to handle patient no-shows and cancelled appointments, particularly when patients repeatedly miss appointments, which may make VAMCs' consult data difficult to assess.[37] For example, if a patient cancels multiple specialty care appointments, the associated consult would remain open and could inappropriately suggest delays in care. To manage this type of situation, one VAMC developed a local consult policy referred to as the "1-1-30" rule. The rule states that a patient must receive at least 1 letter and 1 phone call, and be granted 30 days to contact the VAMC to schedule a specialty care appointment.[38] If the patient fails to do so within this time frame, the specialty care provider may discontinue the consult. According to VAMC officials, several of the consults we reviewed would have been discontinued before reaching the 90-day threshold if the 1-1-30 rule had

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

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

been in place at the time.[39] Furthermore, all of the VAMCs included in our ongoing review had some type of policy addressing patient no-shows and cancelled appointments, each of which varied in its requirements.[40] VHA officials indicated that they allow each VAMC to develop their own approach to addressing patient no-shows and cancelled appointments. Without a standard policy across VHA addressing patient no-shows and cancelled appointments, however, VHA consult data may reflect numerous variations of how VAMCs handle patient no-shows and cancelled appointments.

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

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

At each of the four VAMCs in our 2012 review, we also found inconsistent implementation of VHA's scheduling policy, which impeded scheduling of

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

[40]One of the VAMCs allowed for a maximum number of two no-shows for all specialty appointments, with consideration given to the patient's medical needs. Another VAMC allowed for two no-shows for all specialty care appointments before a consult could be discontinued, but provided no limit for patient cancellations. Two other VAMCs' policies stated that specialty providers should reassess the patient's needs after one no-show and may or may not reschedule the appointment. Finally, the remaining VAMC's policy did not include a limit to the number of no shows allowed for specialty appointments.

timely medical appointments. For example, we found the electronic wait list was not always used to track new patients that needed medical appointments as required by VHA scheduling policy, putting these patients at risk for delays in care. Furthermore, VAMCs' oversight of compliance with VHA's scheduling policy, such as ensuring the completion of required scheduler training, was inconsistent across facilities. At that time, VAMCs also described other problems with scheduling timely medical appointments, including VHA's outdated and inefficient scheduling system, gaps in scheduler and provider staffing, and issues with telephone access. For example, officials at all VAMCs we visited in 2012 reported that high call volumes and a lack of staff dedicated to answering the telephones affected their ability to schedule timely medical appointments.

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

- First, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to improve the reliability of its outpatient medical appointment wait time measures. In response, VHA officials stated that they implemented more reliable measures of patient wait times for primary and specialty care. In fiscal years 2013 and 2014, primary and specialty care appointments for new patients have been measured using time stamps from the VistA scheduling system to report the time elapsed between the date the appointment was created—instead of the desired date—and the date the appointment was completed. VHA officials stated that they made the change from using desired date to creation date based on a study that showed a significant association between new patient wait times using the date the appointment was created and self-reported patient satisfaction with the timeliness of VHA appointments.[41] VA, in its FY 2013 Performance and Accountability Report, reported that VHA completed 40 percent of new patient specialty care appointments within 14 days of the date the appointment was created in fiscal year 2013; in contrast, VHA completed 90 percent of new patient specialty care appointments within 14 days of the desired date in fiscal year

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

2012. VHA also modified its measurement of wait times for established patients, keeping the appointment desired date as the starting point, and using the date of the pending scheduled appointment, instead of the date of the completed appointment, as the end date for both primary and specialty care. VHA officials stated that they decided to use the pending appointment date instead of the completed appointment date because the pending appointment date does not include the time accrued by patient no-shows and cancelled appointments. In a June 5, 2014 statement from the Acting Secretary, VA indicated that it is removing measures related to the 14-day performance goal from VISN and VAMC directors' performance contracts.

- Second, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to ensure VAMCs consistently implement VHA's scheduling policy and ensure that all staff complete required training. In response, VHA officials stated that the department was in the process of revising the VHA scheduling policy to include changes, such as the new methodology for measuring wait times, and improvements and standardization of the use of the electronic wait list. In March 2013, VHA distributed guidance, via memo, to VAMCs describing this information and also offered webinars to VHA staff on eight dates in April and May of 2013. In June 2014, VHA officials told us that they were in the process of further revising the scheduling policy, in part to reflect findings from VA's system-wide access audit, and planned to issue a memo regarding new scheduling procedures at a future date. To assist VISNs and VAMCs in the task of verifying that all staff have completed required scheduler training, VHA has developed a database that will allow a VAMC to identify all staff that have scheduled appointments and the volume of appointments scheduled by each; VAMC staff can then compare this information to the list of staff that have completed the required training. However, as of June 2014, VHA officials have not established a target date for when this database would be made available for use by VAMCs.
- Third, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to require VAMCs to routinely assess scheduling needs for purposes of allocation of staffing resources. VHA officials stated that they are continuing to work on identifying the best methodology to carry out this recommendation, but stated that the database that tracks the volume of appointments scheduled by individual staff also may prove to be a viable tool to assess staffing needs and the allocation of resources. As of June 2014, VHA officials stated that they are continuing to address this

recommendation including through internal and external discussions taking place in May and June 2014 regarding VHA scheduling policy.

- Finally, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to ensure that VAMCs provide oversight of telephone access, and implement best practices to improve telephone access for clinical care. In response, VHA required each VISN director to require VAMCs to assess their current telephone service against the VHA telephone improvement guide and to electronically post an improvement plan with quarterly updates. VAMCs are required to routinely update progress on the improvement plan. VHA officials cited improvement in telephone response and call abandonment rates since VAMCs were required to implement improvement plans. Additionally, VHA officials said that the department has contracted with an outside vendor to assess VHA's telephone infrastructure and business process and was reviewing the findings from the first vendor report in June 2014.

Although VA has initiated actions to address our recommendations, we believe that continued work is needed to ensure these actions are fully implemented in a timely fashion. Our findings regarding incorrect use of the desired date in the scheduling system and the electronic wait list are consistent with VHA's recent findings from its system-wide access audit, indicating continued system-wide problems that could be addressed, in part, by implementing our recommendations. Furthermore, it is important that VA assess the extent to which these actions are achieving improvements in medical appointment wait times and scheduling oversight as intended. Ultimately, VHA's ability to ensure and accurately monitor access to timely medical appointments is critical to ensuring quality health care to veterans, who may have medical conditions that worsen if access is delayed.

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

GAO Contacts and Staff Acknowledgments

For further information about this statement, please contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Key contributors to this statement were Bonnie Anderson, Assistant Director; Janina Austin, Assistant Director; Rebecca Abela; Jennie Apter; Jacquelyn Hamilton; David Lichtenfeld; Brienne Tierney; and Ann Tynan.