Department of Veterans Affairs

Office of Inspector General

Audit of Veterans Health Administration's Reported Medical Care Waiting Lists

VHA can improve the accuracy of reported waiting lists.

Report No. 02-02129-95 **May 14, 2003**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

Introduction

The purpose of the audit was to verify the accuracy of the Veterans Health Administration's (VHA's) reported medical care waiting lists and determine the causes of any inaccuracies found.

Our audit focused on the number of veterans reported on waiting lists (new enrollees and established patients) as of July 15, 2002. We tested the waiting lists by reviewing statistical samples from two Department of Veterans Affairs (VA) Veterans Integrated Service Networks (VISNs). VISN 8 (VA Sunshine Healthcare Network, Bay Pines, FL) and VISN 15 (VA Heartland Network, Kansas City, MO) reported 59,947 veterans on their waiting lists, which was about 19 percent of the 309,186 veterans reported for all VISNs. We tested a sample of 303 veterans reported as new enrollees[1] by VISN 8 and a sample of 252 veterans reported as new enrollees by VISN 15. We also tested a sample of 302 veterans reported as established patients by VISN 8 and a sample of 286 veterans reported as established patients by VISN 15. Further, we contacted the other 20 VISNs and obtained pertinent information regarding their reported waiting lists.

Audit Results

We found that the waiting lists reported for the two VISNs were not accurate. Our review of the new enrollee waiting lists showed that 42 of 303 veterans (14 percent) in VISN 8, and 85 of 252 veterans (34 percent) in VISN 15, should not have been included on the waiting lists. We projected at a 99 percent confidence level that the new enrollee waiting lists for the 2 VISNs were overstated by 4,323 (VISN 8) and 483 (VISN 15) veterans, respectively. Our samples of veterans reported on the established patient waiting lists showed that 127 of 302 veterans (42 percent) in VISN 8, and 155 of 286 veterans (54 percent) in VISN 15, should not have been included on the waiting lists. We projected at a 99 percent confidence level that the established patient waiting lists for the 2 VISNs were overstated by 9,569 and 2,476 veterans, respectively.

The 2 VISNs also erroneously included 44 of 303 veterans (15 percent) in VISN 8, and 66 of 252 veterans (26 percent) in VISN 15, on the new enrollee waiting lists rather than the established patients waiting lists. These veterans had prior visits for VA medical care in the past 24 months. We projected at a 99 percent confidence level that the misclassification resulted in overstating the new enrollee waiting lists and understating the established patients waiting list for the 2 VISNs by 4,529 veterans and 375 veterans, respectively.

[1] VHA staff summarized the reported waiting lists into two categories: (i) the number of new enrollees (veterans who had completed the enrollment process and were waiting for their first clinic appointments to be scheduled) and (ii) the number of established patients (veterans waiting to be scheduled for follow-up care and all veterans who wanted appointments as soon as possible but were scheduled for appointments more than 6 months in the future).

The inaccuracies occurred because appointment schedulers did not update the waiting lists as veterans received appointments or medical care, and they did not enter follow-up appointments appropriately into the Veterans Health Information Systems and Technology Architecture (VistA) scheduling package. Many of the inappropriately scheduled follow-up appointments resulted because the clinic providers did not clearly specify when the veterans should return for their next visits. In addition, some veterans waiting 6 months or more for appointments were inappropriately included because of data entry errors made by appointment schedulers and software problems (FileMan[2]) that resulted in data collection errors.

Based on our sample results from the 2 VISNs, we estimated that the reported nationwide new enrollee waiting list of 155,003 veterans was overstated by about 23,000 veterans (4,806 error cases/32,623 total cases=15 percent x 155,003) and about 23,000 veterans (4,904 error cases/32,623 total cases=15 percent x 155,003) who were misclassified and should have been on the established patient waiting lists. Accordingly, the number of new enrollees reported should have been about 109,000 veterans (155,003 less 46,000 overstated and misclassified).

The nationwide established patient waiting list of 154,183 veterans was overstated by about 68,000 veterans (12,045 error cases/27,324 total cases=44 percent x 154,183) and understated by the 23,000 veterans who were misclassified and erroneously reported on the new enrollee waiting lists. Accordingly, the number of veterans on the established patient waiting lists should have been about 109,000 veterans (154,183 less 68,000 overstated plus 23,000 misclassified). The total waiting list of 309,186 veterans should have been about 218,000 veterans, or 91,000 veterans (29 percent) less than reported.

VHA facility and VISN staffs reviewed the sample cases that we identified and agreed that the veterans should not have been on the waiting lists. Also, while we specifically sampled cases from VISNs 8 and 15, we contacted representatives from each of the remaining 20 VISNs who were responsible for compiling the waiting lists. They all agreed that their reported waiting lists were similarly overstated and estimated that the overstatements ranged from 10 to 80 percent.

VHA managers recognized the need to improve the accuracy of tracking patients who were on waiting lists. In response, they began taking corrective action during our audit and plan to develop a nationwide electronic waiting list. The initial step in this process was the introduction in December 2002 of new software that allows schedulers to enter patients into a facility electronic waiting list through VistA. Future development of the waiting list software in 2003 will include a nationwide rollup of the waiting lists at the facilities into the National Patient Care Database.

