VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6

March 2, 2017
16-02618-424

ACRONYMS

FY	Fiscal Year
GAO	Government Accountability Office
NVCC	Non-VA Care Coordination
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
SOP	Standard Operating Procedures
VA	Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VAMC	Veterans Affairs Medical Center
VCL	Veterans Choice List
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VISTA	Veterans Health Information Systems and Technology Architecture
VSSC	Veteran Support Service Center

EXECUTIVE SUMMARY

Access to health care has been a recurring issue in the Veterans Health Administration (VHA). For more than a decade, the Office of Inspector General (OIG), U.S. Government Accountability Office (GAO), Department of Veterans Affairs (VA), and other organizations have issued numerous reports regarding issues with access to VA care such as veteran wait times, scheduling practices, consult management, and the Veterans Choice Program (Choice). Since the nationwide scandal on patient wait times in 2014, we have continued to identify problems with VHA managing access to health care. Since August 2015, OIG reviews at six VA medical facilities—Colorado Springs, Houston, Oklahoma City, Phoenix, St. Louis, and Tampa—showed that VHA continues to experience significant issues with the reliability of veteran wait times, scheduling practices, consult management, and access to Choice.

Previous reviews focused on individual medical facilities. This audit assesses the reliability of wait time data and timely access within an entire Veterans Integrated Service Network (VISN). Conducting an audit of a VISN, as presented in this report, is important since the VISN is responsible for allocating appropriate resources to its many medical facilities. Information and data related to Access to Care needs to be current, accurate, and available to help VISN leadership address significant changes in health care service demands and gaps in service delivery. We selected VISN 6 for this audit to determine whether it provided new veteran patients timely access to health care within its medical facilities and through Choice, as well as to determine whether VISN 6 appropriately managed consults. This audit was not a clinical review of health care provided to veterans. Rather, the audit focused on measuring wait times for new patients and the accuracy of wait time data within the VISN 6 medical facilities and through Choice.

What We Did

We conducted our audit from April 2016 through January 2017. We reviewed applicable laws, policies, and procedures related to VHA access to health care, wait times, and Choice. We reviewed prior audits and reviews related to VHA access to health care completed by OIG, GAO, and VA. We conducted a statistical sample review of more than 1,400 appointments consisting of 618 new patient appointments, 389 Choice authorizations, 210 discontinued or canceled consults from FY 2016, and 210 specialty care consults open more than 30 days as of March 23, 2016.[1] During our site visits, we discussed our statistical sample review results with medical facility staff assigned to assist us, whereby we received clarification on questions and potential issues.

[1] We used stratified random sampling for all the samples of appointments and consults selected. All records had a known chance of selection. This allowed us to make estimates over the entire population. For additional information on the statistical sampling methodology, see Appendix J.

From May through June 2016, we conducted site visits at 12 VA medical facilities within VISN 6—including seven VA Medical Centers (VAMCs) and five health care centers—as follows:

1. Charles George VAMC (Asheville, NC)
2. Charlotte Health Care Center (Charlotte, NC)
3. Durham VAMC (Durham, NC)
4. Fayetteville Health Care Center (Fayetteville, NC)
5. Fayetteville VAMC (Fayetteville, NC)
6. Greenville Health Care Center (Greenville, NC)
7. Hampton VAMC (Hampton, VA)
8. Hunter Holmes McGuire VAMC (Richmond, VA)
9. Kernersville Health Care Center (Kernersville, NC)
10. Salem VAMC (Salem, VA)
11. W.G. (Bill) Hefner VAMC (Salisbury, NC)
12. Wilmington Health Care Center (Wilmington, NC)

We interviewed more than 300 staff from VHA, the VISN 6 office, and each medical facility we visited. Although this audit was not a clinical review, we referred 84 potentially higher risk patients from our sample appointments and consults to OIG's Office of Healthcare Inspections (OHI) for review. These patients were considered higher risk because they were deceased or experienced more significant delays in care. We referred the medical records for these veterans to OHI to determine whether inappropriate or untimely care resulted in any harm to the veteran. For additional information regarding the extent of our audit, see Appendix I.

What We Found

Our audit estimated that 36 percent of the appointments for new patients at facilities within VISN 6 during the relevant time period had wait times longer than 30 days. We estimated that the average wait time for this 36 percent was 59 days. These numbers are significantly higher than the wait time data that VHA's electronic scheduling system showed. Among other consequences, the inaccurate wait time data resulted in a significant number of veterans not being eligible for treatment through Choice. With respect to those veterans in VISN 6 who received their care through Choice, our audit estimated that 82 percent of the appointments during the relevant time period had wait times longer than 30 days. We estimated that the average wait time for those who received their care through Choice was 84 days. For those veterans who did not receive care through Choice within 30 days, we estimated they waited an average of 98 days to receive their care, which ranged in our sample from 31 to 389 days. OHI did not identify any harm caused by untimely care to the 84 potentially higher risk patients that we referred.

VISN 6 Medical Facilities Did Not Consistently Provide Timely Access to Health Care Needs for New Patient Appointments and Did Not Have Accurate Wait Time Data

VISN 6 medical facilities did not consistently provide timely access to health care for new patient appointments. We used 30 days from a veteran's supported preferred appointment date, a referring provider's clinically indicated date, or the appointment "create date" to determine whether an appointment was timely. This is consistent with VHA's outpatient scheduling and consult policies and guidance. An accurate measurement of wait time is essential because Choice increased eligibility for care in the community to include veterans who had to wait over 30 days for VA appointments. We reviewed a statistical sample of 618[2] new patient appointments completed at VISN 6 medical facilities in the first quarter of FY 2016. We reviewed these appointments to determine whether medical facilities provided timely access for new patient appointments, as well as to assess the accuracy of VISN 6 wait time data. Based on this review, we estimated about 20,600 of 57,000 appointments (36 percent) had wait times greater than 30 days. For those 20,600 appointments, we estimated veterans waited an average of 59 days. This was notably higher than the 5,500 appointments (10 percent) that VHA's electronic scheduling system showed were scheduled greater than 30 days.

To evaluate VISN 6, we compared VISN 6 practices and procedures to VHA's outpatient scheduling and consult policy and guidance. In accordance with VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010), we measured the wait time from the veteran's desired (preferred) appointment date—if the scheduler documented that date in VHA's electronic scheduling system—to the date the appointment was completed. If the scheduler did not document the veteran's preferred appointment date in VHA's electronic scheduling system, we started the wait time calculation on the date VHA initially scheduled the appointment (appointment create date).

Scheduler audit assessment criteria require the patient's desired appointment date to be entered into the appointment comments to evaluate the appropriateness of the appointment scheduled. As prescribed by VHA training material, *Stepping Through the Scheduling Process* CLARIFICATION OF VHA OUTPATIENT SCHEDULING POLICY AND PROCEDURES, July 7, 2015, for mental health care and specialty care consults, we measured the wait time from the referring provider's clinically indicated date to the date the appointment was completed. Absent a clinically indicated date, or if the patient canceled the previous appointment, we used the veteran's preferred appointment date, if the scheduler documented that date in VHA's electronic scheduling system. If the scheduler did not document the veteran's preferred appointment date in VHA's electronic scheduling system, we started the wait time calculation based on the appointment create date.

Based on our statistical sample review, we broke down the 57,000 appointments by type and estimated that:

[2] We reviewed 630 sample cases, consisting of 420 completed new patient appointments in primary care and mental health and 210 completed specialty care consults. Of the 210 completed specialty care consults, 12 consults had completed care without having an appointment created in VHA's electronic scheduling system. Our population consisted of primary care appointments and mental health care appointments completed in the first quarter of FY 2016, and specialty care consults created in first quarter of FY 2016 and completed as of March 23, 2016.

- Of 10,700 primary care appointments, 3,500 (33 percent) had wait times greater than 30 days, with an average wait time of 51 days for those 3,500 appointments. This compared to an estimated 1,900 of 10,700 primary care appointments (17 percent) VHA's electronic scheduling system showed were scheduled greater than 30 days.
- Of 4,800 mental health care appointments, 780 (16 percent) had wait times greater than 30 days with an average wait time of 59 days for those 780 appointments. This compared to an estimated 260 of 4,800 mental health care appointments (5 percent) VHA's electronic scheduling system showed were scheduled greater than 30 days.
- Of 41,500 specialty care appointments, 16,300 (39 percent) had wait times greater than 30 days with an average wait time of 60 days for those 16,300 appointments.[3] This compared to an estimated 3,400 of 41,500 specialty care appointments (8 percent) VHA's electronic scheduling system showed were scheduled greater than 30 days.

We found that VISN 6 did not capture accurate wait time data primarily because medical facility staff did not consistently enter correct clinically indicated or supported preferred appointment dates when scheduling new patient appointments. Requiring schedulers to document those occasions where a veteran has a preferred appointment date is an internal control that mitigates the opportunities for schedulers to routinely and inappropriately designate all scheduled appointments as preferred appointment dates in order to show substantially reduced wait times. Of the estimated 20,600 appointments with wait times greater than 30 days, staff entered incorrect clinically indicated or unsupported preferred appointment dates for 15,300 appointments (74 percent) that made it appear as though the wait time was 30 days or less.

This occurred because VHA staff generally used unsupported preferred appointment dates to measure primary care appointment wait times. VHA Memorandum, *Inappropriate Scheduling Practices* (April 26, 2010) provided guidance that stated the "desired date" should be entered in the appointment comments to ensure that the appointment was appropriately scheduled. OIG considered preferred appointment dates unsupported when we did not identify corroborating evidence in the scheduling system or patient's health records, such as the scheduling system's comment field. Furthermore, VHA staff frequently used preferred appointment dates instead of using the referring provider's clinically indicated date to measure wait times for mental health care and specialty care consults. Because the medical facility did not consistently enter correct clinically indicated or supported preferred appointment dates when scheduling appointments, we estimated staff did not identify about 13,800 of these 15,300[4] appointments (90 percent) where veterans should have been added to the Veterans Choice List (VCL). This would have provided the veterans with the option of receiving care in the community through Choice.

[3] We included VHA's top 12 specialty care clinics in our audit (based on nationwide volume): Physical Therapy, Cardiology, Audiology, Dermatology, Podiatry, Optometry, Orthopedics, Gastroenterology, Physical Medicine and Rehabilitation Service, Urology, Ophthalmology, and General Surgery.

[4] Out of the 15,300 appointments, we identified a projected 1,500 new patient appointments in which the veteran was added to the VCL even though VA reported a wait time less than 30 days for the completed appointment. We found this occurred because of scheduling errors like inputting an incorrect preferred appointment date on the VCL and rescheduling a previous appointment that VHA originally reported as being greater than 30 days as less than 31 days for the rescheduled appointment.

Staff entered incorrect clinically indicated or unsupported preferred appointment dates because VISN 6 and medical facility management did not ensure staff from medical facilities consistently implemented VHA's scheduling requirements. VHA Directive 2010-027 states that VISN Directors, or designees, are responsible for the oversight of scheduling, consult management, and wait lists for eligible veterans. Furthermore, the directive states that VA facility directors, or designees, are responsible for implementing procedures related to providing timely access to health care at their facilities.

Since 2014, VHA has provided periodic guidance and training to clarify scheduling procedures. This included a memo issued by VHA to the VISNs on June 8, 2015, titled *CORRECTION: Clarification of Veterans Health Administration (VHA) Outpatient Scheduling Policy and Procedures and Interim Guidance*, as well as training information titled *Stepping Through the Scheduling Process* (July 2015) provided to VA medical facilities by VHA's Access and Clinic Administration Program Office. However, VHA did not publish its updated Outpatient Scheduling directive until July 2016 and its updated Consult directive until August 2016. Without accurate wait time data, VHA and VISN 6 leadership did not have the information needed to identify and resolve potential access to care issues or to justify the need for additional resources.

VISN 6 medical facilities did not consistently conduct scheduler audits, which have been required since January 2008. VHA Memorandum, *Monitoring Tool for Supervision of Schedulers* (January 11, 2008), formalized the process for VHA facilities to assure effective, ongoing oversight of Veterans Health Information Systems and Technology Architecture (VistA) menu options to schedule outpatient appointments. VHA Directive 2010-027 required facilities to conduct VISN-approved yearly scheduler audits of the timeliness and appropriateness of scheduling actions and the accuracy of desired dates.

In June 2014, VISN 6 provided guidance to the VISN 6 medical facilities' chiefs of Health Administration Services and associate directors regarding scheduler audits. This guidance included a Microsoft Excel spreadsheet template from VHA's 2008 memo to be used as a tool for auditing staff going forward. The spreadsheet audit template included questions for the supervisor to assess whether the desired date was accurate and if the appointment was appropriately scheduled. The VA medical facilities in VISN 6 conducted some scheduler audits during FY 2016. However, they did not cover all clinics and services. According to the 2008 VHA memo, all supervisors should sample 10 appointments for each person they directly supervise who use scheduling menu options, and all schedulers and all supervisors of schedulers should be reviewed yearly.

VISN 6 medical facilities provided evidence of some scheduler audits conducted during FY 2015, and four of the seven medical facilities provided partial results of FY 2016 scheduler audits.[5] The 2008 VHA memo also stated that the purpose of these audits was to create a clear oversight process that is tied to individual performance, document this oversight, identify and

[5] The medical facilities provided varying documentation regarding the scheduler audits they conducted. This documentation did not provide sufficient evidence for us to evaluate certain aspects of the scheduler audits at each facility, such as determining how many services or schedulers they audited, the number of audits conducted during FY 2016, the error rates identified in their scheduler audits, or if the audit results were discussed with the schedulers.

retrain schedulers when necessary, and create and maintain dialogue with schedulers about the importance of accuracy. However, based on the documentation in the scheduler audits, supervisors did not always discuss the results with the schedulers.

VISN 6 Wait Times for Health Care Through the Veterans Choice Program Was Not Consistently Timely

For veterans who were authorized Choice care, VISN 6 medical facility staff did not consistently ensure Health Net[6] provided the authorized health care within 30 days as required by the contract with VA. We reviewed a statistical sample of 389 Choice authorizations provided to Health Net by VISN 6 medical facility staff during the first quarter of FY 2016. Based on our sample results, we estimated that for the approximately 34,200 veterans who were authorized[7] Choice care in VISN 6, approximately 22,500 veterans received their authorized care through Choice. As discussed in Finding 2, many of the problems in obtaining timely access to care through Choice were caused by Health Net.

We estimated that overall, the approximately 22,500 veterans who received Choice care waited an average of 84 days to get their care through Health Net. We estimated it took medical facility staff an average of 42 days to provide the authorization to Health Net to begin the Choice process and 42 days for Health Net to provide the service. We identified delays related to authorizations for primary care, mental health care, and specialty care. VHA's Chief Business Officer addressed a potential cause for delay in creating appointments by executing a contract modification effective November 1, 2015. This change allowed Health Net to initiate phone contact with a veteran to arrange a Choice appointment rather than require the veteran to contact Health Net as was required prior to the change. Our analysis showed that, while still untimely, this change lowered the percentage of veterans who waited more than five days for Health Net to create an appointment from 86 percent to 69 percent.

VISN 6 medical facility staff did not ensure they had sufficient staffing resources to provide access to timely Choice care to all eligible veterans. Since VA implemented Choice in November 2014, VISN 6 non-VA care work requirements have increased by over 200 percent. In FY 2014, processing Non-VA Care Coordination (NVCC) authorizations was the NVCC staff's primary work requirement until Choice began later in the fiscal year. Choice expanded the work requirements of the NVCC staff to address veterans' care needs throughout the Choice process. In addition to the actions needed to process NVCC authorizations, they must also process VCL lists and Choice consults; create Health Net authorizations; and process Health Net returns, which require NVCC staff to resubmit the authorization or find care in the community through traditional NVCC processes. As of July 2016, we calculated that due to the significant increase in the NVCC work requirements and limited additions of NVCC staff for most of the seven medical facilities, each VISN 6 NVCC full-time equivalent would have to address over twice as many veterans' NVCC work requirements than in FY 2014.

[6] Health Net Federal Services, LLC (Health Net) is the contractor VISN 6 uses to coordinate veterans' Choice appointments.
[7] VHA Choice Program documentation provided to VA medical facility staff requires veterans to opt in to Choice prior to VA medical facility staff authorizing Choice.

NVCC staff at the seven VISN 6 medical facilities did not adequately monitor Health Net's information to ensure veterans received timely care and Health Net returned authorizations in compliance with the contract timeliness requirements. As a result, Choice did not reduce wait times to receive necessary medical care for many veterans in VISN 6 as intended. We estimated that about 18,500 of 22,500 veterans (82 percent) who received their health care through Choice did not receive the care within 30 days of the date VA identified the veteran's need for Choice care.[8]

VISN 6 Did Not Consistently Manage the Timeliness of Specialty Care Consults

VISN 6 medical facility staff did not always timely complete new patients' appointments for consults, and schedulers did not use the referring providers' clinically indicated date when scheduling appointments for consults of new patients. We reviewed a statistical sample of 210 open specialty care consults that exceeded 30 days as of March 23, 2016. For each consult, we measured the wait time from the referring provider's clinically indicated date to the date the appointment was completed or to the date of our review if the patient was still waiting for the appointment. In instances where the patient canceled or did not show for their appointment, we used the veteran's subsequent preferred appointment date if the scheduler documented that date in VHA's electronic scheduling system. If the scheduler did not document the veteran's preferred appointment date in VHA's electronic scheduling system, we started the wait time calculation based on the subsequent appointment create date.

Based on our sample review of open specialty care consults, we found that patients received the requested care for an estimated 9,000 of 22,000 consults (41 percent) at the time of our review in April and May 2016, and waited an average of 61 days for care. Patients had yet to receive care for an estimated 6,700 of 22,000 consults (over 30 percent), and those patients were waiting an average of 68 days at the time of our review in April and May 2016. We determined that an estimated 2,300 of 22,000 consults (over 10 percent) were designated as future care consults in which the requesting provider requested care for a date more than 90 days in the future. Staff discontinued or canceled, in some cases inappropriately, the remaining estimated 4,000 of 22,000 consults (over 18 percent) at the time of our review in April and May 2016.

These consult management issues occurred because specialty service staff did not always receive and review consults timely, and staff did not contact patients and schedule their appointments for consults timely. VISN and medical facility staff stated they monitored pending consults through various reports. However, we found that services did not always act upon the consults timely. Schedulers stated they believed the high volume of consults and the multiple other tasks schedulers have to complete contributed to the delays in scheduling the appointments. In addition, we found that clinicians receiving consults provided schedulers a clinically indicated date later than what was on the consults from the referring provider an estimated 15 percent of the time. VHA had not published its updated Consult directive until August 2016, and instead provided periodic guidance and training regarding consult management. Some facility directors (two), associate and assistant directors (two), and chiefs of staff (two) disagreed with VHA

[8] We calculated the overall Choice wait time from the date a VA provider created a consult or the veteran was placed on the VCL to the completed appointment.

guidance to use the referring provider's clinically indicated date. In addition, clinicians, administrative officers, and schedulers in specialty care services told us they did not have sufficient new patient appointment availability due to access challenges, such as not having enough providers or space. As a result, many patients who received consults to specialty care services experienced long wait times, which were not accurately reflected in VA's calculated wait times. Patients who waited greater than 30 days, but whose wait time was not accurately recorded as greater than 30 days, did not receive an opportunity to obtain Choice care.

We also reviewed a separate statistical sample of 210 specialty care consults requested during the first quarter of FY 2016 that staff discontinued or canceled. Based on that review, we found that staff inappropriately discontinued or canceled an estimated 4,600 of 17,900 consults (26 percent). Staff discontinued or canceled consults that needed prerequisite tests completed, consults for which insufficient information was submitted with the consult, following a single patient cancellation or no-show, or without making the required three documented attempts to contact the patient to schedule an appointment prior to closing the consult. Some staff disagreed with, or were unaware of, specific consult management procedures regarding discontinuing and canceling consults.

Clinicians and a chief of staff disagreed with VHA guidance that requires at least two patient cancellations or no-shows before discontinuing a consult. They believed they should make the clinical decision to discontinue a consult after a single no-show or patient cancellation. In addition, staff did not always make or document three attempts to contact the patient, and staff failed to appropriately document a valid reason why they closed a consult. Of the estimated 4,600 inappropriately discontinued or canceled consults, patients had not received the requested care for an estimated 3,100 consults, or experienced additional delays in requested care for an estimated 1,100 consults. For the remaining inappropriately closed consults, patients actually received the care, but the consult was incorrectly recorded as discontinued or canceled instead of appropriately recorded as completed.

System-Wide Access Audit

In May and June 2014, VA conducted a system-wide Access Audit to ensure a full understanding of VA's policy among scheduling staff, identify inappropriate scheduling practices, and review wait list management. The VA Access Audit flagged 112 facilities for further review because of concerns that indicated inappropriate scheduling practices or interviewed staff indicated they had received instruction to modify scheduling dates. The VA Access Audit flagged seven locations in VISN 6 for further review, including one VAMC (Richmond). A VA Access Audit and Wait Times Fact Sheet for VISN 6, dated June 9, 2014, stated that VA was already taking corrective action to address issues resulting from the audit. In February 2015, the Joint Commission conducted an unannounced review at the Richmond VAMC that also reported insufficient compliance regarding appointment timeliness.

Conclusion

VISN 6 did not consistently provide timely access to health care for new patients at its VA medical facilities and through Choice during the relevant time periods. It also did not have accurate wait time data. Our assessment of wait times for new patient appointments shows a

significant difference when compared to wait time data captured in VHA's electronic scheduling system. As a result, we concluded that VHA and VISN 6 leadership relied on wait time data that did not accurately represent how long veterans were waiting for care. VISN 6 also did not consistently manage the timeliness of specialty care consults. OIG has reported that access to health care has been a recurring issue in VHA for over a decade. This audit demonstrates that many of the same access to care conditions reported over the last decade continued to exist within VISN 6 medical facilities in 2016.

What We Recommended

In this report, we made 10 recommendations. We made four recommendations to the then-Under Secretary for Health regarding monitoring controls over scheduling requirements, wait time data, and Choice. The remaining six recommendations were to the VISN 6 Director to strengthen controls over access to health care and consult management within the VISN. This included ensuring staff used clinically indicated and preferred appointment dates consistently, medical facilities conduct required scheduler audits, staffing resources are adequate to ensure timely access to health care through Choice, and consults are managed effectively.

Management Comments

The then-Under Secretary for Health concurred with Recommendations 1, 4, 6, and 7, and concurred in principle with Recommendations 2, 3, 5, 8, 9, and 10. The then-Under Secretary for Health stated that VHA would implement Recommendations 1, 2, 3, 5, 8, 9, and 10 by July 2017. Furthermore, in his response in Appendix K, he stated that Recommendations 4, 6, and 7 had been completed.