It is important that the waiting list data be accurate because VHA uses the data in planning budget priorities, measuring performance, and determining whether strategic goals are met. Inaccurate waiting lists compromise the ability to assess and manage demand and the credibility of VHA responses to internal and external stakeholder concerns.

[2] FileMan is computer database software used to organize and manage VistA records.

Recommendations

We recommended that the Under Secretary for Health take the following actions to improve the accuracy of the waiting lists:

1. Provide refresher training for staff using the VistA scheduling package, to include the need to frequently update waiting list names and to enter follow-up appointments (intended to be 6 or more months in the future) correctly in the scheduling package. Also, provide direction to healthcare providers to specify in the electronic progress notes in VistA when they want the veterans to be scheduled for their next appointments.

2. Update the FileMan routine so that it does not include veterans appropriately scheduled (either those scheduled within 6 months or those scheduled intentionally for more than 6 months in the future and entered appropriately into the scheduling package), erroneous appointments, duplicate names, or cancelled appointments on the waiting lists.

3. Expedite the implementation and monitor the accuracy of the Electronic Waiting List (EWL) software.

The Under Secretary for Health agreed with the findings and recommendations and provided acceptable implementation plans. We consider all issues resolved. However, we will follow up on planned actions until they are completed.

(original signed by Deputy Assistant Inspector General for Auditing: John S. Bilobran)
MICHAEL SLACHTA, JR.
Assistant Inspector General for Auditing

Results and Recommendations

The Veterans Health Administration Can Improve the Accuracy of Reported Medical Care Waiting Lists

Introduction

Beginning July 15, 2002, VHA began summarizing the reported waiting lists into two categories: (i) the number of new enrollees and (ii) the number of established patients. The July 15, 2002, nationwide waiting lists for new enrollees numbered 155,003 veterans and for established patients numbered 154,183 veterans, for a total of 309,186 veterans.

We reviewed samples of the July 15, 2002, waiting lists reported by VISNs 8 and 15 to determine whether the numbers reported were accurate. VISNs 8 and 15 reported 59,947 veterans on waiting lists, which was 19 percent of the 309,186 veterans reported for all VISNs.

We tested a sample of 303 veterans reported as new enrollees by VISN 8 and a sample of 252 veterans reported as new enrollees by VISN 15. We also tested a sample of 302 veterans reported as established patients by VISN 8 and a sample of 286 veterans reported as established patients by VISN 15. The four samples revealed that the reported waiting lists were overstated because facilities included veterans who did not belong on the lists or were misclassified.

Audit Results

Facilities Overstated the Number of New Enrollees on the Waiting Lists

Some of the veterans reported as new enrollees waiting for their first clinic appointments did not belong on the waiting lists. These patients (i) already had appointments scheduled within 6 months, (ii) did not desire VA care, (iii) had moved out of the VISN service area or died, or (iv) had not completed the enrollment process by July 15, 2002.

- VISN 8 reported 31,190 new enrollees on the waiting lists, but 42 of the 303 (14 percent) veterans we tested in our sample should not have been on the lists. We projected at a 99 percent confidence level that VISN 8's new enrollee waiting lists were overstated by 4,323 (14 percent x 31,190).

- VISN 15 reported 1,433 new enrollees on the waiting lists, but 85 of the 252 (34 percent) veterans we tested in our sample should not have been on the lists. We projected at a 99 percent confidence level that VISN 15's new enrollee waiting lists were overstated by 483 (34 percent x 1,433).

The 127 veterans should not have been on the waiting lists for the following reasons:

- 102 veterans had received medical care or had been scheduled for appointments within 6 months, but facility staff did not remove their names from the waiting lists.
- 18 veterans only wanted to enroll in the VA system for possible future medical care and did not desire appointments.
- 3 veterans moved out of the VISNs' service areas or died.
- 4 veterans had not completed the enrollment process, so were not yet eligible for appointments.

(See Appendix C on page 10 for further explanation of the causes of new enrollee waiting list overstatement.)

Based on our projections for the 2 VISNs, we estimated that the nationwide new enrollee waiting list of 155,003 veterans was overstated by about 23,000 (4,806 error cases/32,623 total cases=15 percent x 155,003).

Facilities Also Overstated the Number of Established Patients on the Waiting Lists

Many of the veterans reported as established patients waiting to be scheduled for primary care or specialty care clinic appointments, or waiting more than 6 months for scheduled appointments, did not belong on the waiting lists. These veterans already had appointments scheduled within 6 months, did not need appointments within 6 months, or moved out of the VISNs' service areas or died.

- VISN 8 reported 22,755 established patients on the waiting lists. We tested 302 veterans in our sample and found that 127 (42 percent) should not have been on the lists. We projected at a 99 percent confidence level that VISN 8's established patient waiting list was overstated by 9,569 (42 percent x 22,755).
- VISN 15 reported 4,569 established patients on the waiting lists. We tested 286 veterans in our sample and found that 155 (54 percent) should not have been on the lists. We projected at a 99 percent confidence level that VISN 15's established patient waiting list was overstated by 2,476 (54 percent x 4,569).

The 282 veterans should not have been on the waiting lists for the following reasons:

- 179 veterans had follow-up appointments intentionally scheduled more than 6 months in the future; therefore, there were no delays in providing medical care. For example, the health care provider wanted a veteran to return in 9 months. If the scheduler entered the appointment correctly into the VistA scheduling package, it would show that the veteran was scheduled when the provider intended. This appointment was entered incorrectly, and, as a

result, it showed that the veteran wanted an immediate appointment, but had to wait 9 months before he could be scheduled for an appointment.

- 33 veterans' appointments had already occurred prior to July 15, 2002, but their names were not removed from the waiting lists.

- 4 veterans moved out of the VISNs' service areas or died.

- 5 veterans repeatedly cancelled or did not show up for appointments. VISN and facility staff agreed that these veterans should be contacted to determine whether they desired further VA medical care.

- 25 veterans had follow-up appointments appropriately scheduled more than 6 months in the future and the schedulers entered the appointments correctly, but the FileMan routine erroneously included them on the waiting lists.

- 13 veterans had follow-up appointments scheduled within 6 months.

- 10 misidentified appointments did not represent veterans waiting for outpatient medical care.[3] The appointments had no identifying information such as veterans' names and social security numbers.

- 13 veterans cancelled appointments prior to July 15, 2002, but the FileMan routine erroneously included them on the waiting lists.

Overstatements described in the first four bullets above resulted from appointment or data entry errors, while overstatements described in the last four bullets resulted from data collection errors that occurred when the FileMan routine was applied to VistA records.

(See Appendix C on pages 10-12 for further explanation of the causes of established patient waiting list overstatement.)

Based on our projections for the 2 VISNs, we estimated that the nationwide established patient waiting list of 154,183 veterans was overstated by about 68,000 (12,045 error cases/27,324 total cases=44 percent x 154,183).

(See Appendix D on pages 13-15 for a description of our sample methodology and results.)

[3] The waiting list survey included only those veterans who were waiting for outpatient medical care in one of the primary care clinics or in one of five major specialty care clinics – Cardiology, Urology, Orthopedics, Audiology, and Eye Care (Optometry and Ophthalmology), which represent approximately 80 percent of VA's outpatient workload.

Veterans on the New Enrollee Waiting Lists Should Have Been on the Established Patient Waiting Lists

Significant numbers of veterans reported on the new enrollee waiting lists were misclassified since they received prior VA medical care at least once in the past 24 months. These veterans should have been reported on the established patient waiting lists. Some of the facilities included everyone not assigned to primary care panels as new enrollees when they were already established patients in specialty care clinics or at other VHA facilities.

- At VISN 8, we found that 44 of the 303 (15 percent) veterans that we tested in our sample were misclassified. We projected at a 99 percent confidence level that 4,529 (15 percent x 31,190) VISN 8 veterans should have been on the established patient waiting lists.

- At VISN 15, we found that 66 of the 252 (26 percent) veterans that we tested in our sample were misclassified. We projected at a 99 percent confidence level that 375 (26 percent x 1,433) VISN 15 veterans should have been on the established patient waiting lists.

Based on our projections for the 2 VISNs, we estimated that nationwide a total of about 23,000 veterans (4,904 error cases/32,623 total cases=15 percent x 155,003) were misclassified and should have been on the established patient waiting lists rather than the new enrollee waiting lists.

VHA Staff Agreed with Our Findings

VHA staff from the facilities and VISNs reviewed the sample cases that we believed should not have been on the waiting lists, and they agreed with our findings. Although we only sampled cases from VISNs 8 and 15, we contacted all of the other VISN representatives responsible for compiling the waiting lists. They all agreed that they experienced similar error rates in their reporting of waiting list numbers.

VISN staff reported that schedulers encountered difficulty determining when to schedule veterans for future appointments. Many of the inappropriately scheduled follow-up appointments resulted because the clinic providers did not clearly specify when the veterans should return for their next visits. When providers only directed that veterans were to return as needed, or to return on a routine basis, schedulers frequently entered follow-up appointments inappropriately into the VistA scheduling package. Since the schedulers did not have specific timeframes to determine when the providers wanted the veterans to return, they entered the appointments without specifying desired future dates and set the appointments for many months in the future. As a result, the software calculated the waiting times as the entire time from the current dates to the dates of the next appointments, rather than calculating the waiting times from the dates the veterans should have been scheduled to the dates that the appointments were actually scheduled.

Those facilities that reviewed some or all of the veterans identified with the FileMan routine found errors ranging from 10 to 80 percent. They described the same reasons for these errors as

those we identified in our sample reviews: (i) follow-up appointments entered incorrectly in the VistA scheduling package; (ii) inclusion of veterans appropriately scheduled (either those scheduled intentionally for more than 6 months in the future or those scheduled within 6 months); and (iii) erroneous appointments, duplicate names, or cancelled appointments on the waiting lists. They also noted that much of the data was compiled manually, which also contributed to the inaccuracies.

Causes for Overstatement of the Waiting Lists

The number of veterans reported on medical care waiting lists was significantly overstated for the following reasons:

- Veteran names were not removed from the waiting lists when they received appointments, received medical care, or no longer needed appointments.

- The schedulers entered follow-up appointments, which were intended to be scheduled more than 6 months in the future, inappropriately in the VistA scheduling package as described in the example at the bottom of page 2 or because healthcare providers did not clearly specify when the veterans should return for their next visits.