The then-Under Secretary added that he appreciated OIG's efforts to describe veterans' overall experience with obtaining health care and acknowledged that OIG shares VHA's concern and commitment to ensure veterans have timely access to appropriate high quality health services. However, the then-Under Secretary responded that, because OIG uses a methodology to calculate wait times that is incongruent with VHA policy, he cannot concur with some of the conclusions in this report nor use them for management decisions. Specifically, the then-Under Secretary stated that when a scheduler enters the patient's preferred date in the electronic data field, the scheduler has appropriately documented the veteran's preferred appointment date, and that no other documentation is required to prove that the scheduler correctly entered the veteran's preferred date.

OIG Response

The then-Under Secretary's planned corrective actions to our recommendations are acceptable. We will monitor VHA's progress and follow up on the implementation of our recommendations until all proposed actions are completed. As of February 2017, VHA had not provided us with the evidence necessary to close Recommendations 4, 6, and 7. Once we receive such evidence, we will examine it carefully to determine whether VHA's actions are sufficient to close the recommendations.

We acknowledge VHA's concerns with our assessment of the data entered in the patient preferred date field of the scheduling system. However, we assessed the accuracy of the patient preferred dates entered in the electronic data field based on VHA guidance in place during the scope of our audit, which included VHA Memorandum, *Inappropriate Scheduling Practices* (April 26, 2010), that stated the desired date should be entered in the appointment comments. Under this standard, of the statistical sample of 618 new patient appointments in Finding 1, we found that staff entered preferred dates that resulted in inaccurate wait times for an estimated 74 percent of appointments.

In July 2016, after the scope of the data assessed for this audit, VHA updated its scheduling policy (VHA Directive 1230, July 15, 2016). VHA's new policy does not require additional documentation to support a veteran's preferred date. It does require schedulers to enter the clinically indicated date, when present, into the preferred date field when scheduling appointments. As we applied VHA's updated policy to our statistical sample of 618 new patient appointments in Finding 1 for comparative purposes, we still found that staff entered preferred dates resulting in inaccurate wait times for an estimated 59 percent of appointments. Thus even if we calculate wait times using VHA's updated policy, which was not in effect during the scope of our audit, there were still significant inaccuracies.

VA data reliability continues to be a high-risk area. In 2015, GAO concluded that VA health care is a high-risk area and added it to GAO's High Risk List (High Risk Series—An Update, February 2015). One of the reasons GAO placed VA health care as a high-risk area was because of inadequate oversight and accountability. In its report, GAO stated VA's oversight efforts are often impeded by its reliance on facilities' self-reported data, which lack independent validation and are often inaccurate or incomplete. In 2017, GAO recommended VA's immediate attention to improving oversight of access to timely medical appointments, including the development of wait-time measures that are more reliable and not prone to user error or manipulation (High Risk Series, February 2017). In addition, GAO's Standards for Internal Control in the Federal Government states that all transactions and other significant events need to be clearly documented. It also states that by implementing preventive controls, the organization can mitigate risks from occurring. This is consistent with the issues of this report, as well as other OIG, GAO, and VA reports, of inappropriate scheduling practices used by employees regarding veteran preferences for appointment dates.

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INTRODUCTION

Recurring Issues

Access to health care has been a recurring issue in the Veterans Health Administration (VHA). For more than a decade, the Office of Inspector General (OIG), U.S. Government Accountability Office (GAO), Department of Veterans Affairs (VA), and other organizations have issued numerous reports regarding issues with access to VA care, veteran wait times, scheduling practices, consult management, and, more recently, the Veterans Choice Program (Choice). Since the nationwide scandal on patient wait times in 2014, we have continued to identify problems with VHA managing access to health care.

Since August 2015, OIG has reported at six VA medical facilities—Colorado Springs, Houston, Oklahoma City, Phoenix, St. Louis, and Tampa—that VHA continues to experience significant issues with veteran wait times, scheduling practices, consult management, and Choice. Conducting an audit of an entire Veterans Integrated Service Network (VISN), as presented in this report, is important since the VISN is responsible for allocating appropriate resources to its many medical facilities. Information and data related to access to care needs to be current, accurate, and available to help VISN leadership address significant changes in health care service demands and gaps in service delivery.

Objective

While our previous reviews focused on an individual facility, we expanded our scope of this audit to assess the status of access within a VISN to provide VHA management further information to make the changes necessary to improve access to care. We selected VISN 6 for this audit to determine whether it provided new veteran patients timely access to health care within its medical facilities and through Choice, as well as determine whether VISN 6 appropriately managed consults. Specifically, we conducted this audit to answer the following three objectives.

1. Did VISN 6 record accurate wait time data for new patient appointments and provide veterans with timely access to health care within its VA medical facilities?
2. Did VISN 6 provide veterans with timely access to health care through the Veterans Choice Program?
3. Did VISN 6 appropriately manage consults?

This audit was not a clinical review of health care provided to veterans. Rather, the audit focused on measuring wait times for new patients and the accuracy of wait time data within the VISN 6 medical facilities and through Choice.

VISN 6

The VA Mid-Atlantic Health Care Network (VISN 6) comprises seven main VA medical facilities located in: Asheville, NC; Durham, NC; Fayetteville, NC; Hampton, VA; Richmond, VA; Salem, VA; and Salisbury, NC. VISN 6 also includes five health care centers and 30 Community Based Outpatient Clinics.

Scheduling Outpatient Appointments

The *VHA Outpatient Scheduling Processes and Procedures* (VHA Directive 2010-027, June 9, 2010) provided policy to VHA staff regarding the scheduling of outpatient clinic appointments and for ensuring the competency of staff directly or indirectly involved in any, or all, components of the scheduling process. This directive expired in June 2015, but VHA had not updated it with a new directive until July 2016. Because VHA had not rescinded or superseded the policy following its expiration in June 2015, and prior to July 2016, the directive was still in effect during our audit review period.

VHA Directive 2010-027 stated that VISN Directors, or designees, are responsible for the oversight of scheduling, consult management, and wait lists for eligible veterans. Furthermore, the directive states that VA facility directors, or designees, are responsible for implementing procedures related to providing timely access to health care at their facilities.

On June 8, 2015, VHA issued a memo, *CORRECTION: Clarification of Veterans Health Administration (VHA) Outpatient Scheduling Policy and Procedures and Interim Guidance* to the VISNs. This included Outpatient Scheduling Standard Operating Procedures (SOPs). The SOP stated that VHA measures patient wait times using the patient's preferred date or the clinically indicated date as the first reference point, and the pending or completed appointment date as the second reference point. Once entered, the clinically indicated or patient preferred date will not be changed unless the patient cancels and reschedules the appointment. VHA's Outpatient SOP also states that appointments must be made with input from the patient, and staff must make a minimum of three documented attempts (usually two phone calls and a letter) on separate days to contact the veteran to schedule the appointment.

In July 2015, VHA's Access and Clinic Administration Program Office provided training information to VA medical facilities—*Stepping Through the Scheduling Process*. The guidance states that the date entered into the earliest appropriate date field of the consult (soon to be renamed the clinically indicated date) is the date it would be clinically appropriate for the consult appointment to be scheduled. This date should never be based on clinic availability. It further states that schedulers should use the clinically indicated date entered into the consult by the sending provider as the clinically indicated date/preferred date (currently desired date) for scheduling. Another key point the training stated was that the clinically indicated date should not be changed by the receiving provider.

Scheduler Audits

VHA Memorandum, *Monitoring Tool for Supervision of Schedulers* (January 11, 2008), formalized the process for VHA facilities to assure effective, ongoing oversight of Veterans Health Information Systems and Technology Architecture (VistA) menu options to schedule outpatient appointments. VHA Directive 2010-027 required facilities to conduct VISN-approved yearly scheduler audits of the timeliness and appropriateness of scheduling actions and the accuracy of desired dates. Although this policy expired in June 2015, VHA had not rescinded or superseded the policy until July 2016, and the directive was still in effect during our audit review period.

Veterans Choice Program

The Veterans Access, Choice, and Accountability Act of 2014 (VACAA) was enacted on August 7, 2014 to improve veterans' access to VA medical services by appropriating about $10 billion for veterans to receive care from non-VA providers. On July 31, 2015, the VA Budget and Choice Improvement Act was enacted, which, among other things, expanded eligibility requirements and required VA to develop a plan to consolidate all non-VA provider programs under a single program called the Veterans Choice Program.

Veterans are eligible for Choice when a VA medical facility cannot directly provide the necessary care, a VA medical facility cannot provide the veteran with an appointment within 30 days of the clinically indicated or preferred appointment date, or a veteran resides more than 40 miles from the VA medical facility that is closest to the veteran's residence or the veteran faces an unusual or excessive burden traveling to the closest VA medical facility. VHA established a hierarchy of care that VA medical facilities are required to follow when providing care in the community. This hierarchy makes Choice the primary provider of care in the community. Choice documentation provided to VA medical facility staff requires veterans to opt in to Choice prior to VA medical facility staff authorizing its use.

Consult Management

A clinical consultation is provided by a physician or other health care provider in response to a request seeking opinion, advice, or expertise regarding evaluation or management of a specific patient problem. Furthermore, a clinical consultation request is initiated by a physician or appropriate source with the clear expectation that a reply will be provided in a timely fashion.

The *VHA Consult Policy* (VHA Directive 2008-056, September 16, 2008) provided criteria to VHA staff on appropriate consult management. This directive expired in September 2013, but VHA had not replaced it with an updated policy until August 2016. VHA's Consult Management Business Rules (May 2014) provided guidance on when staff can discontinue or cancel a consult. VHA created National Guidance for Discontinuing or Cancelling Consults (June 2015) which stated that clinicians and non-clinicians can discontinue consults under certain circumstances, and that facilities are

required to document the reason for discontinuing a consult. Detailed information about VHA's consult policies can be found at Appendix H.

Other Information

- Appendices A through G provide results of our audit for each VA medical facility within VISN 6.[9]
- Appendix H provides additional background information.
- Appendix I provides details of our scope and methodology.
- Appendix J provides details on our statistical sampling methodology.
- Appendix K provides management comments.

[9] Estimates throughout this report are VISN-wide weighted averages based on our sample results from all VISN medical facilities. The specific site results in Appendices A through G were the raw sample results used for the VISN estimates.

RESULTS AND RECOMMENDATIONS

Finding 1 VISN 6 Medical Facilities Did Not Consistently Provide Timely Access to Health Care Needs for New Patient Appointments and Did Not Have Accurate Wait Time Data

VISN 6 medical facilities did not consistently provide timely access to health care for new patient appointments. We reviewed a statistical sample of 618 new patient appointments completed at VISN 6 medical facilities in FY 2016.[10] We reviewed these appointments to determine whether medical facilities provided timely access to new patient appointments, as well as to assess the accuracy of VISN 6 wait time data. Based on this review, we estimated that about 20,600 of 57,000 appointments (36 percent) had wait times greater than 30 days. For those 20,600 appointments, we estimated that veterans waited an average of 59 days. This was notably higher than the estimated 5,500 appointments (10 percent) that VHA's electronic scheduling system showed were scheduled greater than 30 days.

We identified delays related to new patient appointments for primary care, mental health care, and specialty care. Specifically, based on our statistical sample review, we broke down the 57,000 appointments by type and estimated that:

- Of 10,700 primary care appointments, 3,500 (33 percent) had wait times greater than 30 days with an average wait time of 51 days for those 3,500 appointments. This compared to an estimated 1,900 of 10,700 primary care appointments (17 percent) VHA's electronic scheduling system showed were scheduled greater than 30 days.
- Of 4,800 mental health care appointments, 780 (16 percent) had wait times greater than 30 days with an average wait time of 59 days for those 780 appointments. This compared to an estimated 260 of 4,800 mental health care appointments (5 percent) VHA's electronic scheduling system showed were scheduled greater than 30 days.
- Of 41,500 specialty care appointments, 16,300 (39 percent) had wait times greater than 30 days with an average wait time of 60 days for those 16,300 appointments. This compared to an estimated 3,400 of 41,500 specialty care appointments (8 percent) VHA's electronic scheduling system showed were scheduled greater than 30 days.

[10] We used stratified random sampling for all the samples selected. All records had a known chance of selection. This allowed us to make estimates over the entire population. For additional information on the statistical sampling methodology, see Appendix J.

To evaluate VISN 6, we compared VISN 6 practices and procedures to VHA's outpatient scheduling and consult policy and guidance. We found that VISN 6 did not capture accurate wait time data primarily because VA medical facility staff did not consistently enter correct clinically indicated or supported preferred appointment dates when scheduling new patient appointments. Requiring schedulers to document those occasions where a veteran has a preferred appointment date is an internal control that mitigates the opportunities for schedulers to routinely and inappropriately designate all appointments as preferred appointment dates in order to show substantially reduced wait times.

Of the estimated 20,600 appointments with wait times greater than 30 days, staff entered incorrect clinically indicated or patient preferred appointment dates that were not supported by comments in the electronic scheduling system for an estimated 15,300 appointments (74 percent), which made it appear as though the wait time was 30 days or less. This occurred because VHA staff generally used unsupported preferred appointment dates to measure primary care appointment wait times. VHA Memorandum, *Inappropriate Scheduling Practices* (April 26, 2010), provided guidance that stated the desired date should be entered in the appointment comments to ensure that the appointment was appropriately scheduled.

OIG considered preferred appointment dates unsupported when we did not identify corroborating evidence in the scheduling system or patient's health records, such as the scheduling system's comment field. Furthermore, VHA staff frequently used preferred appointment dates instead of using the referring provider's clinically indicated date to measure wait times for mental health care and specialty care consults. In addition, for these 15,300 appointments, we estimated that staff did not identify about 13,800 appointments (90 percent) where veterans should have been added to the Veterans Choice List (VCL). This is vital because adding veterans to the VCL provides them the option of receiving care in the community through Choice.

Staff entered incorrect clinically indicated or unsupported preferred appointment dates primarily because VISN 6 and medical facility management did not ensure staff consistently implemented VHA's scheduling requirements. Since 2014, VHA has provided periodic guidance and training to clarify scheduling procedures. However, VHA did not publish its updated Outpatient Scheduling directive until July 2016 and its updated Consult directive until August 2016. Furthermore, VISN 6 medical facilities did not consistently conduct scheduler audits, which have been required since January 2008.

As a result of the above issues, VHA and VISN 6 leadership relied on wait time data that did not accurately represent how long veterans were waiting for care. Without accurate wait time data, VHA and VISN 6 leadership did

not have reliable information to identify and resolve potential access to care issues within their facilities or justify the need for additional resources.

While this audit was not a clinical review, we consulted with OIG's Office of Healthcare Inspection (OHI) to review 33 sample patients who received primary care, mental health care, or specialty care during FY 2016. OHI found no evidence of harm associated with delays in the sampled care for these 33 patients.

New Patient Appointments Were Not Consistently Timely

VISN 6 medical facility appointments for new patients were not consistently timely. VHA defines a new patient[11] as a patient who has not completed an appointment within a specific clinic type within the past 24 months, which also includes newly enrolled veterans who have never had a VA appointment at the medical facility. For the purposes of this audit, we used 30 days from a veteran's supported preferred appointment date, a referring provider's clinically indicated date, or the appointment create date to determine whether an appointment was timely. This is consistent with VHA's outpatient scheduling and consult policies and guidance.

We reviewed a statistical sample of 618 new patient appointments completed at VISN 6 medical facilities in FY 2016. Based on this review, we estimated that about 20,600 of 57,000 new patient appointments (36 percent) within primary care, mental health care, and specialty care had wait times greater than 30 days. This is significant because when a veteran is scheduled for an appointment more than 30 days from the clinically indicated or preferred appointment date, medical facility staff must add the veteran's name to the VCL to indicate that the veteran is eligible for care in the community and initiate the Choice process.

Primary Care

We reviewed a random statistical sample of 210 new primary care appointments completed at VISN 6 medical facilities during the first quarter of FY 2016. We reviewed these appointments to determine whether medical facilities provided timely access to new patient appointments, as well as to assess the accuracy of VISN 6 wait time data. We measured wait time for primary care appointments in accordance with VHA policy and guidance. In accordance with VHA Directive 2010-027, we measured the wait time from the veteran's preferred appointment date—if the scheduler documented that date in VHA's electronic scheduling system—to the date the appointment was completed. If the scheduler did not document comments of the veteran's preferred appointment date in VHA's electronic scheduling system, we started the wait time calculation on the date VHA initially scheduled the appointment (appointment create date).

[11] According to VHA Support Service Center Completed Appointments Cube Data Definitions (Last updated 12/17/2015)

We determined veterans waited longer for new primary care appointments as compared to what VISN 6 captured for its wait time data. Specifically, we estimated that 3,500 of 10,700 primary care appointments (33 percent) had wait times greater than 30 days compared with the estimated 1,900 of 10,700 appointments (17 percent) that VHA's electronic scheduling system showed were scheduled greater than 30 days. For these 3,500 appointments, we estimated that veterans waited an average of 51 days for care with a range of 31 to 145 days based on our statistical sample results.

Example 1 highlights an enrolled veteran who had been seen previously, but not within the last 24 months at the time of the appointment.

Example 1

A primary care appointment for a veteran was scheduled on August 17, 2015 for an October 1, 2015 appointment. We determined that the scheduler used the appointment date of October 1, 2015 as the veteran's preferred appointment date. We did not identify any documentation or justification supporting the selected preferred appointment date of October 1, 2015. VHA Memorandum, *Inappropriate Scheduling Practices* (April 26, 2010), provided guidance that stated the desired date should be entered in the appointment comments to ensure that the appointment was appropriately scheduled. Due to the lack of documentation, we concluded that the veteran had been waiting for care since the appointment was created. While VHA data showed the veteran waited zero days, we determined the veteran waited a total of 45 days.

Mental Health Care

We reviewed a random statistical sample of 210 new mental health care appointments completed at VISN 6 medical facilities during the first quarter of FY 2016. We reviewed these appointments to determine whether medical facilities provided timely access to new patient appointments, as well as to assess the accuracy of VISN 6 wait time data. We measured wait time for mental health care appointments in accordance with VHA policy and guidance. As prescribed by VHA training material, *Stepping Through the Scheduling Process* CLARIFICATION OF VHA OUTPATIENT SCHEDULING POLICY AND PROCEDURES (July 7, 2015), if the mental health care appointment was the result of a consult, we measured the wait time from the referring provider's clinically indicated date to the date the appointment was completed. If the appointment was the result of a walk-in, we used that date to measure the wait time. If the previous appointment was canceled by the patient or the patient did not show up for an appointment, we used the veteran's preferred appointment date—if the scheduler documented that date in VHA's electronic scheduling system—to the date the appointment was completed. If the scheduler did not document the veteran's preferred appointment date in VHA's electronic scheduling system, we started the wait time calculation on the date VHA initially scheduled the appointment (appointment create date).

Based on this review, we found that a higher percentage of veterans received timely mental health care than veterans requesting primary care and specialty care appointments. However, we also determined veterans waited longer for new mental health care appointments as compared to what VISN 6 captured for its wait time data. Specifically, we estimated that 780 of 4,800 appointments (16 percent) had wait times greater than 30 days compared with the estimated 260 of 4,800 appointments (5 percent) that VHA's electronic scheduling system showed were scheduled greater than 30 days. For those 780 appointments, veterans waited an average of 59 days for care with a range of 17 to 126 days based on our statistical sample results.

Example 2 details a new mental health care appointment that we determined had a total wait time of 120 days, but staff recorded it in VHA's electronic scheduling system as a zero-day wait.

Example 2

On July 21, 2015, a provider requested a mental health consult for a veteran with a clinically indicated date of the same day. On the following day, an appointment was scheduled for September 25, 2015 with consult comments stating the patient's preferred appointment date was July 23, 2015. Since staff scheduled the appointment beyond 30 days, they appropriately placed the veteran on the VCL. On September 21, 2015, another scheduler canceled the appointment because all the appointments for September 25 were canceled in this clinic, and this scheduler rescheduled the veteran for a November 20, 2015 appointment. However, this scheduler recorded the veteran's preferred appointment date as November 20, 2015, and therefore VA's electronic scheduling system showed a zero-day wait for this appointment, but the veteran actually waited 120 days for the November 20, 2015 appointment.

Specialty Care

We reviewed a random statistical sample of 210 specialty care consults created during the first quarter of FY 2016 that were completed as of March 23, 2016. From these 210 specialty care consults, 198 were associated with new specialty care appointments in VHA's electronic scheduling system at VISN 6 medical facilities.[12] We reviewed these appointments to determine whether medical facilities provided timely access to new patient appointments, as well as to assess the accuracy of VISN 6 wait time data. We measured wait time for specialty care appointments in accordance with VHA policy and guidance. In accordance with VHA Directive 2010-027 and as prescribed by VHA training material, for each consult we measured the wait time from the referring provider's clinically indicated date to the date the appointment was completed. Absent

[12] Out of the 210 completed specialty care consults, patients of 12 consults had care provided but did not have an appointment in VHA's electronic scheduling system.

a clinically indicated date, or if a patient canceled the previous appointment, we used the veteran's preferred appointment date, if the scheduler documented that date in VHA's electronic scheduling system. If the scheduler did not document the veteran's preferred appointment date in VHA's electronic scheduling system, we started the wait time calculation based on the appointment create date.

We determined veterans waited longer for new specialty care appointments as compared to what VISN 6 recorded for calculating its wait time data. Specifically, we estimated that 16,300 of 41,500 appointments (39 percent) had wait times greater than 30 days compared with the 3,400 of 41,500 appointments (8 percent) that VHA's electronic scheduling system showed were scheduled greater than 30 days. For those 16,300 appointments, veterans waited an average of 60 days for care with a range of 31 to 150 days based on our statistical sample results.

Staff did not always timely act upon consult requests. VHA Directive 2008-056 (September 16, 2008), as well as VHA's Consult Management Business Rules (May 2014) required staff to act upon clinic consult requests within 7 days. To act upon a consult means to review the consult and/or schedule the veteran for an appointment. We estimated that staff did not timely act upon 3,100 of 43,600 clinic consult requests (7 percent) within the required seven days, taking an average of 15 days to initiate any action.

In addition, staff did not always timely schedule appointments for specialty care consults. On average, specialty care services scheduled (created) the patients' appointments 10 days after the referring provider requested the consult. As of July 2016, VHA did not have a timeliness standard to schedule the veteran's appointment once the referring provider requested a consult. These delays had a negative effect on providing veterans timely access to new specialty care appointments.

Example 3 details a specialty care appointment where a veteran experienced significant delays in receiving care.