- The FileMan routine overstated the number of veterans waiting 6 months or more for appointments because it included veterans appropriately scheduled (either those scheduled within 6 months or those scheduled intentionally for more than 6 months in the future, and the scheduler entered the data appropriately into the scheduling package), erroneous appointments, duplicate names, or cancelled appointments.

Corrective Action Taken by VHA Managers

When we discussed the results of our review, VHA management recognized the need to improve the accuracy of tracking veterans who were on waiting lists. They provided VISN representatives with continual updates to the FileMan routine in an effort to improve the accuracy of the data collection. They also plan to develop a nationwide electronic waiting list. The initial step in this process was the introduction in December 2002 of new software that allows schedulers to enter veterans into a facility electronic waiting list through VistA. Future development of the waiting list software in 2003 will include a nationwide rollup of veterans on the list into the National Patient Care Database. A nationwide electronic waiting list will help to identify veterans in need of appointments, to manage veterans' access to outpatient care, and to aid in assessing the demand for medical services at VA medical centers (VAMCs).

Conclusion

It is important that the patient waiting list data be accurate because VHA uses the information in planning budget priorities, measuring performance, and determining whether strategic goals are met. Inaccurate patient waiting lists compromise VHA's ability to assess and manage demand.

Based on the results of our samples from VISNs 8 and 15, we estimated that the nationwide new enrollee waiting list of 155,003 veterans should have been about 109,000 (155,003 less 23,000 overstated and less 23,000 misclassified). The nationwide established patient waiting list of 154,183 veterans should have been about 109,000 (154,183 less 68,000 overstated plus 23,000 misclassified). Accordingly, the total waiting list of 309,186 should have been about 218,000 or 91,000 less than reported.

For More Information

- Background information is discussed in Appendix A, page 8.
- The audit objectives, scope, and methodology are discussed in Appendix B, page 9.
- More detailed information on the causes of the overstatement of new enrollees and established patients on the waiting lists is provided in Appendix C, pages 10-12.
- The audit sampling methodology and results are discussed in Appendix D, pages 13-15.

Recommendations

We recommended that the Under Secretary for Health take the following actions to improve the accuracy of the waiting lists:

1. Provide refresher training for staff using the VistA scheduling package, to include the need to frequently update waiting list names and to enter follow-up appointments (intended to be 6 or more months in the future) correctly in the scheduling package. Also, provide direction to healthcare providers to specify in the electronic progress notes in VistA when they want the veterans to be scheduled for their next appointments.

2. Update the FileMan routine so that it does not include veterans appropriately scheduled (either those scheduled within 6 months or those scheduled intentionally for more than 6 months in the future and entered appropriately into the scheduling package), erroneous appointments, duplicate names, or cancelled appointments on the waiting lists.

3. Expedite the implementation and monitor the accuracy of the EWL software.

Under Secretary for Health's Comments

1. Concur. Training material on both the EWL and the scheduling software has been provided to all sites. The WebEx (EWL) training for the VISNs took place October 15th through the 31st, 2002. Ongoing training is available to all employees on the VistA University website. User reference cards were also mailed to each VAMC. The Office of Information, with VISN 18, is also currently developing a training video that reviews the EWL functionality and appointment wait time management. Monitoring of the use of the EWL and scheduling

applications is done locally and through analysis of the data at VAMC, VISN and national levels.

Currently, physicians communicate the request to schedule the next appointment in a variety of ways, including text orders in Computerized Patient Record System (CPRS) and annotations on the encounter form. Re-engineered CPRS, scheduled for roll out in March 2005, together with the new scheduling software, scheduled for national release in FY 2006, will allow the provider direct interaction with scheduling software.

2. Concur. A developer is working to define requirements to improve functionality of FileMan routines in relation to this issue. Once the requirements are defined, we will provide an estimated date for delivery.

3. Concur. The EWL software supplements the VistA Scheduling Software. A project team has been established to work in developing additional requirements for EWL. As requirements are defined, patches to VistA will be developed and released nationally. Ultimately, full EWL functionality will be included in the Scheduling replacement application scheduled for national release in FY 2006. The new reports in the EWL software that are being developed will be used to quantify the number of patients waiting on the electronic wait list. The first EWL transmission occurred March 15, 2003. Every site is expected to monitor the accuracy of their data on the EWL. Monthly reports on EWL data from the national roll-up report will be sent to the VISNs for their review. There are rules that are being used to build these reports. Examples of some of the rules are as follows:

- A patient will be counted as "waiting" on the wait list if they are waiting more than 30 days beyond their desired appointment date.

- Patients waiting for either a primary care provider or a primary care appointment will be rolled together and counted as waiting for primary care.

- Reports will show the number of patients waiting more than 30 days beyond their desired appointment dates; using both the EWL and the scheduling software, since both these represent patients in a waiting status, just processed differently.

(See Appendix E on pages 16-19 for the full text of the Under Secretary's comments.)

Office of Inspector General Comments

The Under Secretary's implementation plans are acceptable, and we consider all issues resolved. However, we will follow up on implementation of planned corrective actions.

Background

On March 7, 2002, VHA requested nationwide data on waiting lists be developed because of reported appointment scheduling delays for patient care. Each of the 22 VISNs compiled their data, reported by component facilities, on waiting lists as of March 14, 2002. The March 14 waiting lists totaled 238,334 veterans. The waiting lists were a snapshot of those lists (electronic or manual) maintained by clinics/facilities for veterans who could not be scheduled for appointments because of capacity limitations. The VISNs did not validate the data being submitted to VHA by the field facilities. The VA Chief of Staff asked the Office of Inspector General to verify the reported waiting list totals.

During our review, VHA managers acknowledged that the March 14 totals were inaccurate and inconsistent. For example, some VISNs reported that no waiting lists existed because everyone had appointments scheduled, although some of these scheduled appointments were many months in the future. To address this inconsistency in future waiting list surveys and to capture those veterans who were waiting excessive amounts of time for medical care appointments that were desired sooner, VHA staff created and sent to the VISNs a FileMan routine to identify those veterans waiting more than 6 months to be scheduled for "next available" appointments. VISN coordinators reported that using the FileMan routine resulted in numbers much greater than the numbers self-reported by the facilities. The June 3, 2002, waiting lists totaled 324,871.

In VISN 15, the coordinator noted that the FileMan routine captured inappropriate data that inflated the waiting lists, such as veterans who had cancelled their appointments or veterans who only needed routine appointments with nursing to have blood pressure checked or have shots administered. We confirmed similar data validity problems at other VISNs through telephone contacts with their coordinators.

On July 15, 2002, VHA began receiving bimonthly waiting lists, but they did not validate the accuracy of the lists submitted by the VISNs. VHA staff summarized the reported waiting list totals into two categories – new enrollees and established patients. VHA defined new enrollees as veterans who had completed the enrollment process and were waiting for their first clinic appointments to be scheduled. VHA defined established patients as veterans who had prior visits for VA medical care and were now waiting to be scheduled for follow-up care and all veterans, new or established, who desired appointments as soon as possible, but were scheduled for appointments more than 6 months in the future (from the FileMan routine). On July 15, 2002, the nationwide new enrollee waiting list was reported as numbering 155,003 veterans, and the nationwide established patients waiting list was reported as numbering 154,183 veterans, for a total of 309,186 veterans.

Objectives, Scope, and Methodology

Objectives

The purpose of the audit was to verify the accuracy of VHA's reported medical care waiting lists and determine the causes of any inaccuracies found.

Scope and Methodology

Our audit focused on the number of veterans reported on waiting lists as of July 15, 2002. We assessed VHA waiting list survey instructions, procedures, and operations. To accomplish our objectives we:

- Reviewed statistical samples of new enrollees on the waiting lists in VISNs 8 and 15 as of July 15, 2002 (universes were 31,190 for VISN 8 and 1,433 for VISN 15), waiting for their first clinic appointments to be scheduled, to determine whether the reported waiting lists were accurate.
- Reviewed statistical samples of established patients on the waiting lists in VISNs 8 and 15 as of July 15, 2002, waiting to be scheduled for follow-up primary care or specialty care clinic appointments and all veterans who wanted appointments as soon as possible but were scheduled electronically for appointments more than 6 months in the future (universes were 22,755 for VISN 8 and 4,569 for VISN 15), to determine whether the reported waiting lists were accurate.
- Contacted representatives from each VISN to determine their procedures for accumulating the waiting lists, whether their waiting lists were overstated, and their views on improving the process.
- Referred those cases we identified as erroneously included on the waiting lists and misclassified to VISN and facility managers to confirm our findings.
- Applied the error rate percentages from our samples to the nationwide universes of 155,003 (new enrollees) and 154,183 (established patients) to estimate the nationwide results.

Causes of Inaccurately Reported Waiting Lists

Causes of New Enrollee Waiting List Overstatement

- Facility staffs were not diligent in updating the waiting lists. Some of the waiting lists were kept manually on handwritten lists or on electronic spreadsheets that were manually updated. These were not reviewed and updated to exclude those veterans who had received medical care or were given appointments.

- Veterans that had moved out of the VISNs' service areas or died were not removed from the lists before the data was compiled for the waiting list survey.

- Some veterans on the waiting lists were not seeking VA care. They did not intend to use any VA medical services, but enrolled as a safety net in case they needed access to those services in the future. One VISN sampled the results of their first waiting list survey and found that 29 percent of the veterans on the new enrollee waiting list did not want appointments for medical services. Another VISN reviewed a number of veterans who did not show up for scheduled appointments and found that many did not want appointments when they enrolled. The facility scheduled them for appointments without asking whether they wanted care. Since these veterans were not waiting for access to VA medical care, they should not have been included on the waiting lists.

- Veterans must have completed the enrollment process, including submission of means test information, before they could be scheduled for their initial medical care appointments. Unless they needed emergency or urgent care, these veterans should not have been included on the waiting lists until their enrollments were complete.

Causes of Established Patient Waiting List Overstatement

Errors in Appointment or Data Entry

Most of the overstated waiting list cases occurred because of data entry errors by the schedulers. Examples are as follows:

- Veterans with appointments who were intentionally scheduled more than 6 months in the future should not be on the waiting lists. Schedulers can enter appointments as either "next available clinic appointment" or "not next available appointment" in the computerized VistA scheduling package. When the scheduler enters a return appointment as "next available" erroneously, and then sets the appointment for many months in the future, the waiting time is calculated from the date the scheduler entered the appointment to the actual date of the appointment. The veteran is included on the waiting list erroneously because it appears that he had to wait months until he could get an appointment. The scheduler should have entered "not next available," and then specified a future date for the veteran's next appointment.