Example 3

On November 18, 2015, a provider requested a consult for ophthalmology with a clinically indicated date for November 19, 2015. On November 19, 2015, a clinician reviewed and instructed scheduling staff to set up an appointment. On November 20, 2015, a scheduler made the appointment for January 14, 2016. Per guidance, the scheduler should have entered the clinically indicated date of November 19, 2015 into VA's scheduling system, but instead the scheduler entered the appointment date of January 14, 2016. The veteran waited 56 days to receive care, but VA reported a zero-day wait time for this veteran.

Inaccurate Wait Time Data

VISN 6 did not capture accurate wait time data primarily because medical facility staff did not consistently follow VHA's scheduling guidance for entering the referring provider's clinically indicated date or a documented veteran's preferred appointment date when scheduling new appointments. We estimated that staff incorrectly recorded clinically indicated or unsupported preferred appointment dates for about 41,900 of 57,000 new patient appointments (74 percent) that understated veterans' average wait times for their VA appointments by about 25 days. This occurred because VHA staff generally used unsupported preferred appointment dates to measure appointment wait times. This included an estimated 32,100 instances when schedulers did not enter comments into VHA's scheduling system to document the veteran's preferred appointment date. Furthermore, VHA staff frequently did not use the referring provider's clinically indicated date to measure wait times for mental health care and specialty care consults.

VHA Directive 2010-027 stated that when scheduling patients in response to consults, the provider-specified time frame for appointments needs to be the date of the provider request, unless otherwise specified by the provider. In addition, according to an October 21, 2015 VHA Memorandum, *VHA Consult Initiatives*, referring providers must enter the clinically indicated date solely based on what is best to meet the patient's needs, and receiving providers must not alter the clinically indicated date. In instances where the referring provider does not specify a clinically indicated date, schedulers should use the veteran's preferred appointment date to measure the wait time.

Table 1 estimates the number of appointments when staff entered clinically indicated or preferred appointments dates that resulted in inaccurate wait times, as well as the average number of days to complete the appointments.

Table 1. Average Time To Complete New Patient Appointments

Appointment Type	Appointments With Inaccurate Wait Time Data	VA-Calculated Wait Time	OIG-Determined Wait Time	Difference
Primary Care	5,200	8 Days	27 Days	19 Days
Mental Health	2,700	6 Days	26 Days	20 Days
Specialty Care	34,000	10 Days	36 Days	27 Days
Totals*	**41,900**	**9 Days**	**34 Days**	**25 Days**

Source: VA OIG analysis of statistically sampled new patient appointments

**Note: Totals were rounded based on the overall weighted average results of the statistical analysis so the columns do not sum exactly to the total.*

Eligible Veterans Not Added to VCL

Inaccurate wait time data affected veterans' access to care in the community through Choice. Of the estimated 20,600 appointments with wait times greater than 30 days, staff entered clinically indicated or unsupported preferred appointment dates for 15,300 appointments (74 percent) that made it incorrectly appear as though the wait time was 30 days or less. Because medical facility staff did not consistently enter correct clinically indicated or supported preferred appointment dates when scheduling appointments, we estimated that staff did not identify about 13,800 of these 15,300 veterans (90 percent) who should have been added to the VCL. As a result, these 13,800 veterans were not provided the option to receive care in the community through Choice. Even though staff did not enter correct clinically indicated or supported preferred appointment dates, they added the remaining 1,500 veterans to the VCL.

Example 4 shows an appointment where VHA inaccurately captured the veteran's wait time.

Example 4

> On October 9, 2015, a consult request was placed for audiology with a clinically indicated date on that same date. Although a clinician reviewed the consult within six days, it took a total of 34 days for a scheduler to schedule an appointment for February 2, 2016. Although the veteran's actual wait time was 116 days for this appointment, the veteran was not added to the VCL and was not provided the option to receive Choice care.

Why This Occurred

These wait time issues occurred primarily because VISN 6 and medical facility management did not ensure staff from medical facilities consistently implemented VHA's scheduling requirements. VHA Directive 2010-027 stated that VISN Directors, or designees, are responsible for the oversight of scheduling, consult management, and wait lists for eligible veterans. Furthermore, the directive states that VA facility directors, or designees, are responsible for implementing procedures related to providing timely access to health care at their facilities. We determined there was an inconsistent understanding among staff for entering the referring provider's clinically indicated date or documented veteran's preferred appointment date when scheduling new appointments. VA medical facility management—such as the chiefs of Health Administration Services and scheduling supervisors—did not ensure scheduling staff understood these requirements.

Lack of Formal Policy

Since 2014, VHA's Office of the Deputy Under Secretary for Health for Clinical Operations and VHA's Access and Clinic Administration Program Office has provided periodic scheduling guidance through memos and training materials. Outpatient scheduling and consult guidance clarifying scheduling procedures was provided to VISN Directors in May, June, and October 2015, and February 2016. Furthermore, in July 2015, VHA's Access and Clinic Administration Program Office provided training information—*Stepping Through the Scheduling Process*—to VA medical

facilities, which stated that staff should use the referring provider's clinically indicated date when scheduling new patient appointments from consults. However, VHA did not publish its updated Outpatient Scheduling directive until July 2016 and its updated Consult directive until August 2016.

Disagreement With VHA Guidance

Some VISN 6 medical facility management—such as facility directors (two), associate and assistant directors (two), and chiefs of staff (two)—disagreed with VHA's guidance related to using the referring provider's clinically indicated date. In these instances, management disagreed because it felt that receiving providers should determine the clinically indicated date; however, this conflicts with VHA's current scheduling guidance. By publishing the updated Consult directive, VHA will have formal, comprehensive, and current criteria to hold managers and staff accountable to comply with scheduling requirements.

Our Recommendation 1 addresses the need to hold VISN 6 and its medical facility directors accountable for complying with scheduling requirements.

Our Recommendation 2 addresses the need to ensure VISN 6's medical facility staff understands and follows VHA's scheduling requirements for using the referring provider's clinically indicated date or veteran's preferred appointment date.

Scheduler Audits Not Completed

VISN 6 medical facilities did not consistently conduct scheduler audits, which have been required since January 2008. VHA Memorandum, *Monitoring Tool for Supervision of Schedulers* (January 11, 2008), formalized the process for VHA facilities to assure effective, ongoing oversight of VistA menu options to schedule outpatient appointments, and required a scheduler audit plan and tools to be in use at all facilities by February 18, 2008. VHA Memorandum, *Inappropriate Scheduling Practices* (April 26, 2010), provided guidance that required the desired date be entered in the appointment comments to ensure that the appointment was appropriately scheduled. Scheduler audits from VISN 6 also evaluated whether schedulers appropriately documented the desired date in the appointment comments. VHA Directive 2010-027 required facilities to conduct VISN-approved yearly scheduler audits of the timeliness and appropriateness of scheduling actions and the accuracy of desired dates.

In June 2014, VISN 6 provided guidance to the VISN 6 medical facilities' chiefs of Health Administration Services and associate directors regarding scheduler audits. This guidance included a Microsoft Excel spreadsheet template from VHA's 2008 memo to be used as a tool for auditing staff going forward. This template included questions for the supervisor to assess whether the desired date was accurate and if the appointment was appropriately scheduled.

The VA medical facilities in VISN 6 conducted some scheduler audits during FY 2016. However, they did not cover all clinics and services. According to the 2008 VHA memo, all supervisors should sample 10 appointments for each person they directly supervise who use scheduling menu options, and all schedulers and all supervisors of schedulers should be reviewed yearly. VISN 6 medical facilities provided evidence of some scheduler audits conducted during FY 2015, and four of the medical facilities provided partial results of FY 2016 scheduler audits.

The 2008 VHA memo also stated that the purpose of these audits was to create a clear oversight process that is tied to individual performance, document this oversight, identify and retrain schedulers when necessary, and create and maintain dialogue with schedulers about the importance of accuracy. However, based on the documentation provided, the audit methods used by the VISN were not consistent for all facilities and supervisors did not discuss the results with the schedulers.[13] The following are examples of issues we identified:

- The VA medical facility in Salem, VA, did not audit all schedulers or all services, but conducted scheduler audits for some clinics and schedulers during FY 2016. VISN 6 provided documentation that showed a limited number of scheduler audits were conducted in FY 2016 and supervisors identified errors; however, the results were not discussed with the schedulers. Staff at Salem, including the administrative officer for Primary Care, confirmed that scheduler audits were not conducted in all clinics or for all staff with scheduling access.
- The VA medical facility in Fayetteville, NC, did not audit all schedulers or all services. The assistant chief of Health Administration Services told us they had no formal process for conducting the audits. VISN 6 provided documentation that showed Fayetteville conducted a limited number of scheduler audits during July 2015. We did not identify evidence that indicated Fayetteville conducted scheduler audits during FY 2016.
- The VA medical facility in Asheville, NC, did not audit all schedulers or all services, and did not discuss scheduling discrepancies noted during scheduler audits with scheduling staff. VISN 6 provided documentation that showed Asheville conducted a limited number of scheduler audits during FY 2015. However, it did not indicate supervisors discussed the

[13] The medical facilities provided varying documentation regarding the scheduler audits they conducted. This documentation did not provide sufficient evidence for us to evaluate certain aspects of the scheduler audits at each facility, such as to determine: how many services or schedulers they audited, number of audits conducted during FY 2016, error rates identified in their scheduler audits, or if the audit results were discussed with the schedulers.

results of the audits with schedulers, or that audits were conducted during FY 2016.

- The VA medical facility in Hampton, VA, did not perform scheduler audits because supervisors told us they did not understand the requirement. VISN 6 provided documentation that showed Hampton monitored appointments via emails to determine if they should be added to the VCL and electronic wait list during FY 2015. We did not identify evidence that indicated Hampton conducted scheduler audits during FY 2016.
- The VA medical facility in Richmond, VA, did not audit all schedulers or all services, but conducted scheduler audits for some clinics and schedulers during FY 2016. We identified data that showed Richmond completed a limited number of audits for FY 2016 through July 2016. VISN 6 also provided evidence of a limited number of scheduler audits completed during FY 2015.
- The VA medical facility in Salisbury, NC, did not audit all schedulers or all services, but conducted scheduler audits for some clinics and schedulers during FY 2016. We identified data that showed Salisbury completed a limited number of audits for FY 2016 through July 2016. VISN 6 also provided evidence of a limited number of scheduler audits completed during FY 2015.
- The VA medical facility in Durham, NC, did not audit all schedulers or all services, but completed a limited number of scheduler audits for some clinics and schedulers during FY 2015 and FY 2016 through July 2016. We identified data that showed Durham completed 21 scheduler audits during FY 2016 and about 200 scheduler audits were conducted in FY 2015.

Our Recommendation 3 addresses the need to ensure VISN 6 medical facility directors conduct required scheduler audits and take corrective actions as needed based on audit results.

What Resulted

These issues resulted in veterans experiencing unnecessary delays in receiving new primary care, mental health care, and specialty care appointments. In addition, wait time data for new patient appointments at VISN 6 medical facilities were not always accurate, and in some cases did not reflect actual wait times experienced by veterans obtaining health care in VISN 6. Without accurate wait time data, VHA and VISN 6 leadership did not have reliable information to identify and resolve potential access to care issues within their facilities or justify the need for additional resources.

We consulted with OIG's Office of Healthcare Inspection (OHI) to review 33 patients who received primary care, mental health care, or specialty care during FY 2016, to make a determination as to whether the patients received the requested services, and if not, the extent to which patients were

potentially harmed by not receiving the requested services. We referred these sample patients to OHI because we determined they either died during FY 2016, experienced significant delays in care, or experienced delays in receiving urgent consults. Of these 33 patients OHI reviewed, they found no evidence of harm associated with the delays. In addition, OHI identified consults in which the indicated "Stat" urgency level was not clinically appropriate based on the indication for the requested service.

Conclusion

VISN 6 and medical facility leadership did not ensure veterans were provided timely access to health care. VHA Directive 2010-027 stated that VISN Directors, or designees, are responsible for the oversight of scheduling, consult management, and wait lists for eligible veterans. Furthermore, the directive states that VA facility directors, or designees, are responsible for implementing procedures related to providing timely access to health care at their facilities. VISN 6 medical facilities did not consistently provide timely access to health care for new patient appointments during the relevant time periods.

We identified more delays for new patient appointments for primary care, mental health care, and specialty care higher than what VHA reported. In addition, VISN 6 VA medical facility directors did not ensure they followed VHA's procedures for scheduling appointments. We found that VA medical facility staff did not consistently enter correct clinically indicated or preferred appointment dates when scheduling appointments. As a result, recording these dates incorrectly understated VISN 6 wait time data, and then VHA and VISN 6 leadership relied on wait time data that did not accurately represent how long veterans waited for care, which affects their ability to influence necessary changes.

Recommendations

1. We recommended the Under Secretary for Health establish a method to monitor and ensure Veterans Integrated Service Network compliance with scheduling requirements.

2. We recommended the director of Veterans Integrated Service Network 6 ensure that staff at all VA medical facilities use the referring provider's clinically indicated date, when available, or documented veteran's preferred appointment date, when scheduling new patient appointments.

3. We recommended the director of Veterans Integrated Service Network 6 ensure VA medical facilities conduct required scheduler audits and take corrective actions as needed based on audit results.

Management Comments

The then-Under Secretary for Health concurred with Recommendation 1, concurred in principle with Recommendations 2 and 3, and stated that VHA would implement the recommendations by July 2017.

The then-Under Secretary responded that, because OIG used a methodology to calculate wait times that was incongruent with VHA policy, he could not concur with some of the conclusions in this report nor use them for management decisions. Specifically, the then-Under Secretary stated that when a scheduler enters the patient's preferred date in the electronic data field, the scheduler has appropriately documented the veteran's preferred appointment date, and that no other documentation is required to prove that the scheduler correctly entered the veteran's preferred date. The then-Under Secretary for Health's entire verbatim response is located in Appendix K.

OIG Response

VHA's planned corrective actions to our recommendations are acceptable. We will monitor VHA's progress and follow up on the implementation of our recommendations until all proposed actions are completed.

We acknowledge VHA's concerns with our assessment of the data entered in the patient preferred date field of the scheduling system. However, we assessed the accuracy of the patient preferred dates entered in the electronic data field based on VHA guidance in place during the scope of our audit, which included VHA Memorandum, *Inappropriate Scheduling Practices* (April 26, 2010), that stated the desired date should be entered in the appointment comments. Under this standard, of the statistical sample of 618 new patient appointments, we found that staff entered preferred dates that resulted in inaccurate wait times for an estimated 74 percent of appointments. In July 2016, after the scope of this audit, VHA updated its scheduling policy (VHA Directive 1230, July 15, 2016).

VHA's new policy does not require additional documentation to support a veteran's preferred date. It does require schedulers to enter the clinically indicated date, when present, into the preferred date field when scheduling appointments. Applying VHA's updated policy to our statistical sample of 618 new patient appointments for comparative purposes, we still found that staff entered preferred dates that resulted in inaccurate wait times for an estimated 59 percent of appointments. Thus, even if we calculate wait times using VHA's updated policy, which was not in effect during the scope of our audit, there were still significant inaccuracies.

VA data reliability continues to be a high-risk area. In 2015, GAO concluded that VA health care is a high-risk area and added it to GAO's High Risk List (*High Risk Series—An Update*, February 2015). One of the reasons GAO placed VA health care as a high-risk area was inadequate oversight and accountability. In its report, GAO stated VA's oversight efforts are often impeded by its reliance on facilities' self-reported data, which lack independent validation and are often inaccurate or incomplete. In

2017, GAO recommended VA's immediate attention to improving oversight of access to timely medical appointments, including the development of wait-time measures that are more reliable and not prone to user error or manipulation (*High Risk Series,* February 2017). In addition, GAO's *Standards for Internal Control in the Federal Government* states that all transactions and other significant events need to be clearly documented. It also states that by implementing preventive controls the organization can mitigate risks from occurring. This is consistent with the issues of this report, as well as other OIG, GAO, and VA reports, of inappropriate scheduling practices used by employees regarding veteran preferences for appointment dates.

Finding 2 VISN 6 Wait Times for Health Care Through the Veterans Choice Program Was Not Consistently Timely

Although many of the problems obtaining timely access to care through Choice were due to VISN 6's Choice Program third party administrator, Health Net,[14] VISN 6 medical facility staff added to access delays by not consistently processing and monitoring Choice authorizations timely. We identified delays related to authorizations for primary care, mental health care, and specialty care. We reviewed a statistical sample[15] of 389 Choice authorizations provided to Health Net by VISN 6 medical facility staff during the first quarter of FY 2016. We estimated that about 11,800 veterans, who were authorized for Choice care, did not receive the authorized care through Choice, and the approximately 22,500 veterans who received Choice care experienced an average wait of about 84 days.

This occurred primarily because VISN 6 had not provided sufficient Non-VA Care Coordination (NVCC) staff to its seven medical facilities to meet the growing work requirements of NVCC, to include Choice. Since VA implemented Choice in November 2014, VISN 6 NVCC work requirements increased about 200 percent. Although the seven VISN 6 medical facilities we reviewed used different procedures to manage their increased workload, the facilities had not adequately staffed their NVCC program. Without sufficient staffing, NVCC staff could not adequately monitor Health Net's portal to ensure veterans received timely care and ensure Health Net timely returned authorizations in compliance with contract requirements. As a result, Choice did not reduce wait times for a significant number of veterans in VISN 6 as intended. We estimated that, overall, about 18,500 of 22,500 veterans (82 percent) who received their health care through Choice, did not receive the care within 30 days of the date VA identified the veteran's need for Choice care.[16]

We consulted with OHI to review the electronic health records of eight patients who received authorizations for Choice care during FY 2016 to determine whether the patients received the requested services, and if not, the extent to which patients were potentially harmed by not receiving the requested services. We referred these patients from our sample to OHI because we determined that they died during FY 2016. Of these eight patients OHI reviewed, OHI found no evidence their deaths were associated with delays in care.

[14] VA's current third party administrator for the Choice Program contract in VISN 6 is Health Net.
[15] See Appendix J for a detailed description of our sampling methodology.
[16] We calculated the overall Choice wait time from the date a VA provider created a consult or the veteran was placed on the VCL to the completed appointment.

Choice Care Not Provided

We estimated that overall, Health Net did not provide the authorized care for about 11,800 of 34,200 veterans (34 percent) authorized[17] for Choice care in VISN 6 during the first quarter of FY 2016.

Table 2 shows the estimated number of Choice care authorizations for primary care, mental health care, and specialty care, the number of completed authorizations, and the number and percentage of authorizations not completed.

Table 2. Number and Percent of Completed Choice Care Authorizations

Type of Care	Total Choice Authorizations	Number of Authorizations Completed Through Choice	Number of Authorizations Not Completed Through Choice	Percent of Authorizations Not Completed Through Choice
Primary Care	850	380	470	55%
Mental Health	200	99	100	51%
Specialty Care	33,200	22,000	11,200	34%
Total*	**34,200**	**22,500**	**11,800**	**34%**

Source: VA OIG analysis of VHA and Health Net data.

**Note: Totals were rounded based on the overall weighted average results of the statistical analysis so the columns do not sum exactly to the total.*

NVCC staff stated that Health Net returned authorizations in large numbers and returned some authorizations without adequate justification. For example, during the first quarter of FY 2016, the Fayetteville VA medical facility had more than 1,900 authorizations returned by Health Net. Many of these were months after the medical facility submitted the authorizations to Health Net. After receiving these returned authorizations, VA medical staff had to continue to find VA or NVCC providers that could provide care for these veterans, which further delayed the veterans' care.

Based on information provided by Health Net staff, they returned unfulfilled authorizations to VISN 6 facilities primarily because they could not contact the veteran or schedule care agreeable to the veteran within 30 days. NVCC staff at multiple locations stated even though Health Net records indicated they had placed the calls to the veterans, the veterans indicated to VA staff that they had not received any calls from Health Net. These staff also noted instances where Health Net used the contact number on record rather than an updated contact number the NVCC staff had provided to Health Net with the

[17] VHA Choice Program documentation provided to VA medical facility staff requires veterans to opt in to Choice prior to VA medical facility staff authorizing Choice.

authorization, or Health Net stated that no phone number was listed but the phone number was clearly marked in the authorization.

Example 5 describes the difficulty the VA facilities and Health Net have coordinating veteran contact based on one of our observations.

Example 5

> NVCC staff at the Richmond VA medical facility downloaded a recently returned authorization from Health Net that showed two telephone contact attempts and a letter was mailed to the veteran by Health Net staff. NVCC staff then called the veteran, whose spouse answered the telephone. The spouse explained that she had heard from Health Net on two occasions the same day. However, according to the spouse, because the veteran had difficulty speaking on the phone, Health Net staff refused to speak in detail with the spouse and said they would mail information to the veteran to authorize the spouse to speak on his behalf. The veteran had not received the information and no subsequent telephone calls were received prior to Health Net's return of the authorization. Health Net's information showed two attempted phone calls on the same day, as well as a letter being mailed to the veteran. VHA system documentation supported the spouse's statement that no letter was sent.

VHA's chief business officer addressed the untimely return of authorizations by executing a contract modification effective June 1, 2016. This modification required Health Net to return authorizations after two business days for urgent care and five business days for routine care if an appointment had not been scheduled.

Our Recommendation 4 addresses the need to implement monitoring controls to ensure Health Net returns authorizations after two business days for urgent care and five business days for routine care if an appointment had not been scheduled.

Choice Care Not Timely

VISN 6 did not consistently provide Choice care within 30 days for primary care, mental health care, or specialty care. We estimated that about 22,500 of 34,200 veterans (66 percent) authorized for Choice care in VISN 6 during the first quarter of FY 2016 received their authorized care. Overall, we estimated these 22,500 veterans waited an average of 84 days, an average of 42 days for VA staff to provide the authorization to Health Net and 42 days for Health Net to provide the service. Of these, we estimated about 18,500 veterans (82 percent) did not receive care within 30 days of the date VA identified the veteran's need for Choice care, which was when the provider created the consult or the veteran was placed on the VCL. For those veterans who did not receive care within 30 days, we estimated they waited an average of 98 days to receive their care, which ranged in our sample from 31 to 389 days.

Although all three categories averaged between 16 and 19 percent of veterans receiving care within 30 days, the average wait time for all veterans in each category varied. Specialty care took the longest, with veterans waiting an average of 85 days, mental health care averaged 77 days, and primary care averaged 66 days.

Table 3 below provides the time VA took to process an authorization and the time veterans waited after Health Net received the authorization for each of the three categories of care.

Table 3. Average Wait Time for Veterans To Receive Choice Care

Type of Care	Average Days for VA To Authorize Care	Average Days From Authorization to Date Care Received	Total Average Wait Days
Primary Care	10	56	66
Mental Health	37	40	77
Specialty Care	43	42	85
Weighted Average Results	**42**	**42**	**84**

Source: VA OIG analysis of VHA and Health Net data.

**Note: Totals were rounded based on the overall weighted average results for all three types of care from the statistical analysis and cannot be calculated by use of simple averaging.*

Our analysis of the Choice authorization process showed that about 97 percent of the Choice care authorized by VISN 6 medical facilities was for specialty care. Since we found similar results for each type of care, and NVCC staff used the same processes and procedures to authorize primary care, mental health care, and specialty care within each facility, we did not provide separate discussions for each type of care in this Finding.

Why This Occurred

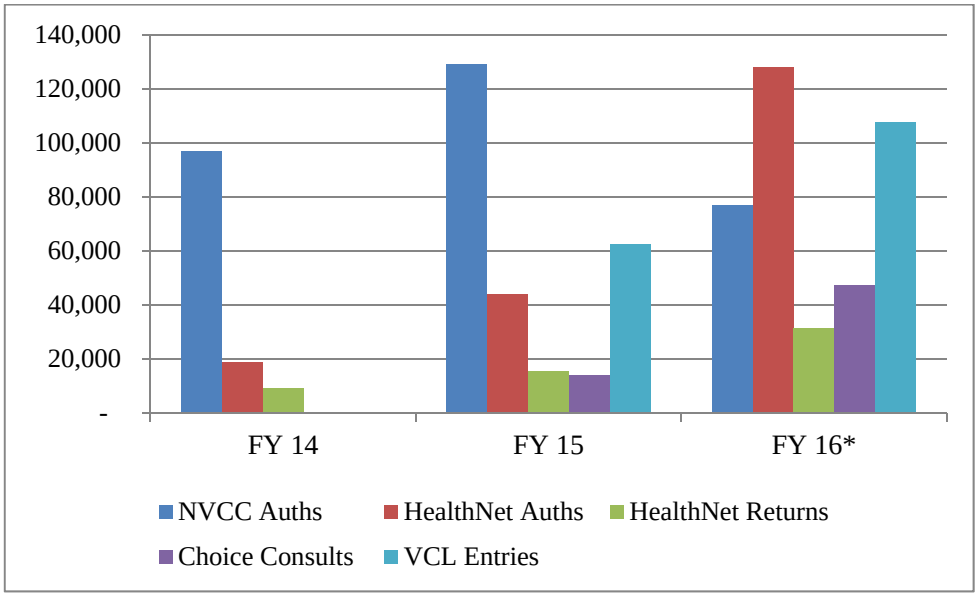
These issues occurred primarily because staffing resources were not sufficient to manage effectively the increased NVCC workload. Since VA implemented Choice in November 2014, the work requirements for VISN 6 NVCC staff has increased over 200 percent[18] based on VHA data. In FY 2014, processing traditional NVCC authorizations was the NVCC staff's primary workload requirement until Choice began later in the fiscal year and the facilities began processing Health Net authorizations and

[18] Based on VHA's data, we projected the workload by dividing the number reported by the approximate number of months that had occurred at the time of review to obtain a monthly number and then multiplied by 12 to estimate a full year.

returns. However, on July 31, 2015, Choice eligibility expanded and the work required to process the number of actions NVCC staff needed to take to address veterans' care needs throughout the Choice process increased significantly. NVCC staff must take actions to process traditional NVCC authorizations, Choice care from the VCL and Choice consults, Health Net authorizations, and Health Net returns requiring NVCC staff to resubmit the authorization or find care in the community through traditional NVCC processes. A number of NVCC supervisors and staff indicated that the workload has increased significantly since they implemented Choice and staffing levels were not adequate to meet the workload.

We calculated that each NVCC full-time equivalent staff member, based upon staffing reported by VISN 6 medical facilities, took actions to address about 660 veteran NVCC work requirements needs per year in FY 2014. As of July 2016, we calculated that due to the significant increase in the NVCC workload and limited additions of NVCC staff for most of the seven medical facilities, each VISN 6 NVCC full-time equivalent staff member would have to address over twice as many veterans' NVCC requirements than in FY 2014, or about 1,590 per year. Figure 1 shows the significant growth in the number of actions needed by VISN 6 NVCC medical facility staff to address veterans' needs to access Choice and traditional NVCC care in the community.

Figure 1. VISN 6 Workload Growth Increase Due to Choice



Source: VHA data systems provided actual numbers through June 30, 2016

**Note: FY 2016 estimated based on fiscal year-to-date as of June 30, 2016. See Footnote 18 on previous page for how OIG calculated.*

Manual Procedures Hinder Timely Authorization

We estimated VISN 6 facility staff took an average of 42 days to provide the approximately 34,200 authorizations created during the first quarter of FY 2016 to Health Net because manual procedures impeded NVCC staff's ability to provide timely authorizations to Health Net. NVCC staff at the VISN 6 facilities stated they must manually review each active NVCC authorization to determine if the authorization had been provided to Health Net, and if so, they must then monitor Health Net's portal to determine the status of each Health Net authorization until the appointment information is updated.

When Health Net schedules an appointment for a veteran, VA staff need to enter that information on the VA consult, which will update the status to scheduled. However, since active NVCC consults include those waiting for an authorization to be submitted to Health Net and those which Health Net had not yet scheduled an appointment, NVCC staff could not accurately estimate how many veterans were currently waiting for a Choice appointment. NVCC staff stated that an indeterminate number of active consults may have been scheduled, but either Health Net had not updated its portal or VA did not have the resources to review the information and update the consult status. If no one inquired about a particular consult, or staff did not update the consult status timely, the consults would remain incomplete, further delaying the veteran's care.

Staffing Was Not Sufficient To Ensure Health Net Acted Timely

NVCC staff did not adequately monitor Health Net's portal to provide responses to inquiries from Health Net and determine the status of incomplete authorizations. NVCC staff from the VISN 6 medical facilities stated that due to limited staffing resources, they were not able to adequately monitor Health Net's portal or keep up with their other NVCC tasks.

The VA's Choice contract required Health Net to create an appointment for the veteran within five business days of receiving the authorization. Of the 34,200 authorizations, we estimated Health Net created about 28,200 appointments. Of the estimated 28,200 appointments Health Net created during our audit period, we estimated Health Net did not record the dates it created an appointment for about 1,200 appointments (four percent). These dates are necessary for VA staff to enforce compliance with the contract requirement to schedule an appointment within five business days. For the estimated 27,000 appointments with appointment create dates, we estimated appointments were made more than five business days after Health Net received the authorization for about 19,600 appointments (73 percent).

The Health Net contract also required the contractor to provide the Choice care appointment within 30 days of the clinically indicated date VA provided to Health Net on the Choice authorization. However, we estimated that VA facility staff did not provide a clinically indicated date to Health Net for about 14,000 of the 34,200 authorizations (41 percent). If VA does not provide a clinically indicated date as required by the contract, they cannot

enforce compliance with the 30-day requirement. We also found that Health Net did not consistently meet the requirement to provide a Choice appointment within 30 days. While we estimated VA scheduled appointments for about 28,200 authorizations, VA provided the clinically indicated date for about 20,300 authorizations. For those 20,300 authorizations, we estimated that 13,300 veterans (66 percent) did not receive the Choice appointment within 30 days of the clinically indicated date.

VHA's chief business officer addressed a potential cause for delays in creating appointments by executing a contract modification effective November 1, 2015. This change allowed Health Net to initiate phone contact with a veteran to arrange a Choice appointment rather than require the veteran to contact Health Net as was required prior to the change. Our analysis showed that, while still untimely, this change slightly lowered the percentage of veterans who waited more than five days for Health Net to create an appointment. Based on Health Net data, we estimated that during October 2015, about 86 percent of veterans waited more than five business days for Health Net to create an appointment after they received an authorization. However, after November 1, 2015, about 69 percent of veterans waited more than five business days for Health Net to create an appointment after they received an authorization. For the veterans who waited more than 30 days for their Choice appointment, the percentage difference before and after the change in procedures on November 1, 2015 was not statistically significant.

Our Recommendation 5 addresses the need for VISN 6 management to ensure NVCC staffing is sufficient to administer the requirements of the Choice Program in a timely manner.

Our Recommendation 6 addresses the need for VISN 6 management to implement controls to ensure Health Net creates an appointment for the veteran within five business days of receiving the authorization.

Our Recommendation 7 addresses the need for the Under Secretary for Health to ensure all data required to manage the third party administrator contracts provided by VA and the third party administrators are complete, accurate, and timely.

What Resulted

Choice did not reduce wait times to receive necessary medical care for many veterans in VISN 6 as intended. We estimated that about 66 percent of veterans authorized for Choice received the care—with an estimated 18 percent of those veterans receiving the authorized care within 30 days. However, for veterans whose Choice care was not timely or was eventually returned due to Health Net's inability to provide timely care, these veterans encountered further delays in efforts to obtain care through VA or traditional NVCC options in the community.

We consulted with OHI to review eight patients who received authorizations for Choice care during FY 2016 to determine whether the patients received the requested services, and if not, the extent to which patients were potentially harmed by not receiving the requested services. We referred these patient records from our sample to OHI because we determined that they died during FY 2016. Of these eight patients OHI reviewed, they found no evidence of harm associated with any of the delayed care.

Conclusion

The increased administrative burdens placed on the medical facility staff to implement Choice, combined with limited staffing resources, have hampered VISN 6 facilities' ability to provide access to timely Choice care. Our estimated average wait time to receive Choice care of 84 days was almost three times longer than the goal of 30 days. During the period of our review, Choice was far from meeting its goal of improving the timeliness of health care for veterans in VISN 6. Many of the problems obtaining access to care through Choice were due to VISN 6's network provider, Health Net. However, VHA and VISN 6 leadership are responsible for improving Choice to better provide for VISN 6's veterans' health care needs as intended.

Recommendations

4. We recommended the Under Secretary for Health implement monitoring controls to ensure the third-party administrators return authorizations after two business days for urgent care and five business days for routine care if an appointment had not been scheduled.

5. We recommended the director of Veterans Integrated Service Network 6 ensure Non-VA Care Coordination staffing is sufficient to timely administer the requirements of the Choice Program.

6. We recommended the Under Secretary for Health implement controls to ensure the third-party administrators create an appointment for the veteran within five business days of receiving an authorization.

7. We recommended the Under Secretary for Health to ensure all data required to manage the third-party administrator contracts provided by the VA and the third-party administrators are complete, accurate, and timely.

Management Comments

The then-Under Secretary for Health concurred with Recommendations 4, 6, and 7, and concurred in principle with Recommendation 5. The then-Under Secretary stated that VHA would implement Recommendation 5 by July 2017. He stated that Recommendations 4, 6, and 7 were completed. The then-Under Secretary for Health's entire verbatim response is located in Appendix K.

OIG Response

The then-Under Secretary for Health's planned corrective actions are acceptable. We will monitor VHA's progress and follow up on the implementation of our recommendations until all proposed actions are completed.

As of February 2017, VHA had not provided us the evidence necessary to close Recommendations 4, 6, and 7. While VHA implemented contract changes and increased monitoring to address Recommendations 4 and 6, according to the data in VHA's response, there has not been substantial improvement to date. We will continue to monitor progress until Health Net has demonstrated substantial, sustained improvement. To address Recommendation 7, VHA stated its "data tracker" tool has improved the data collection process and overall third-party administrator data accuracy and integrity. Prior to closing this recommendation, we request that VHA provide data tracker reports that support substantial, sustained improvement. Once we receive and examine the evidence for each recommendation, we will determine if VHA's actions are sufficient to close the recommendations.

Finding 3 VISN 6 Did Not Consistently Manage the Timeliness of Specialty Care Consults

VISN 6 medical facility staff did not always timely complete new patients' appointments for consults, and schedulers did not always use the referring providers' clinically indicated date when scheduling appointments for consults of new patients. In addition, staff inappropriately discontinued or canceled consults an estimated 26 percent of the time.

This occurred primarily because specialty care service staff did not always receive and review consults timely, and they did not contact patients and schedule appointments for consults timely. In addition, VHA had not published its updated Consult directive until August 2016. Instead, VHA provided periodic guidance and training regarding consult management. We found that clinicians receiving consults provided schedulers a clinically indicated date later than what was on the consults from the referring provider. Furthermore, some staff disagreed with, or were unaware of, specific VHA consult management procedures regarding discontinuing and canceling consults.

As a result, many patients who received consults to specialty care services experienced long wait times, and those wait times were not accurately reflected in VA's calculated wait times. Veterans who waited greater than 30 days did not receive an opportunity to obtain Choice care because staff did not accurately record their wait times. In addition, inappropriately discontinued or canceled consults led to veterans not receiving the requested care, or experiencing additional delays in requested care.

We consulted with OHI to review electronic health records of 43 patients in our sample who received a consult to specialty care during FY 2016. OHI found no evidence of harm associated with delays in the sample care for these 43 patients.

Care for Consults Not Always Timely

Patients referred to specialty care services within VISN 6 medical facilities did not always receive timely care. We reviewed a statistical sample of 210 open specialty care consults at VISN 6 medical facilities that exceeded 30 days, as of March 23, 2016. This consisted of over 20,000 patients waiting for about 22,000 open consults that exceeded 30 days at that point in time. Subsequently, during our review in April and May 2016, we found that patients had received the requested care, patients were still awaiting care, or staff closed their consults.

- Patients received the requested care for an estimated 9,000 of 22,000 consults (41 percent) at the time of our review in April and May 2016. We determined those patients waited an average of 61 days to receive the requested care based on our statistical sample results.

- Patients had yet to receive care for an estimated 6,700 of 22,000 consults (30 percent), and those patients were waiting an average of 68 days at the time of our review in April and May 2016. We determined that an estimated 2,300 of 22,000 consults (10 percent) were designated as future care consults[19] in which the requesting provider requested care for a date more than 90 days in the future.

- Staff either discontinued or canceled, in some cases inappropriately, the remaining estimated 4,000 of 22,000 consults (18 percent) as of the time of our review in April and May 2016. These consults were closed an average of 110 days after the request. Based on interviews with schedulers or notes within the consults, staff could not reach the patient for scheduling, the patient canceled or did not show for their appointment, or the service requested additional prerequisites from the referring provider.

We measured wait time for specialty care appointments for consults consistent with VHA policy and guidance. In accordance with VHA Directive 2010-027 (June 9, 2010), the updated Standard Operating Procedure to VHA Directive 2010-027 (June 8, 2015), and as prescribed by VHA training material, we measured the wait time of each consult from the referring provider's clinically indicated date to the date the appointment was completed. If the patient was still waiting for the appointment, we measured to the date of our review. In instances where the patient canceled or did not show for their appointment, we used the veteran's subsequent preferred appointment date if the scheduler documented that date in VHA's electronic scheduling system. If the scheduler did not document the veteran's preferred appointment date in VHA's electronic scheduling system, we started the wait time calculation based on the subsequent appointment create date.

Incorrect Use of the Clinically Indicated Date

As identified in Finding 1, VISN 6 medical facility schedulers did not always use the referring providers' clinically indicated date when scheduling appointments for consults of new patients. VHA Directive 2010-027 stated that when scheduling patients in response to consults, the provider-specified time frame for appointments needs to be the date of the provider request, unless otherwise specified by the provider. In addition, according to an October 21, 2015 VHA memo, referring providers must enter the clinically indicated date solely based on what is best to meet the patient's needs, and receiving providers must not alter the clinically indicated date.

Of 42 schedulers interviewed, 18 (43 percent) stated they used the receiving providers' clinically indicated date rather than the referring providers' clinically indicated date when scheduling appointments for consults.

[19] Future care consults are requests for care that are medically appropriate more than 90 days after requested; VHA does not require staff to schedule them immediately.

Based on our statistical sample of 210 specialty care consults that were open as of March 23, 2016, we estimated schedulers entered a date in the scheduling system that was later than the referring provider's clinically indicated date for about 84 percent of consults (12,700 of 15,100) with a preferred date entered in the system. In those instances, we estimated that schedulers recorded a date that was an average of 61 days later than the referring provider's clinically indicated date.

Staff Inappropriately Closed Consults

VISN 6 medical facility staff inappropriately discontinued and canceled consults. We also reviewed a statistical sample of 210 specialty care consults requested during the first quarter of FY 2016 that staff discontinued or canceled. This was from an estimated 17,900 consults in which VISN 6 medical facility staff discontinued or canceled. Based on that review, we determined staff inappropriately discontinued or canceled an estimated 4,600 of 17,900 consults (26 percent). Staff inappropriately closed consults for myriad reasons, which included the following.

- **No Prerequisite Tests:** Staff discontinued or canceled consults that needed prerequisite tests completed or insufficient information was submitted with the consult. VHA's National Guidance for Discontinuing or Cancelling Consults stated that consults should not be canceled or discontinued because prerequisite tests or treatments had not been done. Instead, the consult should be completed as an e-consult[20] with instructions to the ordering provider on what tests or treatments are required and to resubmit the consult after that, if needed.
- **One No-Show or Patient Cancelation:** Staff discontinued or canceled consults following a single patient cancellation or no-show. VHA's National Guidance for Discontinuing or Cancelling Consults required at least two patient cancellations or no-shows before a clinician discontinues a consult. VHA's Outpatient Scheduling SOP also states that a clinician may, if deemed clinically appropriate, authorize discontinuation of a consult (and efforts to reschedule appointment) after two patient no-shows.
- **Insufficient Attempts to Contact:** Staff discontinued or canceled consults without making the required three documented attempts to contact the patient to schedule an appointment prior to closing the consult. VHA's Outpatient Scheduling SOP requires schedulers to make a minimum of three documented contacts (usually two phone calls and a letter) on separate days.
- **No Documented Reason:** Staff discontinued or canceled consults without providing a documented reason why the consult was being discontinued. VHA's National Guidance for Discontinuing or

[20] An e-consult is a consult where a clinical question can be answered without requiring an in-person examination.

Cancelling Consults states staff must always document the reason for discontinuation, with instructions to order a new consult if needed.

Urgent Consults

Of the 420 total consults we reviewed, all but three of them were labeled as routine. Of the three that were not labeled as routine, two were labeled as "Stat" and one as "Today."[21] OHI determined that the Stat urgency documented for those two consults was likely in error based on the patients' medical records. Example 6 details one of the Stat consults.

Example 6

One Stat consult was received and screened the same day the consult was released. According to the facility, the screening provider erroneously changed the status of the consult to "scheduled," which resulted in no action on the consult for nearly three months. The service was later unsuccessful in contacting the patient to schedule an appointment, and discontinued the consult. There was no documented evidence in the patient's medical records that showed the patient received care at VA since that consult was discontinued, at the time of our review in April 2016. OHI determined that the Stat urgency was likely in error based on the pathology report from the patient's colonoscopy in 2012. The facility has been unable to contact the patient despite multiple attempts. Furthermore, OHI determined that the patient received care in the community, but it remained unclear if he had the recommended follow-up colonoscopy. Although unlikely, a definitive conclusion that the patient was not negatively affected by a delay is not possible.

The consult with an urgency of Today was canceled by a clinician because it was created in error. The erroneous consult was a request for care of a fractured right hand. We identified no additional evidence that the patient or clinician requested care for the patient's hand and determined the clinician did not intend to create this consult.

Why This Occurred

Patients did not receive timely specialty care primarily because specialty care service staff did not timely receive and review consults and schedulers did not timely schedule appointments for consults. In addition, clinicians provided schedulers a different clinically indicated date when scheduling appointments for consults. Furthermore, some staff disagreed with, or were unware of, specific consult management procedures regarding discontinuing and canceling consults.

[21] As of October 21, 2015, VHA standardized clinical consult urgency statuses into two categories—Stat and Routine. For the purpose of consults, Stat is defined as an "immediate" need and should be completed within 24 hours unless otherwise indicated.

Consults Not Scheduled Timely

Clinicians did not always act upon consults timely. This means the receiving service did not always receive and review consults within VHA's seven-day goal. Of the estimated 22,000 open consults that exceeded 30 days as of March 23, 2016, specialty service staff took action on an estimated 19,300 of the consults at the time of our review. However, services receiving consults did not act upon an estimated 4,300 of 19,300 consults (22 percent) within seven days. We estimated that the receiving service took an average of 10 days to act upon the estimated 19,300 consults. VISN and medical facility staff stated they monitored pending consults through various reports. However, we found that services did not always act upon the consults timely.

Our Recommendation 8 addresses the need to ensure VISN 6 medical facilities timely address consults pending greater than seven days.

Once received and reviewed by the clinicians, schedulers did not schedule appointments for consults timely. On average, we estimated that the specialty care service staff scheduled (created) the patients' appointments 25 days after the referring provider requested the consult. These 25 days included the estimated 10 days to act upon the consult, in addition to the number of days it took to contact the patient and schedule an appointment.

Schedulers stated they believed the high volume of consults and the multiple other tasks schedulers have to complete contributed to the delays in scheduling the appointments. At least seven schedulers told us they had issues scheduling consults timely because they also had to answer incoming calls and attend to patients at the front desk. According to facility staff, three of the VISN 6 medical facilities—Asheville, Salem, and Salisbury—used teams of schedulers that only scheduled appointments for consults and were not responsible for front office duties, such as assisting patients and answering incoming calls.

Our Recommendation 9 addresses the need to identify and implement best practices to timely schedule appointments for consults upon receipt and review by the receiving specialty care clinicians.

Clinically Indicated Dates Based on Availability

As identified in Finding 1, staff used incorrect clinically indicated dates when scheduling consults. Facility directors, associate and assistant directors, and chiefs of staff disagreed with VHA guidance to use the referring provider's clinically indicated date. Clinicians, administrative officers, and schedulers in specialty care services told us they did not have sufficient new patient appointment availability due to access challenges, such as not having enough providers or space. During interviews with 26 schedulers, 20 (77 percent) said their clinics' next available appointment was greater than 30 days in the future.

We found that clinicians receiving consults provided schedulers a clinically indicated date later than what was on the consult from the referring provider.

Based on our sample review of open consults, for an estimated 3,400 of 22,000 consults (15 percent), the receiving provider specifically noted a clinically indicated date in the note of the consult that was later than the clinically indicated date provided by the referring provider.

Examples 7 and 8 detail instances in which services used a later clinically indicated date based on clinic availability.

Example 7

The Ophthalmology Service at the Richmond VAMC consistently provided schedulers a clinically indicated date of 90 days for the consults they received. One scheduler in that service told us that if they had more opportunities for appointments, they would be able to see patients within 30 days. For example, a primary care provider requested a consult, and upon receipt and review of the consult on the same day, the specialty care provider added a note to the consult that included "clinically indicated date 90 days." Based on the clinically indicated date noted by the ophthalmology clinician, the appointment was scheduled about 50 days later than the referring provider's clinically indicated date.