  For example, a healthcare provider stated in the electronic progress notes on March 18, 2002, that the veteran was to return for a follow-up visit in 1 year. The scheduling clerk entered an

appointment for March 14, 2003, for the veteran to a specialty care clinic, but entered the appointment as "next available." As a result, the veteran was inappropriately included on the waiting list because the scheduling package calculated that the veteran waited 361 days for his specialty clinic appointment, when he actually received the appointment at the appropriate time.

- Scheduling clerks often encountered difficulty determining when to schedule veterans for future appointments because the clinic providers did not clearly specify when the veterans should return for the next visits. Many of the progress notes did not specify timeframes for the next visits and only noted that the veterans were to return as needed on a routine basis. For example, according to the scheduling clerk, one clinic provider desired follow-up appointments with veterans in 6 to 9 months; but he wrote, "schedule for next available clinic" in the progress notes. He wrote specific orders for veterans he wanted to return as soon as possible. The scheduling clerks entered the follow-up appointments as "next available appointment," but scheduled the veterans for appointments that were more than 6 months in the future. This resulted in these veterans being erroneously reported on the waiting list when their appointments were actually scheduled when the provider intended.

- Facility staff did not always remove veterans' names from the waiting lists when they received medical care or no longer needed appointments. For example, some veterans on the waiting lists were scheduled for appointments that had occurred before July 15, 2002, or the veterans had died or moved out of the VISNs' service areas.

- Some veterans continually cancelled or did not show up for appointments, yet they were rescheduled repeatedly. VISN and facility staff agreed that these veterans should not be rescheduled after two or three missed appointments and should be contacted to determine whether they desire VA medical care.

Some facilities had already identified the scheduling difficulties while reviewing the results of the average clinic wait times for their performance measure clinics. For example, the coordinator at VISN 15 reported that VAMC St. Louis staff found that their clinic wait times were inflated when the scheduling clerks entered appointments inappropriately. They began refresher training for the schedulers on how to enter follow-up appointments correctly. As a result, they only had two veterans reported on the July 15, 2002, waiting lists.

During our telephone calls to other VISNs, the VISN 1 (VA New England Healthcare System, Bedford, MA) coordinator reported that VAMC Manchester staff had also begun refresher training on the VistA scheduling package for their schedulers. The providers noticed that the waiting times for those veterans who needed appointments as soon as possible ("next available") decreased when those veterans who only needed later follow-up appointments ("not next available") were scheduled appropriately.

Errors in Waiting List Data Collection

The FileMan routine overstated the number of veterans waiting 6 months or more for appointments. The routine included cases such as appointments intentionally scheduled for 6

months or more in the future that the scheduling clerks entered appropriately in the VistA scheduling package, appointments within the 6-month timeframe, or appointments that were misidentified. In addition, the routine did not filter out appointments cancelled by the clinics or duplicate names. The following examples illustrate some of the inappropriate cases:

- Appointments were intended to be scheduled more than 6 months in the future, and the scheduling clerks entered the data into the VistA scheduling package appropriately. For example, a veteran had an appointment for a specialty care clinic on February 12, 2002. The healthcare provider specified in the electronic progress notes that the veteran should return to the clinic in 1 year. The scheduling clerk entered the desired date as February 10, 2003, and set the appointment for that date. Although 363 days would have elapsed between appointments, the veteran should not have appeared on the waiting list because he was scheduled when the healthcare provider intended.

- Appointments were scheduled within 6 months. A veteran had an appointment for a primary care clinic on April 18, 2002. The scheduling clerk entered a follow-up appointment for July 24, 2002, 97 days from the first appointment. Since the veteran had an appointment and it was less than 6 months in the future, this veteran should not have appeared on the waiting list.

- Appointments were misidentified. Several appointments had no identifying veteran names or social security numbers, so they did not represent veterans waiting for medical care. In addition, some appointments were for inpatient care, fee basis medical care, or ambulatory surgery rather than outpatient care. In addition, some were for clinics that were not one of the five performance measure clinics, such as Dermatology. None of these appointments should have been included on the waiting lists.

- Appointments were cancelled before July 15, 2002. A veteran had an appointment for a specialty clinic, scheduled on February 28, 2002, for June 25, 2002. The veteran cancelled the appointment on May 29, 2002, and rescheduled for July 18, 2002, within 6 months. This veteran should not have been included on the waiting list.

We also found that the FileMan routine duplicated some names on the waiting lists. At 1 facility, 612 veterans were reported as waiting more than 6 months for appointments in a specialty clinic. The 612 names reported by the facility consisted of 306 veterans repeated twice.

Sample Methodology and Results

Our audit of VHA's reported medical care waiting lists involved sampling plans for evaluating the accuracy of medical care waiting lists reported by VISNs 8 and 15 for new enrollees and for established patients as of July 15, 2002.

A. New Enrollees

Audit Universes

The audit universes consisted of 31,190 new enrollees on the VISN 8 waiting lists and 1,433 new enrollees on the VISN 15 waiting lists as of July 15, 2002, waiting for their first clinic appointments to be scheduled.

Sample Design

The purpose of our sample selection was to determine if the number of veterans reported on the new enrollee waiting lists was accurate. From the new enrollee waiting list universes, we randomly sampled 303 cases from VISN 8 and 252 cases from VISN 15.