Example 8

A Service Chief at the Durham VAMC stated that the receiving providers in the service routinely note in the comments of routine consults a clinically indicated date that is 15 days in the future. She stated this was a common practice in the service due to clinic availability. For example, the clinician noted in one consult—which had a clinically indicated date from the referring provider of December 9, 2015—to "Please schedule within 30 days of clinically indicated date of January 1, 2016." The patient was scheduled for an appointment on January 28, 2016. Based on the clinically indicated date on the consult, the patient waited 50 days. By the Service Chief changing the clinically indicated date the calculated wait time became 27 days.

As identified in Finding 1, our Recommendation 2 addresses the need to ensure VISN 6 medical facilities accurately record patient wait times based on the referring provider's clinically indicated date in order to provide leadership with an accurate representation of new patient wait times.

Unclear About Consult Rules

VISN 6 medical facility staff inappropriately closed consults because they disagreed with or were unaware of specific consult management procedures regarding discontinuing or canceling consults. Clinicians and a chief of staff disagreed with VHA guidance that requires at least two patient cancellations or no-shows before discontinuing a consult. They believed they should make the clinical decision to discontinue a consult after a single no-show or patient cancellation.

In addition, staff did not always make or document three attempts to contact the patient, and staff failed to document appropriately a valid reason why they closed a consult. Management acknowledged schedulers did not appropriately document attempts to contact patients. Although they did not give a reason why the schedulers did not provide appropriate documentation, they said staff had since been educated on proper procedures. Clinicians generally did not use the e-consult function to complete a consult when it lacked prerequisite tests or insufficient information was submitted with the consult because they were unaware of the requirements to use e-consults or the clinic had not yet established use of the e-consult function. They instead discontinued or canceled the consults.

About 12 percent of schedulers (5 of 42) we interviewed were either unsure of when to discontinue or cancel a consult or cited incorrect guidance. About 29 percent of schedulers (12 of 42) said they had only received initial training when they first started scheduling and 12 percent (5 of 42) said they received only on-the-job training or informal training.

Our Recommendation 10 addresses the need to ensure VISN 6 medical facilities establish a mechanism to routinely audit closed consults to ensure they are in accordance with VHA policy, and to take corrective actions as needed based on audit results.

What Resulted

Patients who received consults to specialty care services experienced long wait times. Over 20,000 patients had open consults that exceeded 30 days as of March 23, 2016, and those who received the requested care at the time of our review in April and May 2016 waited an average of 61 days. Veterans did not always receive an opportunity to obtain Choice care because staff did not accurately record their wait times.

Inappropriately closed consults led to patients not receiving the requested care or experiencing additional delays in requested care. We reviewed a statistical sample of 210 specialty care consults requested during the first quarter of FY 2016 that staff discontinued or canceled—which consisted of a population of about 17,900 consults. Based on that review, we determined staff inappropriately discontinued and canceled an estimated 4,600 of 17,900 consults (26 percent). For those estimated 4,600 consults, we found that patients had yet to receive care, experienced delays in care, or staff incorrectly discontinued or canceled their consults after care was timely completed. Specifically:

- For an estimated 3,100 of 4,600 inappropriately discontinued or canceled consults (67 percent), patients had yet to receive the requested care at VA based on evidence in the electronic health record as of the time of our review in April and May 2016.
- For an estimated 1,100 of 4,600 inappropriately discontinued or canceled consults (24 percent), patients later received the requested care, but

experienced additional delays. On average, we estimated these patients waited over 100 more days after staff inappropriately discontinued or canceled the consult.

- For an estimated 410 of 4,600 inappropriately discontinued or canceled consults (9 percent), patients actually received the care, but the consult was discontinued or canceled instead of appropriately completed.

We consulted with OHI to review information of 43 patients who received a consult to specialty care during FY 2016, in order to make a determination as to whether the patients received the requested services and if not, the extent to which patients were potentially harmed by not receiving the requested services. We referred patients' information from our sample to OHI because we determined they were deceased, experienced delays in receiving urgent consults, or had not received care following an inappropriately closed consult. Of these 43 patients OHI reviewed, they found no evidence of harm associated with any of the delays. In addition, OHI identified instances in which the indicated Stat urgency level was not clinically appropriate based on the indication for the requested service.

Conclusion

During the relevant time period, VISN 6 medical facilities did not always provide timely care to patients referred to specialty care. We found that patients experienced delays in receiving their requested specialty care, and in some cases had yet to receive the requested care. In addition, we determined that staff inappropriately discontinued and canceled consults. As a result, patients who received consults to specialty care services experienced long wait times, and inappropriately closed consults led to veterans not receiving the requested care, or experiencing additional delays in requested care.

Recommendations

8. We recommended the director of Veterans Integrated Service Network 6 ensure services monitor and timely address consults pending greater than seven days.

9. We recommended the director of Veterans Integrated Service Network 6 identify and implement best practices to timely schedule appointments for consults upon receipt and review by the receiving specialty care clinicians.

10. We recommended the director of Veterans Integrated Service Network 6 establish a mechanism to routinely audit closed consults to ensure they are in accordance with Veterans Health Administration consult business rules, and take corrective actions as needed based on audit results.

Management Comments

The then-Under Secretary for Health concurred in principle with Recommendations 8, 9, and 10, and stated that VHA would implement the recommendations by July 2017. The then-Under Secretary for Health's entire verbatim response is located in Appendix K.

OIG Response

Planned corrective actions are acceptable. We will monitor VHA's progress and follow up on the implementation of our recommendations until all proposed actions are completed.

Appendix A Asheville, NC, VAMC Summary Results

We conducted a site visit to the Asheville, NC, VAMC during the week of May 23, 2016. We interviewed 22 employees and conducted scheduler observations in the Primary Care, Mental Health, and Specialty Care Clinics. The numbers in the tables below only reflect the raw sample results and were used to project the weighted averages VISN-wide. These individual facility results should not be used to compare with results at other facilities.

Table 4 summarizes results of our statistical sample review of new patient appointments.

Table 4. Sample Results–New Patient Appointments

Appointment Type	Cases Reviewed	Wait Time 30 Days or Less	Wait Time Over 30 Days	Average Wait Time (VA)	Average Wait Time (OIG)	Number With Incorrect Date Used
Specialty Care	25	13 (52%)	12 (48%)	5 Days	32 Days	22 (88%)
Primary Care	30	25 (83%)	5 (17%)	2 Days	19 Days	24 (80%)
Mental Health	30	30 (100%)	0 (0%)	3 Days	6 Days	18 (60%)
Totals	**85**	**68 (80%)**	**17 (20%)**	**3 Days**	**18 Days**	**64 (75%)**

Source: VA OIG analysis of statistically sampled new patient appointments

Table 5 summarizes results of our statistical sample review of veterans' health care through Choice. We reviewed all authorizations for strata with fewer than 30 valid authorizations during our sample period.

Table 5. Sample Results–Choice Care

Appointment Type	Cases Reviewed	Veterans Who Received Choice Care	Average Time To Authorize	Average Wait Time for Choice Care	Veterans Who Did Not Receive Choice Care
Specialty Care	30	18 (60%)	34 Days	86 Days	12 (40%)
Primary Care	2	1 (50%)	17 Days	76 Days	1 (50%)
Mental Health	7	0 (0%)	20 Days	N/A	7 (100%)
Totals	**39**	**19 (45%)**	**30 Days**	**86 Days**	**20 (51%)**

Source: VA OIG analysis of statistically sampled Choice authorizations

Table 6 summarizes results of our statistical sample review of open specialty care consults that exceeded 30 days as of March 2016.

Table 6. Sample Results–Open Consults

Consults Reviewed	Veterans Received Care	Average Wait Time (OIG)	Veterans Were Still Waiting for Care	Average Days Waiting (OIG)	Veterans' Consult Was Closed or Future Care
30	19 (63%)	42 Days	2 (7%)	60 Days	9 (30%)

Source: VA OIG analysis of statistically sampled open specialty care consults as of the time of our review in April and May 2016

Table 7 summarizes results of our statistical sample review of discontinued and canceled consults.

Table 7. Sample Results–Discontinued and Canceled Consults

Consults Reviewed	Appropriately Discontinued or Canceled	Inappropriately Discontinued or Canceled	Veterans Had Not Received Requested Care*	Veterans Received Delayed Care	Veterans Received Care**
30	27 (90%)	3 (10%)	3	0	0

Source: VA OIG analysis of statistically sampled discontinued and canceled specialty care consults as of the time of our review in April and May 2016

** Of the inappropriately discontinued or canceled consults, these veterans had not received the requested care at the time of our review.*

*** Of the inappropriately discontinued or canceled consults, these veterans received the requested care as requested, but the consult was discontinued or canceled instead of completed.*

Appendix B Durham, NC, VAMC Summary Results

We conducted a site visit to the Durham, NC, VAMC during the week of May 23, 2016. We interviewed 50 employees and conducted scheduler observations in the Primary Care, Mental Health, and Specialty Care Clinics. The numbers in the tables below only reflect the raw sample results and were used to project the weighted averages VISN-wide. These individual facility results should not be used to compare with results at other facilities.

Table 8 summarizes results of our statistical sample review of new patient appointments.

Table 8. Sample Results–New Patient Appointments

Appointment Type	Cases Reviewed	Wait Time 30 Days or Less	Wait Time Over 30 Days	Average Wait Time (VA)	Average Wait Time (OIG)	Number With Incorrect Date Used
Specialty Care	30	23 (77%)	7 (23%)	4 Days	20 Days	22 (73%)
Primary Care	30	14 (47%)	16 (53%)	12 Days	27 Days	20 (67%)
Mental Health	30	23 (77%)	7 (23%)	3 Days	19 Days	20 (67%)
Totals	**90**	**60 (67%)**	**30 (33%)**	**6 Days**	**22 Days**	**62 (69%)**

Source: VA OIG analysis of statistically sampled new patient appointments

Table 9 summarizes results of our statistical sample review of veterans' health care through Choice. We reviewed all authorizations for strata with fewer than 30 valid authorizations during our sample period.

Table 9. Sample Results–Choice Care

Appointment Type	Cases Reviewed	Veterans Who Received Choice Care	Average Time To Authorize	Average Wait Time for Choice Care	Veterans Who Did Not Receive Choice Care
Specialty Care	30	22 (73%)	58 Days	104 Days	8 (27%)
Primary Care	2	1 (50%)	8 Days	23 Days	1 (50%)
Mental Health	30	19 (63%)	33 Days	66 Days	11 (37%)
Totals	**62**	42 (68%)	**44 Days**	**85 Days**	**20 (32%)**

Source: VA OIG analysis of statistically sampled Choice authorizations

Table 10 summarizes results of our statistical sample review of open specialty care consults that exceeded 30 days as of March 2016.

Table 10. Sample Results–Open Consults

Consults Reviewed	Veterans Received Care	Average Wait Time (OIG)	Veterans Were Still Waiting for Care	Average Days Waiting (OIG)	Veterans' Consult Was Closed or Future Care
30	8 (27%)	93 Days	8 (27%)	79 Days	14 (47%)

Source: VA OIG analysis of statistically sampled open specialty care consults as of the time of our review in April and May 2016

Table 11 summarizes results of our statistical sample review of discontinued and canceled consults.

Table 11. Sample Results–Discontinued and Canceled Consults

Consults Reviewed	Appropriately Discontinued or Canceled	Inappropriately Discontinued or Canceled	Veterans Had Not Received Requested Care*	Veterans Received Delayed Care	Veterans Received Care**
30	21 (70%)	9 (30%)	9	0	0

Source: VA OIG analysis of statistically sampled discontinued and canceled specialty care consults as of the time of our review in April and May 2016

** Of the inappropriately discontinued or canceled consults, these veterans had not received the requested care at the time of our review.*

*** Of the inappropriately discontinued or canceled consults, these veterans received the requested care as requested, but the consult was discontinued or canceled instead of completed.*

Appendix C Fayetteville, NC, VAMC Summary Results

We conducted a site visit to the Fayetteville, NC, VAMC during the week of May 2, 2016. We interviewed 60 employees and conducted scheduler observations in the Primary Care, Mental Health, and Specialty Care Clinics. The numbers in the tables below only reflect the raw sample results and were used to project the weighted averages VISN-wide. These individual facility results should not be used to compare with results at other facilities.

Table 12 summarizes results of our statistical sample review of new patient appointments.

Table 12. Sample Results–New Patient Appointments

Appointment Type	Cases Reviewed	Wait Time 30 Days or Less	Wait Time Over 30 Days	Average Wait Time (VA)	Average Wait Time (OIG)	Number With Incorrect Date Used
Specialty Care	29	18 (62%)	11 (38%)	20 Days	31 Days	23 (79%)
Primary Care	30	12 (40%)	18 (60%)	40 Days	49 Days	10 (33%)
Mental Health	30	27 (90%)	3 (10%)	7 Days	11 Days	11 (37%)
Totals	**89**	**57 (64%)**	**32(36%)**	**22 Days**	**30 Days**	**44 (49%)**

Source: VA OIG analysis of statistically sampled new patient appointments

Table 13 summarizes results of our statistical sample review of veterans' health care through Choice. We reviewed all authorizations for strata with fewer than 30 valid authorizations during our sample period.

Table 13. Sample Results–Choice Care

Appointment Type	Cases Reviewed	Veterans Who Received Choice Care	Average Time To Authorize	Average Wait Time for Choice Care	Veterans Who Did Not Receive Choice Care
Specialty Care	30	15 (50%)	62 Days	110 Days	15 (50%)
Primary Care	30	14 (47%)	12 Days	73 Days	16 (53%)
Mental Health	30	16 (53%)	64 Days	98 Days	14 (47%)
Totals	90	**45 (50%)**	**46 Days**	**94 Days**	**45 (50%)**

Source: VA OIG analysis of statistically sampled Choice authorizations

Table 14 summarizes results of our statistical sample review of open specialty care consults that exceeded 30 days as of March 2016.

Table 14. Sample Results–Open Consults

Consults Reviewed	Veterans Received Care	Average Wait Time (OIG)	Veterans Were Still Waiting for Care	Average Days Waiting (OIG)	Veterans' Consult Was Closed or Future Care
30	11 (37%)	61 Days	15 (50%)	63 Days	4 (13%)

Source: VA OIG analysis of statistically sampled open specialty care consults as of the time of our review in April and May 2016

Table 15 summarizes results of our statistical sample review of discontinued and canceled consults.

Table 15. Sample Results–Discontinued and Canceled Consults

Consults Reviewed	Appropriately Discontinued or Canceled	Inappropriately Discontinued or Canceled	Veterans Had Not Received Requested Care*	Veterans Received Delayed Care	Veterans Received Care**
30	23 (77%)	7 (23%)	5	0	2

Source: VA OIG analysis of statistically sampled discontinued and canceled specialty care consults as of the time of our review in April and May 2016

** Of the inappropriately discontinued or canceled consults, these veterans had not received the requested care at the time of our review.*

*** Of the inappropriately discontinued or canceled consults, these veterans received the requested care as requested, but the consult was discontinued or canceled instead of completed.*

Appendix D Hampton, VA, VAMC Summary Results

We conducted a site visit to the Hampton, VA, VAMC during the week of May 2, 2016. We interviewed 41 employees and conducted scheduler observations in the Primary Care, Mental Health, and Specialty Care Clinics. The numbers in the tables below only reflect the raw sample results and were used to project the weighted averages VISN-wide. These individual facility results should not be used to compare with results at other facilities.

Table 16 summarizes results of our statistical sample review of new patient appointments.

Table 16. Sample Results–New Patient Appointments

Appointment Type	Cases Reviewed	Wait Time 30 Days or Less	Wait Time Over 30 Days	Average Wait Time (VA)	Average Wait Time (OIG)	Number With Incorrect Date Used
Specialty Care	27	18 (67%)	9 (33%)	8 Days	30 Days	26 (96%)
Primary Care	30	20 (67%)	10 (33%)	17 Days	23 Days	11 (37%)
Mental Health	30	27 (90%)	3 (10%)	7 Days	15 Days	22 (73%)
Totals	**87**	**65 (75%)**	**22 (25%)**	**11 Days**	**23 Days**	**59 (68%)**

Source: VA OIG analysis of statistically sampled new patient appointments

Table 17 summarizes results of our statistical sample review of veterans' health care through Choice. We reviewed all authorizations for strata with fewer than 30 valid authorizations during our sample period.

Table 17. Sample Results–Choice Care

Appointment Type	Cases Reviewed	Veterans Who Received Choice Care	Average Time To Authorize	Average Wait Time for Choice Care	Veterans Who Did Not Receive Choice Care
Specialty Care	30	28 (93%)	23 Days	63 Days	2 (7%)
Primary Care	28	19 (68%)	6 Days	41 Days	9 (32%)
Mental Health	0	N/A	N/A	N/A	N/A
Totals	**58**	**47 (81%)**	**15 Days**	**54 Days**	**11 (19%)**

Source: VA OIG analysis of statistically sampled Choice authorizations

Table 18 summarizes results of our statistical sample review of open specialty care consults that exceeded 30 days as of March 2016.

Table 18. Sample Results–Open Consults

Consults Reviewed	Veterans Received Care	Average Wait Time (OIG)	Veterans Were Still Waiting for Care	Average Days Waiting (OIG)	Veterans' Consult Was Closed or Future Care
30	9 (30%)	61 Days	15 (50%)	95 Days	6 (20%)

Source: VA OIG analysis of statistically sampled open specialty care consults as of the time of our review in April and May 2016

Table 19 summarizes results of our statistical sample review of discontinued and canceled consults.

Table 19. Sample Results–Discontinued and Canceled Consults

Consults Reviewed	Appropriately Discontinued or Canceled	Inappropriately Discontinued or Canceled	Veterans Had Not Received Requested Care*	Veterans Received Delayed Care	Veterans Received Care**
30	24 (80%)	6 (20%)	6	0	0

Source: VA OIG analysis of statistically sampled discontinued and canceled specialty care consults as of the time of our review in April and May 2016

** Of the inappropriately discontinued or canceled consults, these veterans had not received the requested care at the time of our review.*

*** Of the inappropriately discontinued or canceled consults, these veterans received the requested care as requested, but the consult was discontinued or canceled instead of completed.*

Appendix E Richmond, VA, VAMC Summary Results

We conducted a site visit to the Richmond, VA, VAMC during the week of May 2, 2016. We interviewed 53 employees and conducted scheduler observations in the Primary Care, Mental Health, and Specialty Care Clinics. The numbers in the tables below only reflect the raw sample results and were used to project the weighted averages VISN-wide. These individual facility results should not be used to compare with results at other facilities.

Table 20 summarizes results of our statistical sample review of new patient appointments.

Table 20. Sample Results–New Patient Appointments

Appointment Type	Cases Reviewed	Wait Time 30 Days or Less	Wait Time Over 30 Days	Average Wait Time (VA)	Average Wait Time (OIG)	Number With Incorrect Date Used
Specialty Care	30	13 (43%)	17 (57%)	9 Days	43 Days	24 (80%)
Primary Care	30	26 (87%)	4 (13%)	6 Days	17 Days	22 (73%)
Mental Health	30	26 (87%)	4 (13%)	5 Days	20 Days	17 (57%)
Totals	**90**	**65 (72%)**	**25 (28%)**	**7 Days**	**27 Days**	**63 (70%)**

Source: VA OIG analysis of statistically sampled new patient appointments

Table 21 summarizes results of our statistical sample review of veterans' health care through Choice. We reviewed all authorizations for strata with fewer than 30 valid authorizations during our sample period.

Table 21. Sample Results–Choice Care

Appointment Type	Cases Reviewed	Veterans Who Received Choice Care	Average Time To Authorize	Average Wait Time for Choice Care	Veterans Who Did Not Receive Choice Care
Specialty Care	30	20 (67%)	39 Days	76 Days	10 (33%)
Primary Care	1	0 (0%)	11 Days	N/A	1 (100%)
Mental Health	9	4 (44%)	34 Days	97 Days	5 (56%)
Totals	40	**24 (60%)**	**37 Days**	**79 Days**	**16 (40%)**

Source: VA OIG analysis of statistically sampled Choice authorizations

Table 22 summarizes results of our statistical sample review of open specialty care consults that exceeded 30 days as of March 2016.

Table 22. Sample Results–Open Consults

Consults Reviewed	Veterans Received Care	Average Wait Time (OIG)	Veterans Were Still Waiting for Care	Average Days Waiting (OIG)	Veterans' Consult Was Closed or Future Care
30	16 (53%)	39 Days	10 (33%)	59 Days	4 (13%)

Source: VA OIG analysis of statistically sampled open specialty care consults as of the time of our review in April and May 2016

Table 23 summarizes results of our statistical sample review of discontinued and canceled consults.

Table 23. Sample Results–Discontinued and Canceled Consults

Consults Reviewed	Appropriately Discontinued or Canceled	Inappropriately Discontinued or Canceled	Veterans Had Not Received Requested Care*	Veterans Received Delayed Care	Veterans Received Care**
30	18 (60%)	12 (40%)	7	4	1

Source: VA OIG analysis of statistically sampled discontinued and canceled specialty care consults as of the time of our review in April and May 2016

** Of the inappropriately discontinued or canceled consults, these veterans had not received the requested care at the time of our review.*

*** Of the inappropriately discontinued or canceled consults, these veterans received the requested care as requested, but the consult was discontinued or canceled instead of completed.*

Appendix F Salem, VA, VAMC Summary Results

We conducted a site visit to the Salem, VA, VAMC during the week of June 6, 2016. We interviewed 33 employees and conducted scheduler observations in the Primary Care, Mental Health, and Specialty Care Clinics. The numbers in the tables below only reflect the raw sample results and were used to project the weighted averages VISN-wide. These individual facility results should not be used to compare with results at other facilities.

Table 24 summarizes results of our statistical sample review of new patient appointments.

Table 24. Sample Results–New Patient Appointments

Appointment Type	Cases Reviewed	Wait Time 30 Days or Less	Wait Time Over 30 Days	Average Wait Time (VA)	Average Wait Time (OIG)	Number With Incorrect Date Used
Specialty Care	29	21 (72%)	8 (28%)	10 Days	22 Days	25 (86%)
Primary Care	30	29 (97%)	1 (3%)	4 Days	10 Days	22 (73%)
Mental Health	30	30 (100%)	0 (0%)	0 Days	3 Days	8 (27%)
Totals	**89**	**80 (90%)**	**9 (10%)**	**5 Days**	**12 Days**	**55 (62%)**

Source: VA OIG analysis of statistically sampled new patient appointments

Table 25 summarizes results of our statistical sample review of veterans' health care through Choice. We reviewed all authorizations for strata with fewer than 30 valid authorizations during our sample period.

Table 25. Sample Results–Choice Care

Appointment Type	Cases Reviewed	Veterans Who Received Choice Care	Average Time To Authorize	Average Wait Time for Choice Care	Veterans Who Did Not Receive Choice
Specialty Care	30	20 (67%)	24 Days	76 Days	10 (33%)
Primary Care	2	1 (50%)	10 Days	28 Days	1 (50%)
Mental Health	4	1 (25%)	134 Days	218 Days	3 (75%)
Totals	**36**	**22 (61%)**	**35 Days**	**80 Days**	**14 (39%)**

Source: VA OIG analysis of statistically sampled Choice authorizations

Table 26 summarizes results of our statistical sample review of open specialty care consults that exceeded 30 days as of March 2016.

Table 26. Sample Results–Open Consults

Consults Reviewed	Veterans Received Care	Average Wait Time (OIG)	Veterans Were Still Waiting for Care	Average Days Waiting (OIG)	Veterans' Consult Was Closed or Future Care
30	20 (67%)	84 Days	7 (23%)	59 Days	3 (10%)

Source: VA OIG analysis of statistically sampled open specialty care consults as of the time of our review in April and May 2016

Table 27 summarizes results of our statistical sample review of discontinued and canceled consults.

Table 27. Sample Results–Discontinued and Canceled Consults

Consults Reviewed	Appropriately Discontinued or Canceled	Inappropriately Discontinued or Canceled	Veterans Had Not Received Requested Care*	Veterans Received Delayed Care	Veterans Received Care**
30	24 (80%)	6 (20%)	0	6	0

Source: VA OIG analysis of statistically sampled discontinued and canceled specialty care consults as of the time of our review in April and May 2016

** Of the inappropriately discontinued or canceled consults, these veterans had not received the requested care at the time of our review.*

*** Of the inappropriately discontinued or canceled consults, these veterans received the requested care as requested, but the consult was discontinued or canceled instead of completed.*

Appendix G Salisbury, NC, VAMC Summary Results

We conducted a site visit to the Salisbury, NC, VAMC during the week of June 6, 2016. We interviewed 49 employees and conducted scheduler observations in the Primary Care, Mental Health, and Specialty Care Clinics. The numbers in the tables below only reflect the raw sample results and were used to project the weighted averages VISN-wide. These individual facility results should not be used to compare with results at other facilities.

Table 28 summarizes results of our statistical sample review of new patient appointments.

Table 28. Sample Results–New Patient Appointments

Appointment Type	Cases Reviewed	Wait Time 30 Days or Less	Wait Time Over 30 Days	Average Wait Time (VA)	Average Wait Time (OIG)	Number With Incorrect Date Used
Specialty Care	28	17 (61%)	11 (39%)	10 Days	30 Days	23 (82%)
Primary Care	30	24 (80%)	6 (20%)	14 Days	16 Days	3 (10%)
Mental Health	30	18 (60%)	12 (40%)	7 Days	28 Days	23 (77%)
Totals	**88**	**59 (67%)**	**29 (33%)**	**10 Days**	**25 Days**	**49 (56%)**

Source: VA OIG analysis of statistically sampled new patient appointments

Table 29 summarizes results of our statistical sample review of veterans' health care through Choice. We reviewed all authorizations for strata with fewer than 30 valid authorizations during our sample period.

Table 29. Sample Results–Choice Care

Appointment Type	Cases Reviewed	Veterans Who Received Choice Care	Average Time To Authorize	Average Wait Time for Choice Care	Veterans Who Did Not Receive Choice Care
Specialty Care	30	20 (67%)	23 Days	64 Days	10 (33%)
Primary Care	8	0 (0%)	17 Days	N/A	8 (100%)
Mental Health	26	11 (42%)	14 Days	49 Days	15 (58%)
Totals	64	**31 (48%)**	**18 Days**	**58 Days**	**33 (52%)**

Source: VA OIG analysis of statistically sampled Choice authorizations

Table 30 summarizes results of our statistical sample review of open specialty care consults that exceeded 30 days as of March 2016.

Table 30. Sample Results–Open Consults

Consults Reviewed	Veterans Received Care	Average Wait Time (OIG)	Veterans Were Still Waiting for Care	Average Days Waiting (OIG)	Veterans' Consult Was Closed or Future Care
30	11 (37%)	54 Days	2 (7%)	59 Days	17 (57%)

Source: VA OIG analysis of statistically sampled open specialty care consults as of the time of our review in April and May 2016

Table 31 summarizes results of our statistical sample review of discontinued and canceled consults.

Table 31. Sample Results–Discontinued and Canceled Consults

Consults Reviewed	Appropriately Discontinued or Canceled	Inappropriately Discontinued or Canceled	Veterans Had Not Received Requested Care*	Veterans Received Delayed Care	Veterans Received Care**
30	22 (73%)	8 (27%)	5	2	1

Source: VA OIG analysis of statistically sampled discontinued and canceled specialty care consults as of the time of our review in April and May 2016

** Of the inappropriately discontinued or canceled consults, these veterans had not received the requested care at the time of our review.*

*** Of the inappropriately discontinued or canceled consults, these veterans received the requested care as requested, but the consult was discontinued or canceled instead of completed.*

Appendix H Background

Access to VA Medical Facility Care

VHA Directive 2010-027 stated that VISN Directors, or designees, are responsible for the oversight of scheduling, consult management, and wait lists for eligible veterans. Furthermore, the directive states that VHA facility directors, or designees, are responsible for implementing procedures related to providing timely access to health care at their facilities.

In 2014, VHA began releasing patient access data to support its mission of providing high quality health care and benefits to veterans. VHA provides patient access data on its website, and they are available for all VA medical centers and community-based outpatient clinics. The patient access data include average wait times, number of patients waiting for a scheduled appointment, and the number of patients that cannot be scheduled for an appointment in 90 days or less. Both completed and pending appointment data are available.

VHA calculates wait times using the "preferred date." The preferred date represents the date for the appointment that is deemed medically appropriate by a clinician, or if no such determination has been made, the date a veteran prefers to be seen.

VHA calculates the wait time for the rescheduled appointments of clinic cancellations and patient cancellations differently.

- If the clinic needs to cancel appointments because it is unable to provide care to the patient at the original appointment time, staff must input the cancellation as a clinic cancellation. According to VHA Directive 2010-027, the veteran's wait time for this appointment would continue to use the original appointment's clinically indicated or preferred date for the rescheduled appointment.
- According to VHA's Outpatient Scheduling SOP (June 2015), if the patient cancels the appointment, the wait time will recalculate based on the patient's new preferred date for the rescheduled appointment.

In addition, VHA Memorandum, *Inappropriate Scheduling Practices* (April 26, 2010), provided guidance that stated the desired date should be entered in the appointment comments to ensure that the appointment was appropriately scheduled.

Access, Choice, and Accountability Act of 2014

The Choice Program requires VA to offer an authorization to receive non-VA care to veterans who are unable to secure an appointment at a VA medical facility within 30 days or who live more than 40 miles from a VA facility. VA facilities began providing Choice care to eligible veterans as of the implementation date of November 5, 2014. Congress authorized Choice

to continue until the date the Veterans Choice Program funds are exhausted, or until August 7, 2017, whichever occurs first.

Effective June 8, 2015, VA implemented the Choice First process that incorporates a Choice Program option earlier in the referral hierarchy when care is not available within VA facilities or the facility cannot meet VHA timeliness standards. The hierarchy is as follows:

- Refer the veteran to another facility. The referring facility may use existing Department of Defense, Indian Health Service facilities, and Tribal organizations agreements to get the veteran care.
- Refer the veteran to Choice when the program covers the needed services.
- Use other traditional non-VA care options if Choice does not cover the needed services.

Veterans Choice Implementation

To fulfill Choice's mission and ensure eligible veterans could obtain services when they called, the contract terms state VA will provide daily updates to the VCL for veterans who are eligible because they have been waiting more than 30 days for their appointment and weekly updates for veterans meeting the 40-mile eligibility rule. VA amended the 40-mile straight-line calculation to use the distance the veteran must travel to the nearest VA medical facility via a mapped route on April 24, 2015.

Prior to Choice, for traditional NVCC, staff reviewed VA physician requests for care in the community (consults) when the VA medical facility could not directly provide appropriate care and therefore could not offer the veteran an appointment. NVCC staff approved the care, created an authorization, and worked directly with the veteran and local care providers in the community to coordinate the care. NVCC staff used the consult to manage the veteran's care including arranging the appointment and communicating with the community provider.

Under Choice, VA medical facilities continued to use consults to manage Choice authorizations when a VA medical facility could not directly provide care. However, under Choice, eligible veterans can choose to have care provided by non-VA providers. Therefore, NVCC staff had to take the additional step of contacting these veterans to ask if the veteran would like to opt in to Choice. Facility staff create a Choice authorization only if a veteran opts in to Choice. If a veteran opts in, staff electronically provide the authorization and other related medical documents, via the contractor portal, to Health Net rather than coordinate the care directly with the provider in the community.

Choice increased eligibility for care in the community to include veterans who had to wait over 30 days for a VA appointment. When VA medical

facility staff schedule an appointment over 30 days in the future, they place the veteran's name on the VCL and facility staff contact the veteran to determine if they wish to opt in. If a veteran opts in, facility staff create a Choice authorization and electronically provide it and other related medical documents via the contractor to Health Net. After Choice care is authorized, NVCC staff must monitor the authorization querying Health Net's information to address any issues, which may affect Health Net's ability to coordinate the authorized care timely.

Consult Policy

VHA Consult Policy (VHA Directive 2008-056) provided criteria to VHA staff on appropriate consult management. This directive expired in September 2013, but VHA had not replaced it with an updated policy until August 2016. VHA's Consult Management Business Rules (May 2014) provided guidance on when staff can discontinue or cancel a consult.

Starting in 2014, VHA began drafting a new consult management directive, handbook, and SOP. In 2015, VHA began providing facilities updated consult management guidance based on these draft policies and distributed an Interim Consult SOP. VHA also developed guidance called National Guidance for Discontinuing or Cancelling Consults, which stated that clinicians and non-clinicians can discontinue consults under certain circumstances and that facilities are required to document the reason for discontinuing a consult. The guidance specifies that a clinician should review the order prior to discontinuing a consultation when the patient canceled multiple times, did not respond to the minimum scheduling efforts, or did not show up for a scheduled appointment multiple times. The guidance also specifies that non-clinicians can discontinue consults under certain conditions. These conditions include if the patient is deceased, the consult was a duplicate request, the patient refused care, or the patient opted for NVCC. VHA's National Guidance for Discontinuing or Cancelling Consults also stated that consults may only be canceled if the ordering provider did not include sufficient information in the consult request, or to correct an error in the Earliest Appropriate Date or Clinically Indicated Date entry.

On June 8, 2015, VHA issued a memo titled *CORRECTION: Clarification of Veterans Health Administration (VHA) Outpatient Scheduling Policy and Procedures and Interim Guidance* to the VISNs. This included Outpatient Scheduling SOPs, which stated that when scheduling in response to a consult, if a patient cannot be reached after three documented attempts, the scheduler must ask the receiving provider for disposition of the consult and these steps must be documented in the patient's record. The memo also stated that a clinician may, if deemed clinically appropriate, authorize discontinuation of a consult (and efforts to reschedule appointment) after two patient no-shows.

Recurring Issues

During the past decade, OIG, GAO, VA, and other organizations have issued numerous reports regarding issues with access to VA care, veteran wait times, scheduling practices, consult management, and more recently, Choice care. Furthermore, since 2014, OIG and VA continued to review and identify inappropriate scheduling practices at VA facilities across the country. In May and June 2014, VA conducted a system-wide Access Audit to ensure a full understanding of VA's policy among scheduling staff, identify inappropriate scheduling practices, and review wait list management. The VA Access Audit flagged 112 facilities for further review because of concerns that indicated inappropriate scheduling practices or interviewed staff indicated they had received instruction to modify scheduling dates.

The VA Access Audit flagged seven locations in VISN 6 for further review, including one VAMC (Richmond). VA flagged these facilities because of concerns that indicated inappropriate scheduling practices or staff indicated they had received instruction to modify scheduling dates. A VA Access Audit and Wait Times Fact Sheet for VISN 6, dated June 9, 2014, stated that VA was already taking corrective action to address issues resulting from the audit. In February 2015, the Joint Commission conducted an unannounced review at the Richmond VAMC and reported insufficient compliance regarding appointment timeliness.

Previous OIG Reports

Since 2014, the OIG has issued numerous reports regarding issues with access to VA care, veteran wait times, scheduling practices, consult management, and Choice care. Since OIG's *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* (Report No. 14-02603-267, August 26, 2014), OIG continued to review and identify inappropriate scheduling practices at VA facilities across the country. The following highlight recently published OIG reports related to access to VA care, Choice, and consult management.

In October 2016, OIG issued a report titled *Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System* (Report No. 15-04672-342, October 4, 2016). The OIG substantiated that in 2015, Phoenix VA Health Care System staff inappropriately discontinued consults. The OIG determined that staff inappropriately discontinued 74 of the 309 specialty care consults (24 percent) we reviewed. This occurred because staff were generally unclear about specific consult management procedures, and services varied in their procedures and consult management responsibilities. As a result, patients did not receive the requested care or they encountered delays in care. This report contained 14 recommendations. The Under Secretary for Health concurred with the recommendation to update VHA's consult policy, and VHA published a new directive on August 23, 2016. The VISN 22 Director also concurred with the remaining recommendations to improve consult management at the Phoenix VA Health Care System.

In June 2016, OIG issued a report titled *Review of VHA's Alleged Manipulation of Appointment Cancellations at VA Medical Center Houston, Texas* (Report No. 15-03073-275, June 20, 2016). There were 223 appointments identified that were incorrectly recorded as patient cancellations during the July 2014 through June 2015 time frame. VHA's recorded wait times did not reflect the actual wait times experienced by the veterans and the wait time remained unreliable and understated. There were six recommendations, including provide training on when to use clinic versus patient cancellation options and how to identify the clinically indicated appointment date. OIG also recommended to improve scheduler audit processes to ensure that managers conduct a complete review of appointment data to ensure scheduling staff are using the correct cancellation type and clinically indicated or preferred appointment date.

In February 2016, OIG issued a report titled *Review of Alleged Patient Scheduling Issues at VA Medical Center Tampa, Florida* (Report No. 15-03026-101, February 5, 2016). It was substantiated that the James A. Haley Veterans' Hospital did not add all eligible veterans to the VCL when their scheduled appointment was greater than 30 days from their preferred date. There were five recommendations, including one for the responsible contracting officer to develop a mechanism to ensure the facility receives prompt notification of scheduled Choice appointments. OIG also recommended to ensure supervisors provide additional training to schedulers regarding the management of the VCL to ensure staff add all eligible veterans to the VCL in a timely manner and that veterans remain on the VCL.

Also in February 2016, OIG issued a report titled *Review of Alleged Untimely Care at the Community Based Outpatient Clinic Colorado Springs, CO* (Report 15-02472-46, February 4, 2016). The allegation was substantiated that the veteran, as well as other eligible Colorado Springs veterans, did not receive timely care in the six reviewed services. There were four recommendations. OIG recommended to ensure scheduling staff use the clinically indicated or preferred appointment dates when scheduling primary care patient appointments. In addition, OIG recommended to ensure that staff place all veterans with appointments occurring over 30 days after the clinically indicated or preferred appointment date on the VCL within one day of scheduling the appointment.

In 2015, OIG issued a report titled *Review of Allegations of Inappropriately Completed Consults and Inappropriate Bonuses at the St. Louis VA Health Care System* (Report No. 14-03434-530, September 29, 2015). The allegation was substantiated; the St. Louis VA Health Care System inappropriately changed the status of consults to "Complete" prior to the provider actually completing the appointment with the patient. There were two recommendations including to ensure scheduling staff receive appropriate training and guidance on proper consult management, as well as

to perform a follow-up analysis and regular oversight of completed consults to ensure consults are not designated as Complete before the provider sees the patient.

Also in 2015, OIG issued a report titled *Review of Alleged Mishandling of Ophthalmology Consults at the Oklahoma City, OK, VA Medical Center* (Report No. 15-02397-494, August 31, 2015). OIG substantiated that ophthalmology and teleretinal imaging staff, and referring providers, acted inappropriately on discontinued consults. Ophthalmology staff discontinued consults without adequate justification and often because they could not provide eye exams to the patients within 30 days. As a result of OIG's inquiries, VAMC leadership reviewed ophthalmology consults discontinued from January 1, 2014 through March 3, 2015 and identified issues with 439 of 1,937 consults. However, ophthalmology leadership did not provide sufficient oversight for processing consults and the VAMC did not have well-defined guidance to ensure staff took appropriate actions when processing consults. OIG recommended the Oklahoma City VAMC Interim Director take appropriate action on patients affected by ophthalmology and teleretinal imaging consults, as well as formalize guidance and train staff on processing consults.

In OIG's *Healthcare Inspection: Evaluation of the Veterans Health Administration's National Consult Delay Review and Associated Fact Sheet* (Report No. 14-04705-62, December 15, 2014), the OIG concluded that because VHA did not implement appropriate control activities, it lacked reasonable assurance that consults were appropriately reviewed and resolved. The OIG also concluded that consults were closed only after ensuring veterans had received the requested services, when appropriate, and, to the extent that consult delays contributed to harm to patients, those patients were notified as required by VHA policy. The OIG recommended that VHA conduct a systematic assessment of the processes each VA medical facility used to address unresolved consults during VHA's system-wide consult review. The OIG also recommended that VHA ensure that if a medical facility's processes are found to have been inconsistent with VHA guidance on addressing unresolved consults, action is taken to confirm patients received appropriate care.

Appendix I Scope and Methodology

Scope

We conducted our audit work from April 2016 through January 2017 to assess veterans' access to health care within VISN 6. Specifically we assessed access to care at VISN 6 medical facilities, access to care through Choice, and appropriate consult management. We analyzed completed VA appointments, created Choice authorizations, and discontinued and canceled consults. Appendix J provides details on our specific scope for each statistical sampling population. In addition, we analyzed consults that were open as of March 23, 2016.

During the audit, we conducted site visits to the seven VA medical facilities and five Health Care Centers in VISN 6 during May and June 2016.

Table 32. VISN 6 VA Medical Centers and Health Care Centers

VA Medical Facility	Location
Charles George VAMC	Asheville, NC
Charlotte Health Care Center	Charlotte, NC
Durham VAMC	Durham, NC
Fayetteville Health Care Center	Fayetteville, NC
Fayetteville VAMC	Fayetteville, NC
Greenville Health Care Center	Greenville, NC
Hampton VAMC	Hampton, VA
Hunter Holmes McGuire VAMC	Richmond, VA
Kernersville Health Care Center	Kernersville, NC
Salem VAMC	Salem, VA
W. G. (Bill) Hefner VAMC	Salisbury, NC
Wilmington Health Care Center	Wilmington, NC

Source: VA OIG

Methodology

To address our audit objectives, we reviewed applicable laws, regulations, policies, procedures, guidelines, and studies. Our review at VISN 6 included the following actions.

- We interviewed over 300 staff, most with direct knowledge and responsibility for patient scheduling and consult management. This included scheduling staff, supervisors, administrative officers, clinicians, chiefs of staff, and management staff. We also conducted interviews with VHA officials and VISN 6 staff.
- We reviewed a statistical sample of VA appointments, Choice authorizations, and consults from VISN 6 medical facilities. Specifically, we reviewed new patient completed appointments in Primary Care, Mental Health, and VHA's top 12 Specialty Care Clinics. VHA's top 12 Specialty Care Clinics in our audit, based on nationwide volume, were Physical Therapy, Cardiology, Audiology, Dermatology, Podiatry, Optometry, Orthopedics, Gastroenterology, Physical Medicine and Rehabilitation Service, Urology, Ophthalmology, and General Surgery. In addition, we reviewed patients authorized for Choice in Primary Care, Mental Health, and VHA's top 12 Specialty Care Clinics. We reviewed open consults (greater than 30 days), and discontinued and canceled consults in VHA's top 12 Specialty Care Clinics. During our site visits, we discussed our sample review results with medical facility staff assigned to assist us, whereby we received clarification on questions and potential issues.
- We conducted an electronic survey of nearly 700 schedulers across all medical facilities in VISN 6 regarding scheduling practices in order to identify potential inappropriate scheduling practices or direction.
- We reviewed prior reports relevant to our audit objectives.
- We identified deceased patients and those who experienced more significant delays in care from our sample cases and consulted with OIG's Office of Healthcare Inspections to determine if the patients received care in a timely fashion.

Fraud Assessment

The audit team assessed the risk that fraud, abuse, and violations of legal and regulatory requirements could occur during this audit. The audit team exercised due diligence in staying alert to any fraud indicators by:

- Performing an assessment to identify fraud indicators and the likelihood of their occurrence
- Interviewing VAMC staff concerning potential fraudulent activities within the scope of our objectives
- Reviewing survey results of nearly 700 schedulers across all medical facilities in VISN 6
- Considering risk factors such as outdated policies and procedures

We did not identify any instances of fraud during this audit.

Data Reliability

We relied on computer-processed data from VHA's Veteran Support Service Center (VSSC) Completed Cube, VA's Corporate Data Warehouse, VHA's VSSC VCL Report, and VHA's VSSC Consult Cube.

To assess the reliability of VSSC Completed Cube data, we compared details of the completed appointment data reported in the Completed Cube with completed appointment data of individual patient records in VHA's Computerized Patient Record System and VistA. To assess the reliability of the Corporate Data Warehouse and Health Net's data, we compared details of the Choice authorizations reported in the Corporate Data Warehouse and Health Net's data with Choice data of individual patient records in VHA's Computerized Patient Record System, Health Net, and the VCL. To assess the reliability of VSSC Consult Cube data, we compared details of the consult data reported in the Consult Cube with consult data of individual patient records in VHA's Computerized Patient Record System. To assess the reliability of VSSC VCL data, we compared details of the VCL data in the VCL report with VCL data of individual patient records in Veteran Health Information Systems and Technology Architecture. We concluded that the data we obtained and relied upon were sufficiently reliable for the purposes of this audit.

Government Standards

We conducted this performance audit in accordance with generally accepted government auditing standards. These 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 objective. The evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Appendix J Statistical Sampling Methodology

To determine whether VISN 6 provided veterans with timely access to health care, we selected a statistical sample of:

1. New patient appointments
2. Completed consults
3. Choice authorizations
4. Open consults
5. Discontinued and canceled consults

Figures and percentages have been rounded for reporting purposes. As a result, totals may not always sum due to rounding.

New Patient Appointments

Population

To determine whether VISN 6 provided timely access to health care at its medical facilities, we selected a statistical sample of completed new patient appointments for primary care and mental health care, and completed consults for specialty care. Our population consisted of 12,197 primary care appointments and 5,800 mental health care appointments completed in the first quarter of FY2016. Our population also included 67,971 specialty care consults created in first quarter of FY 2016 and completed as of March 23, 2016.