Sample Results

	VISN 8	VISN 15	Total
Population Size:	31,190	1,433	32,623
Sample Size:	303	252	
Number of Overstated New Enrollee Veterans:	42	85	
Confidence Interval (+/- Percent):	5.088	6.964	
Lower Limit:	2,736	384	
Upper Limit:	5,910	583	
Point Estimate (Error Cases):	4,323	483	4,806
Number of Misclassified New Enrollee Veterans:	44	66	
Confidence Interval (+/- Percent):	5.188	6.477	
Lower Limit:	2,911	282	
Upper Limit:	6,147	468	
Point Estimate (Error Cases):	4,529	375	4,904

Estimated Number of Overstated New Enrollee Veterans Nationwide

Our samples of veterans reported on the new enrollee waiting lists showed that 42 veterans in VISN 8 and 85 veterans in VISN 15 should not have been included on the waiting lists. We then projected that VISN 8's new enrollee waiting lists were overstated by 4,323 veterans (42/303=14 percent times 31,190). This projection has a confidence level of 99 percent and a confidence interval of +/- 5.088 percent, resulting in a lower limit of 2,736 and an upper limit of 5,910 veterans.

Likewise, we projected that VISN 15's new enrollee waiting lists were overstated by 483 veterans (85/252=34 percent times 1,433). This projection has a confidence level of 99 percent and a confidence interval of +/- 6.964 percent, resulting in a lower limit of 384 and an upper limit of 583 veterans.

Based on our sample results, we estimated that the nationwide universe of 155,003 veterans contained 22,835 (4,806 error cases/32,623 total cases=15 percent x 155,003) that should not have been included on the waiting lists.

Estimated Number of Misclassified New Enrollee Veterans Nationwide

Our samples of veterans reported on the new enrollee waiting lists also showed that 44 veterans in VISN 8 and 66 veterans in VISN 15 should not have been included on the new enrollee waiting lists, but should have been included on the established patient waiting lists. We then projected that 4,529 (44/303=15 percent x 31,190) VISN 8 veterans should not have been on the new enrollee waiting lists, but should have been on the established patient waiting lists. This projection has a confidence level of 99 percent and a confidence interval of +/- 5.188 percent, resulting in a lower limit of 2,911 and an upper limit of 6,147 veterans.

Likewise, we projected that 375 (66/252=26 percent x 1,433) VISN 15 veterans should not have been on the new enrollee waiting lists, but should have been on the established patient waiting lists. This projection has a confidence level of 99 percent and a confidence interval of +/- 6.477 percent, resulting in a lower limit of 282 and an upper limit of 468 veterans.

Based on our sample results, we estimated that, nationwide, 23,301 (4,904 error cases/32,623 total cases=15 percent x 155,003) veterans should have been reported on the established patient waiting lists, rather than the new enrollee waiting lists.

B. Established Patients

Audit Universes

The audit universes consisted of 22,755 established patients on the VISN 8 waiting lists and 4,569 established patients on the VISN 15 waiting lists as of July 15, 2002. These veterans were waiting to be scheduled for follow-up primary care or specialty care clinic appointments and all veterans who wanted appointments as soon as possible, but were scheduled electronically for appointments more than 6 months in the future.

Sample Design

The purpose of our sample selection was to determine if the number of veterans reported on the established patient waiting lists was accurate. From the established patient waiting list universes, we randomly sampled 302 cases from VISN 8 and 286 cases from VISN 15.

Sample Results

	VISN 8	VISN 15	Total
Population Size:	22,755	4,569	27,324
Sample Size:	302	286	
Number of Overstated Established Patients:	127	155	
Confidence Interval (+/- Percent):	7.268	7.347	
Lower Limit:	7,915	2,141	
Upper Limit:	11,223	2,812	
Point Estimate (Error Cases):	9,569	2,476	12,045

Estimated Number of Overstated Established Patients Nationwide

Our samples of veterans reported on the established patient waiting lists showed that 127 veterans in VISN 8 and 155 veterans in VISN 15 should not have been reported on these waiting lists. We then projected that VISN 8's established patient waiting lists were overstated by 9,569 (127/302=42 percent x 22,755). This projection has a confidence level of 99 percent and a confidence interval of +/- 7.268 percent, resulting in a lower limit of 7,915 and an upper limit of 11,223 veterans.

Likewise, we projected that VISN 15's established patient waiting lists were overstated by 2,476 (155/286=54 percent x 4,569). This projection has a confidence level of 99 percent and a confidence interval of +/- 7.347 percent, resulting in a lower limit of 2,141 and an upper limit of 2,812 veterans.

Based on our sample results, we estimated that the nationwide universe of 154,183 veterans contained 67,967 (12,045 error cases/27,324 total cases=44 percent x 154,183) that should not have been reported on the established patient waiting lists.

Appendix E

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: May 1, 2003

From: Under Secretary for Health (10/105E)

Subj.: OIG Draft Audit Report, *Audit of Veterans Health Administration's Reported Medical Care Waiting Lists,* Project Number 2002-02129-R5-0118 (EDMS Folder 219354)

To: Assistant Inspector General for Auditing (52)

1. The appropriate program offices have reviewed this draft report and we provide the following comments and clarifications to the report's findings. We concur with the report recommendations.

2. Despite our efforts and successes with Advanced Clinic Access, it became apparent in FY 2002 that the tremendous growth in enrollment led to patients being placed on waiting lists. These lists were kept locally in a variety of forms including paper lists on index cards, spreadsheets, and even within the VistA hospital computer itself. It was impossible to summarize and analyze the patients on waiting lists because these systems were different from one another and in no way connected. VHA initiated software development to create an electronic wait list (EWL) intended to replace local systems and allow patient information to be rolled-up nationally for analysis. This work was completed in December 2002. The first transmission of data from this software took place in March 2003. We believe accurate data for analysis will reduce the overstating, understating and misclassification of patients on the lists cited by OIG in this report, and provide management with information needed to manage demand and develop strategic plans to reduce the number of patients on waiting lists.

3. An action plan detailing our corrective action in response to the recommendations is attached. If you have any questions, please contact Margaret M. Seleski, Director, Management Review and Administration Service (105E), Office of Policy and Planning, at (202) 273-8360.

(Original Signed by:)

Robert Roswell, M.D.

Attachment

Appendix E

Under Secretary for Health Comments

Action Plan in Response to OIG/GAO/MI Audits/Program Evaluations/Reviews

Name of Report: OIG Draft Audit Report, ***Audit of Veterans Health Administration's Reported Medical Care Waiting Lists***
Project Number: *2002-02129-R5-0118*
Date of Report: Transmitted to VHACO March 6, 2003

Recommendations/ Actions	Status	Completion Date

Recommendations for Executive Action

We recommend that the Under Secretary for Health take the following actions to improve the accuracy of the waiting lists:

1. Provide refresher training for staff using VistA scheduling package, to include the need to frequently update waiting list names and to enter follow-up appointments (intended to be 6 or more months in the future) correctly in the scheduling package. Also, provide direction to health care providers to specify in the electronic progress notes in VistA when they want the veterans to be scheduled for their next appointments.

Concur

Training material on both the Electronic Wait List (EWL) and the scheduling software has been provided to all sites. The WebEx (EWL) training for the VISNs took place October 15 - 31, 2002. Ongoing training is available to all employees on the VistA University website. User reference cards were also mailed to each VAMC. The Office of Information, with VISN 18, is also currently developing a training video that reviews the electronic wait list functionality and appointment wait time management. Monitoring of the use of EWL and scheduling applications is done locally and through analysis of the data at VAMC, VISN and national levels.

Completed 10/31/2002 and Ongoing

Currently, physicians communicate the request to schedule the next appointment in a variety of ways, including text orders in CPRS and annotations on the encounter form. Re-engineered CPRS, scheduled for roll out in March 2005, together with the new scheduling software, scheduled for national release in FY 2006, will allow the provider direct interaction with scheduling software.

In Process 10/31/2006

Appendix E

Under Secretary for Health Comments

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Name of Report: OIG Draft Audit Report, ***Audit of Veterans Health Administration's Reported Medical Care Waiting Lists***
Project Number: *2002-02129-R5-0118*
Date of Report: Transmitted to VHACO March 6, 2003

Recommendations/ Actions	Status	Completion Date

2. Update the FileMan routine, so that it does not include veterans appropriately scheduled (either those scheduled within 6 months or those scheduled intentionally for more than 6 months in the future and entered appropriately into the scheduling package), erroneous appointments, duplicate names, or cancelled appointments on the waiting lists.

Concur

A developer is working to define requirements to improve functionality of FILEMAN routines in relation to this issue. Once the requirements are defined, we will provide an estimated date for delivery.

In Process 3/31/2003 and TBD

3. Expedite the implementation and monitor the accuracy of the electronic waiting list software.

Concur

The EWL software supplements the VistA Scheduling Software. A project team has been established to work in developing additional requirements for EWL. As requirements are defined, patches to VistA will be developed and released nationally. Ultimately, full EWL functionality will be included in the scheduling replacement application scheduled for national release in FY 2006.The new reports in EWL software that are being developed will be used to quantify the number of patients waiting on EWL. The first EWL transmission occurred March 15, 2003. Every site is expected to monitor the accuracy of their data on EWL. Monthly reports on EWL data from the national roll-up report will be sent to VISNs for their review. There are rules that are being used to build these reports. Examples of some of the rules are as follows:

- A patient will be counted as "waiting" on the wait list if they are waiting more than 30 days beyond their desired appointment date.
- Patients waiting for either a primary care provider or a primary care appointment

Appendix E

Under Secretary for Health Comments

Page 3

Name of Report: OIG Draft Audit Report, ***Audit of Veterans Health Administration's Reported Medical Care Waiting Lists***
Project Number: *2002-02129-R5-0118*
Date of Report: Transmitted to VHACO March 6, 2003

Recommendations/ Actions	Status	Completion Date

will be rolled together and counted as waiting for primary care.

- Reports will show the number of patients waiting more than 30 days beyond their desired appointment date; using BOTH EWL and the scheduling software, since both these represent patients in a waiting status, just processed differently.

In Process 10/31/2006

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This report will be available in the near future on the VA Office of Audit web site at http://www.va.gov/oig/52/reports/mainlist.htm.: List *of Available Reports.* This report will remain on the OIG web site for 2 fiscal years after it is issued.