Our scope included only outpatient care; we excluded any care associated with Compensation & Pension exams because those types of appointments are used for veterans' benefits claims and not necessarily out of a demand for new care, resulting in an adjusted universe of 59,138 consults.

We selected only clinical consults because a clinical consultation requires a timely response from a medical professional regarding patient care. This would, therefore, exclude any consults that do not have a timeliness standard including prosthetics, grants, and e-consults (which are considered administrative consults).

We also replaced cases from the Hickory Community Based Outpatient Clinic because they were already established patients; this was an anomaly because the community based outpatient clinics transferred from one parent facility in the VISN to another so several established patients appeared to be "new" when they were not.

We also did not review cases that appeared to be in error, for example, cases with the wrong category of care.

Sampling Design

For new patient appointments and completed consults, we used a stratified random sample. From the population, we reviewed 210 primary care appointments, 210 mental health care appointments, and 210 specialty care consults. All records had a known chance of selection. This allowed us to make estimates over the entire population and by stratum.

Weights

We calculated estimates in this report using weighted sample data. Sampling weights were computed by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

Our review indicated VISN 6 medical facilities did not consistently provide timely access to health care for new patient appointments. We identified delays related to new patient appointments for primary care, mental health care, and specialty care. We estimated about 20,600 of 57,000 appointments (36 percent) had wait times greater than 30 days.

VA medical facility staff also did not consistently enter correct clinically indicated or preferred appointment dates correctly when scheduling appointments. Of the estimated 20,600 appointments with wait times greater than 30 days, staff entered incorrect clinically indicated or preferred appointment dates for 15,300 appointments (74 percent) that made it appear as though the wait time was 30 days or less. Furthermore, staff did not identify about 13,800 out of 15,300 veterans (90 percent) who should have been added to the VCL, which would have provided them with the option to receive care in the community through Choice.

The margins of error and confidence intervals are indicators of the precision of the estimates. If we repeated this audit with multiple samples, the confidence intervals would differ for each sample, but would include the true population value 90 percent of the time.

Table 33 presents the estimates over the sample population, including the sample results, estimate, margin of error, lower 90 percent value, and upper 90 percent value.

Table 33. Statistical Projections–New Patient Care

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Total number of new patient appointments for primary care, mental health care, and specialty care	618	57,016	3,304	53,713	60,320
Total number of new appointments with an OIG wait time greater than 30 days	164	20,616 (36.2%)	2,971 (4.6%)	17,645 (31.6%)	23,587 (40.8%)
For the above, average wait time	164	58.6	4.3	54.3	62.9
Total number of new appointments with a VA wait greater than 30 days	58	5,479 (9.6%)	1,486 (2.6%)	3,993 (7.0%)	6,965 (12.2%)
Total number (for the above OIG wait time) where staff entered incorrect clinically indicated or preferred appointment dates that made it appear as though the wait time was 30 days or less	107	15,267 (74.1%)	2,747 (6.7%)	12,520 (67.4%)	18,013 (80.8%)
Veterans (for the above) who should have been added to the VCL	100	13,815 (90.5%)	2,630 (6.5%)	11,186 (84.0%)	16,445 (97.0%)
Veterans where staff entered incorrect clinically indicated or preferred appointment dates that made it appear as though the wait time was 30 days or less but were added to the VCL	7	1,451 (9.5%)	1,026 (6.5%)	426 (3.0%)	2,477 (16.0%)
Total number of new primary care appointments	210	10,718	280	10,438	10,998
Total number of new primary care appointments with wait times greater than 30 days	60	3,508 (32.7%)	572 (5.3%)	2,936 (27.4%)	4,080 (38.0%)
For the above, average wait time	60	50.9 Days	5.5	45.4	56.4
Total number of new primary care appointments with a VA wait greater than 30 days	31	1,867 (17.4%)	466 (4.3%)	1,401 (13.1%)	2,333 (21.8%)

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Total number of new mental health care appointments	210	4,824	197	4,627	5,022
Total number of new mental health care appointments with wait times greater than 30 days	29	781 (16.2%)	214 (4.4%)	567 (11.8%)	995 (20.6%)
For the above, average wait time	29	59.4 days	8.2	51.2	67.6
Total number of new mental health care appointments with a VA wait greater than 30 days	9	256 (5.3%)	139 (2.9%)	117 (2.4%)	395 (8.2%)
Total number of new specialty care appointments	198	41,474	3,286	38,188	44,760
Total number of new specialty care appointments with wait times greater than 30 days	75	16,327 (39.4%)	2,907 (6.2%)	13,420 (33.2%)	19,235 (45.5%)
For the above, average wait time	75	60.2 days	5.2	55.0	65.4
Total number of new specialty care appointments with a VA wait greater than 30 days	18	3,357 (8.1%)	1,404 (3.3%)	1,952 (4.8%)	4,761 (11.4%)
Total number of new appointments where staff incorrectly recorded the clinically indicated or preferred appointment dates	396	41,913 (73.5%)	3,424 (3.8%)	38,489 (69.7%)	45,337 (77.3%)
For the above, VA-calculated wait time	396	9.2 days	2.0	7.1	11.2
For the above, OIG-determined wait time	396	34.3 days	3.3	31.0	37.6
For the above, difference in wait time	396	25.2 days	2.8	22.4	27.9
From the above, total number of new appointments where staff did not document the preferred appointment date in comments	310	32,094 (76.6%)	3,113 (4.3%)	28,981 (72.3%)	35,207 (80.9%)
From the above, total number of new appointments where staff did not record the clinically indicated date or documented preferred date in the preferred date field	253	33,364 (58.5%)	3,159 (4.2%)	30,205 (54.4%)	36,523 (62.7%)

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
From the above, total number of new appointments where staff entered preferred appointment dates in which there was no clinically indicated date or supported preferred date	143	8,549 (15.0%)	1,572 (2.7%)	6,977 (12.3%)	10,121 (17.7%)
Total number of new primary care appointments where staff incorrectly recorded the clinically indicated or preferred appointment dates	112	5,203 (48.5%)	592 (5.3%)	4,611 (43.3%)	5,795 (53.8%)
For the above, VA-calculated wait time	112	7.5 days	2.2	5.4	9.7
For the above, OIG-determined wait time	112	26.8 days	3.3	23.5	30.1
For the above, difference in wait time	112	19.3 days	3.3	16.0	22.6
Total number of new mental health care appointments where staff incorrectly recorded the clinically indicated or preferred appointment dates	119	2,718 (56.4%)	293 (5.8%)	2,426 (50.6%)	3,011 (62.1%)
For the above, VA-calculated wait time	119	6.1 days	2.1	4.0	8.1
For the above, OIG-determined wait time	119	25.6 days	4.2	21.3	29.8
For the above, difference in wait time	119	19.5 days	4.2	15.4	23.7
Total number of new specialty care appointments where staff incorrectly recorded the clinically indicated or preferred appointment dates	165	33,992 (82.0%)	3,360 (4.9%)	30,632 (77.0%)	37,352 (86.9%)
For the above, VA-calculated wait time	165	9.7 days	2.5	7.2	12.1
For the above, OIG-determined wait time	165	36.2 days	4.0	32.2	40.2
For the above, difference in wait time	165	26.5 days	3.3	23.2	29.9
Total number of completed specialty care consults where staff did not act upon received consults within 7 days	16	3,081 (7.1%)	1,354 (3.1%)	1,728 (4.0%)	4,435 (10.1%)

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
For the above, average days to act upon the received consults	16	14.7 days	3.6	11.1	18.2
Average days to schedule the received consults	210	9.6 days	1.4	8.2	11.0

Source: VA OIG analysis of statistical sample results projected over the sample population

Choice Authorizations

Population

To determine whether VISN 6 provided timely access to health care at its medical facilities, we selected a statistical sample of Choice authorizations for primary care, mental health care, and specialty care. Our population consisted of 1,079 primary care authorizations, 240 mental health care authorizations, and 34,771 specialty care authorizations created during the first quarter of FY 2016.

Sampling Design

For Choice authorizations, we used a stratified random sample based on the three types of care—primary care, mental health care, and specialty care—to select samples for each stratum. Although sample strata included eligibility for those who qualify based on the 40-mile criteria and the 30-day wait, the team decided to review only sample cases where veterans qualified for Choice based on having a wait of greater than 30 days. From the population, we removed invalid authorizations, such as those for an incorrect facility, incorrect service, or those with insufficient information available to review and randomly replaced invalid authorizations when additional items were available in the population, resulting in an adjusted universe of 34,237 authorizations. We reviewed 73 primary care authorizations, 106 mental health care authorizations, and 210 specialty care authorizations. All records had a known chance of selection. This allowed us to make estimates over the entire population and by stratum.

Weights

We calculated estimates in this report using weighted sample data. Sampling weights were computed by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

Table 34 presents estimates over the sample population, including the sample results, estimate, margin of error, lower 90 percent value, and upper 90 percent value.

Table 34. Statistical Projections–Choice Authorizations

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Total number of Choice Authorizations	389	34,237 (94.9%)	908	33,329	35,145
Of the above, number that VA facility staff did not provide a clinically indicated date	159	13,979 (40.8%)	2,119 (6.1%)	11,861 (34.7%)	16,098 (46.9%)
Of the above, number that VA facility staff did provide a clinically indicated date	230	20,258 (59.2%)	2,148 (6.1%)	18,110 (53.1%)	22,405 (65.3%)
Did not receive Choice appointment within 30 days of clinically indicated date	154	13,296 (65.6%)	1,969 (3.1%)	11,327 (62.5%)	15,265 (68.1%)
Total number of Choice authorizations not completed	161	11,758 (34.3%)	2,026 (5.8%)	9,733 (28.5%)	13,784 (40.2%)
Total number of Choice authorizations completed	228	22,479 (65.7 %)	2,066 (5.8 %)	20,413 (59.8 %)	24,545 (71.5 %)
For the above, average wait time until authorized	228	42.2 days	9.6	32.6	51.8
For the above, average wait time from authorization to appointment	228	42.0 days	4.6	37.3	46.6
For the above, overall average wait time	228	84.2 days	11.0	73.2	95.2
Total number of primary care Choice authorizations	73	850 (100%)	56	794	906

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Total number of primary care Choice authorizations not completed	37	466 (54.8%)	111 (12.4%)	355 (42.5%)	577 (67.2%)
Total number of primary care Choice authorizations completed	36	384 (45.2 %)	107 (12.4 %)	277 (32.8 %)	491 (57.5 %)
For the above, average wait time until authorized	36	9.6 days	8.9	0.7	18.6
For the above, average wait time from authorization to appointment	36	56.3 days	12.7	43.6	69.0
For the above, overall average wait time	36	65.9 days	13.7	52.2	79.7
Total number of mental health Choice authorizations	106	201 (100%)	11	191	212
Total number of mental health Choice authorizations not completed	56	102 (50.8%)	17 (8.0%)	85 (42.7%)	119 (58.8%)
Total number of mental health Choice authorizations completed	50	99 (49.2%)	17 (8.0%)	82 (41.2%)	116 (57.3%)
For the above, average wait time until authorized	50	36.5 days	10.7	25.9	47.0
For the above, average wait time from authorization to appointment	50	40.0 days	5.7	34.3	45.6
For the above, overall average wait time	50	77.0 days	12.4	64.6	89.5
Total specialty care Choice authorizations	210	33,186 (100%)	906	32,280	34,092

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Total number of specialty care Choice authorizations not completed	68	11,190 (33.7%)	2,022 (6.0%)	9,168 (27.7%)	13,212 (39.7%)
Total number of specialty care Choice authorizations completed	142	21,996 (66.3%)	2,063 (6.0%)	19,932 (60.3%)	24,059 (72.3%)
For the above, average wait time until authorized	142	42.8 days	9.8	33.0	52.6
For the above, average wait time from authorization to appointment	142	41.7 days	4.7	37.0	46.5
For the above, overall average wait time	142	84.5 days	11.2	73.3	95.8
Total number of Choice authorizations completed within 30 days	41	3,944 (17.5%)	1,379 (5.9%)	2,565 (11.6%)	5,323 (23.5%)
Total number of Choice authorizations not completed within 30 days	187	18,535 (82.5)	2,150 (5.9%)	16,385 (76.5%)	20,685 (88.4%)
Percent of primary care Choice authorizations completed within 30 days	10	16.2%	12.0%	4.2%	28.2%
Percent of mental health Choice authorizations completed within 30 days	9	19.1%	9.4%	9.8%	28.5%
Percent of specialty care Choice authorizations completed within 30 days	22	17.6%	6.1%	11.5%	23.6%

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Average total wait time for those veterans who waited over 30 days	187	98.0 days	11.6	86.4	109.6
Total number of Choice authorization completed within 30 days of CID	91	9,121 (32.5%)	1,869 (6.4%)	7,251 (26.1%)	10,990 (38.8%)
Percent of veterans who waited more than five business days for Health Net to create an appointment after they received an authorization	214	72.8%	6.2%	66.6%	79.1%
For the above, average business days after receiving the authorization for Health Net to create an appointment	214	24.7 days	3.3	21.4	28.0
Percent of veterans who waited more than five business days for Health Net to create an appointment after they received an authorization (during October 2015)	71	85.9%	7.3%	78.5%	93.2%
Percent of veterans who waited more than five business days for Health Net to create an appointment after they received an authorization (after October 2015)	89	69.4%	9.8%	59.6%	79.3%
Total number of veterans Health Net scheduled for a Choice appointment	292	28,159	1,743	26,415	29,902
For the above, veterans who did not receive the Choice appointment within 30 days of the clinically indicated date	201	18,975 (67.5%)	2,160 (6.4%)	16,815 (61.2%)	21,135 (73.9%)
Total contacted/ create dates recorded	287	26,968	1,831	25,137	28,800

Source: VA OIG analysis of statistical sample results projected over the sample population

Open Consults

Population

To determine whether VISN 6 timely completed new patients' appointments for consults at its medical facilities, we selected a statistical sample of open specialty care consults. Our population consisted of 21,960 open specialty care consults that were greater than 30 days old, as of March 23, 2016.

Sampling Design

We used a stratified random sample to select specialty care consults for review. From the population, we reviewed 210 specialty care consults. All records had a known chance of selection. This allowed us to make estimates over the entire population.

Weights

We calculated estimates in this report using weighted sample data. Sampling weights were computed by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

Our review indicated VISN 6 medical facility staff did not timely complete new patients' appointments for consults. Our review of 210 specialty care consults that were open greater than 30 days found that patients received the requested care for an estimated 41 percent of those consults at the time of our review in April and May 2016, and waited an average of 61 days for care. Patients had yet to receive care for the remaining consults because those patients were still waiting for their appointments (30 percent), or were waiting for future care appointments (10 percent) as of our review during April and May 2016, or staff discontinued or canceled the consults (18 percent).

In addition, VA medical facility staff also did not use the referring providers' clinically indicated date when scheduling appointments for consults of new patients. Staff entered incorrect clinically indicated or preferred appointment dates for an estimated 12,700 consults.

The margins of error and confidence intervals are indicators of the precision of the estimates. If we repeated this audit with multiple samples, the confidence intervals would differ for each sample, but would include the true population value 90 percent of the time.

Table 35 presents an estimate over the entire population, including the sample results, estimate, margin of error, lower 90 percent value, and upper 90 percent value.

Table 35. Statistical Projections–Open Consults

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Total number of open consults that were greater than 30 days old, as of March 23, 2016	210	21,960	112	21,848	22,072
Total number of open consults where patients received the requested care	94	8,983 (41.0%)	1,365 (6.0%)	7,618 (35.0%)	10,348 (47.0%)
For the above, average OIG-determined wait time	94	61.4 days	8.1	53.3	69.4
Total number of open consults where patients were waiting for the requested care (excluding future care consults)	59	6,685 (30.4%)	1,253 (5.7%)	5,432 (24.7%)	7,938 (36.2%)
For the above, average OIG-determined pending wait time	59	68.2 days	11.9	56.3	80.1
Total number of open consults where patients were waiting for future care consults	19	2,290 (10.4%)	787 (3.6%)	1,503 (6.8%)	3,077 (14.0%)
Total number of open consults that were discontinued or canceled at the time of our review	38	4,002 (18.2%)	1,074 (4.9%)	2,927 (13.3%)	5,076 (23.1%)
For the above, average time to close consult	38	108.7 days	20.7	88.0	129.4
Total number of open consults where staff entered a preferred date	160	15,083 (68.7%)	1,326 (6.0%)	13,757 (62.7%)	16,409 (74.7%)
Total number of open consults where staff entered a date that was later than the referring provider's clinically indicated date	134	12,667 (84.0%)	1,366 (5.4%)	11,301 (78.6%)	14,033 (89.4%)
For the above, average days beyond the referring provider's clinically indicated date	134	60.7 days	6.5	54.2	67.2
Total number of open consults where receiving provider noted a clinically indicated date different than the referring provider's clinically indicated date	34	3,375 (15.4%)	746 (3.4%)	2,629 (12.0%)	4,121 (18.8%)

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Total number of open consults where staff received consults	188	19,292	847	18,455	20,139
Average days to act upon the received consults	188	9.6 days	2.3	7.3	12.0
Total number of open consults where staff did not act upon received consults within 7 days	30	4,318 (22.4%)	1,086 (5.7%)	3,232 (16.7%)	5,403 (28.0%)
Average days to schedule the received consults	174	25.1 days	4.6	20.5	29.6

Source: VA OIG analysis of statistical sample results projected over the population

Discontinued and Canceled Consults

Population

To determine whether VISN 6 staff appropriately discontinued and canceled consults, we selected a statistical sample of discontinued and canceled specialty care consults. Our population consisted of 17,879 specialty care consults requested during the first quarter of FY 2016 that staff discontinued or canceled.

Sampling Design

We used a stratified random sample to select discontinued and canceled specialty care consults for review. From the population of discontinued and canceled specialty care consults, we reviewed 210 consults. All records had a known chance of selection. This allowed us to make estimates over the entire population.

Weights

We calculated estimates in this report using weighted sample data. Sampling weights were computed by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

Our review indicated VISN 6 medical facility staff inappropriately discontinued and canceled an estimated 4,600 of 17,900 (26 percent) of closed consults. For an estimated 3,100 of 4,600 consults (67 percent), patients had yet to receive the requested care as of our review. For an estimated 1,100 of 4,600 consults (24 percent), patients later received the requested care, but experienced additional delays. On average, these patients waited over 100 more days after staff inappropriately closed the consult. For an estimated 410 of 4,600 consults (9 percent), patients actually received the care at that time, but the consult was discontinued or canceled instead of appropriately completed.

The margins of error and confidence intervals are indicators of the precision of the estimates. If we repeated this audit with multiple samples, the confidence intervals would differ for each sample, but would include the true population value 90 percent of the time.

Table 36 presents an estimate over the entire population, including the sample results, estimate, margin of error, lower 90 percent value, and upper 90 percent value.

Table 36. Statistical Projections–Closed Consults

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Total number of consults that were requested during the first quarter of FY 2016 that staff discontinued or canceled	210	17,879	713	17,166	18,592
Total number of consults that were inappropriately discontinued or canceled	51	4,636 (25.9%)	1,029 (5.6%)	3,666 (20.6%)	5,607 (31.2%)
Of those consults inappropriately discontinued or canceled, total number of patients who had not received the requested care as of our review	35	3,111 (67.1%)	871 (10.8%)	2,288 (55.8%)	3,933 (78.4%)
Of those consults inappropriately discontinued or canceled, total number of patients who later received the requested care, but experienced additional delays	12	1,119 (24.1%)	589 (9.6%)	596 (13.9%)	1,641 (34.3%)
Of those consults inappropriately discontinued or canceled in which patients later received the requested care, average additional days waited	12	104.9 days	24.1	75.8	133.9
Of those consults inappropriately discontinued or canceled, total number of patients who actually received the requested care at that time	4	407 (8.8%)	426 (7.4%)	68 (1.6%)	746 (16.0%)

Source: VA OIG analysis of statistical sample results projected over the population

Appendix K Management Comments

Department of Veterans Affairs Memorandum

Date: February 8, 2017

From: Under Secretary for Health

Subj: OIG Draft Report, *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6* (7723666)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report, Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6. Because OIG uses a methodology to calculate wait times that is incongruent with Veterans Health Administration (VHA) policy, I cannot concur with some of the conclusions in this report nor use them for management decisions. I concur with recommendations 1, 4, 6 and 7. I concur in principle with recommendations 2, 3, 5, 8, 9 and 10. I provide action plans for all of the recommendations in the attachment to this memorandum.

2. I am primarily concerned that OIG used a criterion for determining whether schedulers had appropriately recorded a Veteran's preferred date for their appointment that is not required by our policies. This means the OIG finds our schedulers deficient at doing something that we do not require them to do. It also means the OIG ignored the dates patients told us they wanted to be seen, and selected an earlier date to use for calculating wait times. As a result, the wait times OIG calculates are longer than what VHA reports, simply because the OIG has discounted Veterans' preferred dates for appointments.

3. VHA believes it is very important to respect Veterans preferences for when they want to be seen. We want patients to be seen today if they want care today, and to be seen next week if they want care next week. We want patients to know that we are listening to them and we are trying to make VHA a place where they will get the quality care they want and need. In years gone by, when VHA assigned appointments to Veterans without asking them, Veterans frequently had to cancel or not come to the appointment because they had other plans. When a scheduler enters the patient's preferred date in the electronic data field, the scheduler has appropriately documented the Veterans preferred appointment date. No other documentation is required to prove that the scheduler correctly entered the Veterans preferred date.

4. On another note, I appreciate OIG's efforts to describe Veterans' overall experience with obtaining health care. It is clear that OIG shares VHA's concern and commitment to ensure Veterans have timely access to appropriate high quality health services. The OIG team identifies and makes recommendations for improvement in scheduling compliance, processes, and implementation of the Choice Program.

5. In early to mid-2016, the Department of Veterans Affairs (VA) initiated actions to address all three of the Choice-related third-party administrator recommendations made by OIG. VA believes that actions taken in 2016 fully meet the intention of the OIG recommendations and has therefore, requested closure of those three recommendations.

   (a) In June and July 2016, the Office of Community Care modified the Choice contract with Health Net and TriWest to clarify and improve performance related to appointment scheduling and the timeliness of returning authorizations.

   (b) The modification called for the scheduling of routine authorizations within 5 business days after the creation of the authorization for 95 percent of routine authorizations, with no more than 5 percent being able to be appointed up to the 10 business days. A standard for return of all routine authorizations not appointed was specified for within 10 business days.

   (c) The modification also required the third-party administrator to schedule urgent authorizations within 2 business days after the creation of the authorization and return of the urgent authorizations within 3 business days of the authorization creation.

(d) VA completed analysis of third-party administrator return authorization timeliness and appointment scheduling both before and after the contract modification to gauge its impact. By November 2016, we noted an overall improvement in third-party administrator performance relative to the revised standards. In conjunction with the third-party administrators, VA has also identified further activities that the third-party administrators will be taking in 2017 to drive additional improvements and ensure full compliance with the standards.

(e) Since the Choice contract origination in 2014, VA has worked to design and improve the monthly third-party administrator performance reporting format and its related data collection activities. During first quarter fiscal year 2016, VA expanded automation activities to support third-party administrator data validation and verification. Additional software was implemented by the third-party administrators in early 2016 to assist with identifying data inaccuracies, ensure the complete data set needed for performance reporting, and enable greater reporting consistency between the two Choice contractors. We will continue to aggressively pursue further improvements in 2017 that will give us more timely, accurate and complete visibility into third-party administrator performance. We have outlined several of these planned activities in our response.

6. VHA has made tremendous strides on management of urgent and routine care appointments since OIG conducted this review. In a dynamic environment, we are continuously working to improve access for Veterans. For example:

(a) VHA has focused on Veterans with the most urgent care needs. As of December 31, 2016, 166 of 166 medical centers across VHA implemented same day services in primary care and mental health when care was needed right away. VHA also reduced the number of more urgent referrals to specialists pending over 30 days from 57,000 in November 2015, to less than 300 as of January 2017. The average time for completion of these more urgent referrals is down to 5 days as of December 2016 when it was 39 days in early 2014.

(b) The percentage of Veterans new to Primary Care and Mental Health seen the same day as the request for an appointment was 22 percent and 30 percent respectively in December 2016, both improved when compared with data from early 2014 when the numbers were 18 percent and 26 percent respectively.

(c) VHA has provided approximately 12,000 more appointments within VHA each day compared with 2 years ago.

(d) VHA has expanded capacity by increasing the number of physicians and nurses by 12 percent and increasing efficiency by improving physician productivity by 16 percent over the past 2 years.

(e) VHA has worked to standardize processes by implementing a clinic management program modeled after private sector strong practices to oversee and optimize administrative clinic activities. Along these lines, VHA is also now providing standardized face to face training for all medical support assistants.

(f) VHA also has worked to ensure proper scheduling practices are occurring. In July 2016, updated, simplified scheduling requirements were published in a revised directive. Over 70,000 episodes of directive-related training for over 50,000 staff who schedule appointments was also completed. VHA monitors ongoing scheduling compliance two ways: first with a national “Scheduling Trigger Tool” - which uses internal data to uncover scheduling deficiencies and secondly VHA requires supervisors to perform scheduling audits twice annually with direct feedback and coaching for improvement for the individual schedulers.

7. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

(original signed by:)

David J. Shulkin, M.D.

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report: ***Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6***

Date of Draft Report: January 6, 2017

Recommendations/ Actions	Status	Completion Date

Recommendation 1: We recommended the Under Secretary for Health establish a method to monitor and ensure Veterans Integrated Service Network compliance with scheduling requirements.

VHA Comments: Concur

The Veterans Health Administration (VHA) has already established a method to monitor and ensure Veterans Integrated Service Network (VISN) compliance with scheduling requirements. VHA published updated scheduling requirements in the July 15, 2016 publication of VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*. Implementation of this directive included completion of over 71,000 training events by over 50,000 staff members. In order to assist leaders and managers in complying with scheduling policy, VHA created the Scheduling Trigger Tool to oversee scheduling compliance. This tool combines data from individual access measures in order to uncover issues with scheduling practices at all VA facilities. There are two composite scores, Data Integrity and Scheduling Compliance. The measures are displayed in Statistical Process Control Charts. These charts signal potential changes in scheduling practices that can impact clinic wait times. A set of triggers has been built to summarize data points that show special cause variations and non-random patterns. This trigger tool is available at the VISN and facility levels. The Office of Veterans Access to Care is updating the tool to align with the recently published scheduling policy.

In addition, VHA scheduling policy requires supervisors to perform scheduler audits bi-annually. VHA developed and piloted a Supervisory Appointment Tool to help VISNs conduct required audits. We collect information with the appointment tool that helps us evaluate our scheduling practices, even though not all of the information is required by policy. For example, the appointment tool collects optional comments that schedulers may have written when making appointments, despite the fact that policy does not require schedulers to enter comments related to the preferred date. In order to strengthen National and VISN oversight of the completion of scheduler audits, the Office of Veterans Access to Care will deploy the Supervisory Appointment Tool nationally.

When a scheduler enters the patient's preferred date in the electronic data field, the scheduler has appropriately documented the Veterans preferred appointment date. VHA policy does not require schedulers to enter any other comments or provide any other supporting documentation about the dates patients' prefer for their appointments. VHA finds OIG's audit standard of "supported preferred appointment dates" to be incongruent with VHA policy.

At completion of this action plan, the Office of Veterans Access to Care will provide OIG with the following documentation:

1) VHA Directive 1230: *Outpatient Scheduling Processes and Procedures.* VHA Directive 1230, published July 15, 2016. The published policy can be located at: www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3218
2) Updated Scheduling Trigger Tool data elements aligned with VHA's Directive 1230, *Outpatient Scheduling Processes and Procedures.*
3) Evidence that all VISNs are using the Supervisory Appointment Tool.

Status	Completion Date
In Progress	July 2017

Recommendation 2: We recommended the Director of Veterans Integrated Service Network 6 ensure that staff at all VA medical facilities use the referring provider's clinically indicated date, when available, or documented veteran's preferred appointment date, when scheduling new patient appointments.

VHA Comments: Concur in principle

VHA concurs in principle because we find this recommendation applies to all VISNs, and as such, will be addressed at the level of the national Office of Veterans Access to Care.

When a scheduler enters the patient's preferred date in the electronic data field, the scheduler has appropriately documented the Veterans preferred appointment date. VHA policy does not require schedulers to enter any other comments or provide any other supporting documentation about the dates patients' prefer for their appointments. VHA finds OIG's audit standard of "supported preferred appointment dates" to be incongruent with VHA policy.

VHA's Office of Veterans Access to Care (OVAC) published national policy on scheduling *(VHA Directive 1230: Outpatient Scheduling Processes and Procedures)* and on consult management *(VHA directive 1232: Consult Processes and Procedures).* These policies establish the national definition for "clinically indicated date (CID)*."* Implementation of the Scheduling Directive included completion of over 71,000 training events by over 50,000 staff members. These schedulers were trained on how to handle consult requests per the newly published consult directive in the scheduling training. Additionally, consult directive training is in progress for other groups. As of February 6, 2017, there are approximately 600 people trained. This includes the facility Group Practice Managers (GPM) and the facility points of contact. Training for the licensed Independent Practitioners and Residents are still in progress.

In order to ensure staff use the referring provider's CID, the Office of Veterans Access to Care will:

1.) Complete the training plan to implement VHA Directive 1232: *Consult Processes and Procedures.* There are four target audiences for standardized consult directive training: schedulers, GPMs, providers, and Consult Steering Committee members. Consult training for schedulers is part of the scheduler training addressed in recommendation 1. Training for GPMs, providers and Consult Steering Committee members is in various stages of development and deployment. VHA has already completed numerous training events addressing requirements established in the national consult directive. These include webinars in August and October 2016, Talent Management System modules, and weekly national Consult Performance Improvement calls attended by over 400 VISN and facility consult points of contact, facility Consult Steering Committee members, providers and GPMs.

2.) In order to strengthen National and VISN oversight of the completion of scheduler audits, the Office of Veterans Access to Care will deploy the Supervisory Appointment Tool nationally.

At completion of this action plan, VHA will provide OIG with the following documentation:

1) Evidence of completion of training for the scheduling policy and the consult policy.

2) Evidence that all VISNs are using the Supervisory Appointment Tool.

Status	Completion Date
In Progress	July 2017

Recommendation 3: We recommended the Director of Veterans Integrated Service Network 6 ensure VA medical facilities conduct required scheduler audits and take corrective actions as needed based on audit results.

VHA Comments: Concur in principle

VHA concurs in principle because we find this recommendation applies to all VISNs, and as such, will be addressed at the level of the national Office of Veterans Access to Care. VISN 6, as with all VISNs, will be using the Supervisory Appointment Tool when it is deployed nationally.

VHA scheduling policy requires supervisors to perform scheduling audits bi-annually. VHA developed and piloted a Supervisory Appointment Tool to help VISNs conduct required audits. The appointment tool allows supervisors to record audit activity, which includes oversight of scheduling requirements. We collect significant information with the appointment tool that helps us learn about our scheduling practices, but not all of the information is required by policy.

For example, the appointment tool collects optional comments that schedulers may have written when making appointments, but policy does not require schedulers to enter any comments. In order to strengthen national and VISN oversight of the completion of scheduler audits, the Office of Veterans Access to Care will deploy the Supervisory Appointment Tool nationally.

At completion of this action plan, VHA will provide OIG with the following documentation:

1) Evidence that all VISNs are using the Supervisory Appointment Tool.

Status	Completion Date
In Progress	July 2017

Recommendation 4: We recommended the Under Secretary for Health implement monitoring controls to ensure the third-party administrators return authorizations after 2 business days for urgent care and 5 business days for routine care if an appointment had not been scheduled.

VHA Comments: Concur

The action plan focuses on Health Net because it is the third-party administrator for VISN 6.

On June 1, 2016, VHA's Office of Community Care modified the Choice contract with the contractors to clarify and improve performance related to appointment scheduling and the timeliness of returning authorizations. This modification:

- Requires the contractor to schedule urgent authorizations within two business days after the creation of the authorization. If the contractor cannot schedule the care within 2 business days, the authorization shall be returned on the third business day.
- Enhances the routine authorization return process (with a further contract clarification made on July 21, 2016), requiring the contractor to schedule routine care within 5 business days after the creation of the authorization for 95 percent of these authorizations, with no more than 5 percent being able to be appointed up to 10 business days. The contractor will return all authorizations not appointed by the 10th business day. This enhancement requires the contractors to begin returning authorizations based on the timing limits placed on scheduling appointments; e.g., contractor given the variance (5 percent) to continue trying to schedule an appointment after five business days.

VHA monitored contractor performance for return authorization timeliness both before and after this contract modification to gauge its impact. By November 2016, across all VHA facilities that Health Net supports, their performance demonstrated a significant increase in the timeliness of returns for routine care -- from 31 percent to 76 percent post contract modification. However, in VISN 6 specifically, the timeliness of Health Net return authorizations for routine care, improved only slightly (from 32 percent to 34 percent returned within 10 days). In contrast, there was significant improvement in the timeliness of Health Net's VISN 6 return authorizations for urgent care -- from 34 percent to 45 percent returned within two days. However, for all facilities Health Net supports, their urgent care return authorization timeliness improved only slightly from 31 percent to 32 percent. The table provides Health Net performance results as of November 2016:

Health Net Return Authorizations

Routine authorization returns	VISN 6 Jan 2016-Jun 2016	VISN 6 Jul 2016-Nov 2016	HN All VISN's Jan 2016-Jun 2016	HN All VISN's Jul 2016-Nov 2016
0-9 days	32%	34%	31%	76%
Urgent authorization returns	VISN 6 Jan 2016-Jun 2016	VISN 6 Jul 2016-Nov 2016	HN All VISN's Jan 2016-Jun 2016	HN All VISN's Jul 2016-Nov 2016
0-2 days	34%	45%	31%	32%

During all of 2016, VHA has been regularly monitoring return authorization as well as scheduling timeliness as contractors submit monthly performance reports and as a part of formally conducted quarterly Performance Management Reviews (PMRs) held with them. These formal reviews are a key part of the controls that VHA has established to ensure contractor performance and compliance with contract standards and to discuss issues and opportunities for further improvements needed. During the December 2016 PMR, VHA and Health Net discussed return authorization performance and the additional actions that Health Net will take during 2017 to fully comply with the timeliness standards. VHA will work closely with Health Net as they implement the following improvements in their operations:

- Re-sequencing of those categories of care that require greater time to appoint within Health Net's work distribution tool (i.e. automating their distribution by prioritizing those first)
- Testing the use of Health Net specialized teams (segmenting that work outside of other categories) to expedite appointment scheduling
- Balancing workflow (controlling volume) and staffing of Health Net operations handling referrals, outbound calls and appointing
- Developing enhanced reporting tools that provider greater visibility into the aging process of VA authorizations submitted to Health Net and increasing Health Net workforce leaders' ability to dynamically shift work as necessary to ensure timeliness standards are met
- Creating Health Net system edits that enforce greater compliance around their appointing performance metrics.

VHA also plans to continue its efforts to aggressively drive towards further streamlining of the appointment scheduling and return authorization processes and the timeliness of these activities. As an example, VA is developing a contract modification to address the high volume of urgent authorizations that are not truly "urgent" per contract standards. This contract modification would add a priority between routine and stat (emergent care) thereby providing for truly urgent authorizations to be scheduled within 2 business days and allowing these non-urgent authorizations to be scheduled based on the clinically indicated date. This new priority category would also require scheduling before routine care, which has a 5 business day appointing standard. With this contract change, VA anticipates that the volume of "urgent" authorizations will decrease, therefore decreasing the number of related returns, and impacting on the timeliness of each.

Based on VHA's actions to-date to ensure the timely return of authorizations by third-party administrators, our current monitoring activities and controls surrounding the revised timeliness standards, the improvements in return authorization timeliness noted to-date, as well as the additional actions outlined to drive further timeliness improvements, VHA requests closure of this recommendation.

Status	Completion Date
Complete	January 2017

Recommendation 5: We recommended the Director of Veterans Integrated Service Network 6 ensure Non-VA Care Coordination staffing is sufficient to timely administer the requirements of the Choice Program.

VHA Comments: Concur in principle

VHA concurs in principal because there are many factors that influence timely administration of the Choice Program. We agree that staffing levels have not always matched the rapidly changing workload requirements in the Choice Program in VISN 6. Since the OIG's audit last year, when staffing levels were lower than needed, levels have increased within VHA's facilities. VISN 6 will review whether staffing levels are a contributing factor currently in administering the requirements of the Choice Program at VISN 6.

Status	Target Completion Date
In Progress	July 2017

Recommendation 6: We recommended the Under Secretary for Health implement controls to ensure the third party administrators create an appointment for the veteran within 5 business days of receiving an authorization.

VHA Comments: Concur

The action plan focuses on Health Net because it is the third-party administrator for VISN 6.

The Choice contract modification made on June 1, 2016, and amended in July 2016, revised processing standards for appointment scheduling. These changes require the contractor to schedule care for routine authorizations within 5 business days after the creation of the authorization for 95 percent of these authorizations, with no more than five percent being able to be appointed up to the 10th business day. For urgent appointment scheduling, the contractor is required to schedule these within 2 business days after the creation of the authorization.

VA has analyzed contractor performance for appointment scheduling timeliness both before and after this contract modification to gauge its impact. By November 2016, we noted incremental improvement in Health Net appointment scheduling performance towards the standards set for routine and urgent appointing. In VISN 6 specifically, Health Net routine appointment timeliness increased by 16 percent from pre contract modification levels. Health Net performance across the board increased for routine care scheduling by 14 percent from pre contract modification levels. In the month of November 2016, Health Net also obtained an all-time high of appointing 92.48 percent, of routine care authorizations within 5 business days, just 2.52 percent below revised 95 percent contract standard. For urgent care appointing, Health Net showed only slight improvement in VISN 6 related appointments, while showing a more significant improvement for all VISNs it supported.

Health Net Appointment Scheduling Timeliness

Appointment Type	January – June, 2016	July – November, 2016
Routine:		
VISN 6	63%	79%
All VISNs	73.52%	87.31%*
Urgent:		
VISN 6	76%	77%
All VISNs	51.83%	71.14%

** all-time high performance for November, 2016 of 92.48%*

VHA will continue closely monitoring the timeliness of appointment scheduling. The VHA Office of Community Care now conducts a formalized quarterly Performance Management Reviews (PMR) as part of the overall oversight of the Choice contract. These reviews are a key part of the controls that VHA has established to ensure contractors' performance and compliance with contract standards. During 2016, these reviews covered appointment and return authorization performance as well as confirmed the accuracy and timeliness of performance data received from the contractors. When contractor performance was not within standard, the Office of Community Care issued letters of correction to the contractor. In the December 2016 PMR, it was noted that should Health Net not continue to show improvement towards the 95 percent appointing standard for routine care and/or not meet urgent care standards, VHA will issue a Letter of Correction which will require that Health Net outline their corrective actions to address the deficiency. Further, VHA will assess whether monetary equitable adjustments are needed.

Based on VHA's actions to revise and clarify timeliness standards for routine and urgent care appointing, as well as current monitoring activities designed to ensure that these standards are complied with, VHA requests closure of this recommendation.

Status	Completion Date
Complete	January 2017

Recommendation 7: We recommended the Under Secretary for Health to ensure all data required to manage the third party administrator contracts provided by the VA and the third party administrators is complete, accurate, and timely.

VHA Comments: Concur

The action plan focuses on Health Net because it is the third-party administrator for VISN 6.

The Choice contract requires the contractors provide VHA with a monthly performance report, to include the contract's Quality Assurance Surveillance Plan (QASP) elements. The reports are then used as the basis for performance discussions during the VHA quarterly Performance Management Reviews (PMR). PMR discussions not only cover contractor performance and compliance with contract standards and provisions, but confirm the accuracy, completeness and timeliness of performance data required from the contractor. During the early part of FY16, PMR discussions around data quality and timeliness led to VA issuing two Letters of Corrections (LOCs) that required contractor's corrective actions. VHA received the corrective action plans for these issues and as of June 1, 2016, both LOCs had been remedied. During the most recent PMR conducted in December 2016, no performance data related issues were identified.

Since the Choice contract origination in 2014, VA has worked to design and improve the monthly contractor performance reporting format and its related data collection activities. During first quarter FY2016, VA expanded automation activities to support data contractor quality, validation and verification. Additional software was implemented by the contractors to assist with identifying data inaccuracies before submission to VA, to ensure the complete data set needed for performance reporting, and to enable greater reporting consistency between the two Choice contractors. This "Data Tracker" Tool incorporates automated data checks for each performance report field and includes filters to automatically calculate and report performance levels. The tool has improved the data collection process and overall third-party administrator data accuracy and integrity. It has improved the consistency of reporting. In turn, this has led to more timely validation of contractor's reports and improved quality of the data used during the PMR process and performance discussions.

VHA aggressively pursues further improvements in 2017 that will give the VHA more timely, accurate and complete visibility into contractor performance. Weekly discussions between VHA and the contractors, called "Round Tables," which began in September 2016, as well as VHA internally staffed "portfolio" teams initiated in early 2016 have surfaced improvements for referral, appointing and care coordination processes and data. The three major categories that these discussions have focused on relate to: 1) policy and process enhancements, 2) scaling of existing technological efficiency enhancements to address data collection, reporting and sharing of information and 3) recommended contract enhancements for third-party administrator performance improvement.

VHA requests closure of this recommendation as VHA has implemented controls as well as activities to ensure the completeness, accuracy and timeliness of contractor performance data, with additional activities planned to continue improvements to data quality and integrity.

Status	Completion Date
Complete	January 2017

Recommendation 8: We recommended the Director of Veterans Integrated Service Network 6 ensure services monitor and timely address consults pending greater than 7 days.

VHA Comments: Concur in principle

VHA concurs in principle because some consults, by policy, are permitted to remain pending greater than 7 days, and are thus exempt from this recommendation. The seven day standard does not apply to future care consults. These are situations where the provider intentionally requested care that needs to occur at least 90 days in the future. For example, a provider may start a patient on a new treatment or medicine that the patient needs to take for three months before the specialist can evaluate the patient. In these cases, rushing an appointment by taking actions in seven days could result in an unnecessary clinic visit, a repeat consultation, and inconvenience to the patient. VHA's policy exempts future care consults, as follows: Consults should remain in PENDING status no more than 7 calendar days from the consult creation date. Prosthetics consults and future care consults are exceptions and may remain PENDING for longer than 7 calendar days. Prosthetics consults are exempt because they are handled through different software package that does not accommodate changing the status from "Pending," thus the 7 day calendar tracking doesn't apply.

For those consults to which this recommendation applies, VISN 6 will use existing national reports, including the consult trigger tool and consult cube to examine and improve performance in services where non-future care or prosthetics consults are pending greater than seven days.

Status	Target Completion Date
In Progress	July 2017

Recommendation 9: We recommended the Director of Veterans Integrated Service Network 6 identify and implement best practices to timely schedule appointments for consults upon receipt and review by the receiving specialty care clinicians.

VHA Comments: Concur in principle

VHA concurs in principle because, while there are strong practices that may apply in some settings, a proven standard set of scheduling best practices that apply to all settings does not exist in the health care industry. Local practices tips should not be considered universal "best practices" and VISN 6 should not blindly require all facilities to use them, as they may not be effective in all settings. VHA appreciates that local scheduling services strive to build high performing teams that may be more efficient or effective than services where teams are still forming and whose practices are still norming. Sometimes high performing teams develop practice tips that help them perform optimally. In this report, OIG observed some facilities had higher performing teams than other facilities, and some of them used practice tips that may have helped them be more efficient. To address OIG's recommendation regarding cross sharing of practice tips among facilities, the VISN 6 Director will assess whether any local practice tips should be adopted by other facilities in the VISN, and institute a process for facilities to voluntarily share practice tips, and for facilities to trial and report on effectiveness of using each other's practice tips.

At completion of this action plan, the VISN 6 Director will provide documentation of:

1. The process for VISN 6 facilities to share practice tips for effective and efficient scheduling, and the process for facilities to trial and report on practice tips with each other.
2. The VISN 6 assessment of whether a local practice tip should be adopted across all facilities in the VISN.

Status	Target Completion Date
In Progress	July 2017

Recommendation 10: We recommended the Director of Veterans Integrated Service Network 6 establish a mechanism to routinely audit closed consults to ensure they are in accordance with Veterans Health Administration consult business rules, and take corrective actions as needed based on audit results.

VHA Comments: Concur in principle

VHA concurs in principle because VHA has already established a mechanism for routinely auditing closed consults that requires participation by all VISNs. VISN 6 will follow the mechanism and routinely audit closed consults to ensure they are in accordance with VHA consult business rules and take corrective actions as needed based on audit results.

Two quarterly audits have been conducted. Results of both audit quarters will be provided to VISN 6 in a single report. VISN 6 will develop and implement corrective actions.

At completion of this action, the VISN 6 Director will provide OIG with the following documentation:

1. Results of two completed audit quarters
2. Corrective action plans for audit results that require improvement
3. Evidence of corrective action implementation

Status	Target Completion Date
In Progress	July 2017

For accessibility, the format of the documents presented in this attachment was modified to fit in this document.

Appendix L OIG Contact and Staff Acknowledgments

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