Department of Veterans Affairs
Office of Inspector General

Audit of the Veterans Health Administration's Outpatient Scheduling Procedures

Outpatient scheduling procedures need to be improved to ensure accurate reporting of veterans' waiting times and facility waiting lists.

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Executive Summary

Introduction

At the request of the Secretary of Veterans Affairs, the Office of Inspector General (OIG) audited the Veterans Health Administration's (VHA) compliance with outpatient scheduling procedures to determine the accuracy of the reported veterans' waiting times[1] and facility waiting lists. Our objectives were to determine whether: (1) schedulers followed established procedures when selecting the type of appointment and entering the desired appointment date into the Veterans Health Information Systems and Technology Architecture (VistA) and (2) VHA medical facilities used effective procedures to ensure all veterans either had appointments or were identified on electronic waiting lists.

We visited 8 medical facilities, interviewed 247 schedulers whom medical facility managers identified as being responsible for scheduling appointments, and reviewed 1,104 medical care appointments scheduled for the week of June 21–27, 2004. We also asked 29,818 VHA employees responsible for scheduling appointments to complete a web-based survey designed to capture their training experiences, adequacy of supervision, and scheduling practices. A total of 15,750 employees answered all or part of the survey.

Results

Schedulers Did Not Follow Established Procedures for Creating Appointments

Schedulers did not follow established procedures when selecting the type of appointment and when entering the desired appointment date into VistA. In some cases, supervisors instructed schedulers to create appointments contrary to established scheduling procedures. Schedulers have two key tasks to complete when creating appointments in VistA—selecting the type of appointment and identifying and entering the desired date of care. The two types of appointments are "next available" and "not next available." The next available appointment should be used unless the provider or veteran requests a specific appointment date. The desired date of care is either established by the veteran (wants to be seen immediately) or the provider (needs to be seen immediately or at a specific time, such as in 6 months). VHA measures waiting times by comparing the

[1] Waiting time refers to the number of elapsed days from the desired date of the appointment to the actual date of the appointment.

desired appointment dates to the actual appointment dates. Schedulers created appointments using the wrong:

- Appointment type for 380 (34 percent) of the 1,104 appointments. For 285 (75 percent) of the 380 appointments, schedulers incorrectly selected the not next available appointment date instead of the next available appointment date.

- Desired date for 457 (41 percent) of the 1,104 appointments. The average elapsed-day difference between the desired date shown in the VistA scheduling module and the desired date shown in the medical records was 46 days and ranged from a 472 elapsed days understatement to a 272 elapsed days overstatement.

VHA strives to schedule at least 90 percent of all next available appointments for veterans within 30 days. Of the 1,104 appointments reviewed, schedulers created 315 (28 percent) as next available appointments. We determined that 505 of the 1,104 appointments should have been created as a next available appointment. Of the 505 appointments, only 330 appointments (65 percent) were scheduled within 30 days of the desired date—well below the VHA goal of 90 percent and the medical facilities directors' reported accomplishment of 81 percent. Although the recalculated average waiting time of 30.1 days was consistent with VHA's goal of scheduling appointments within 30 days, it was 44 percent more than the reported average waiting time of 20.9 days.

VHA requires that veterans with service-connected disabilities receive priority access to medical care. Because schedulers did not use the correct scheduling procedures, actual waiting times were understated, resulting in medical facility directors being unaware that 2,009 service-connected veterans waited longer than 30 days from their desired date of care.[2] VHA requires medical facility directors to arrange for veterans to receive care at another VHA medical facility or fee basis care from a non-VA provider at VA expense if the needed care can not be provided within 30 days. Using the error rate from our statistical sample, we estimated that this may impact as many as 24,463 veterans nationwide.

Medical Facilities Did Not Have Effective Electronic Waiting List Procedures

VHA medical facilities did not have effective procedures to ensure all veterans either had appointments within 4 months of the desired date of care or were identified on an electronic waiting list. At 5 of the 8 medical facilities, schedulers understated their electronic waiting lists by 856 veterans.[3] Using the error rate from our statistical sample, we estimated that the electronic waiting lists could be understated by as many as 10,301 veterans nationwide. We also identified clinics with substantial backlogs of consult

[2] The 2,009 service-connected veterans is a projected number based on the actual error rate incurred at the 8 medical facilities we visited. Appendix A describes our sampling methodology and results in detail.

[3] The 856 veterans is a projected number based on the actual error rate incurred at 5 of the 8 medical facilities we visited. Appendix A describes our sampling methodology and results in detail.

referrals where veterans did not have appointments within 7 business days and were not included on the electronic waiting lists. Further, 17 (7 percent) of the 247 schedulers we interviewed told us they maintained informal waiting lists (a list other than the electronic list) of veterans who needed appointments.

VHA Did Not Have an Adequate Training Program for Schedulers

VHA did not have an adequate training program for schedulers. Instead, schedulers received most of their training as on-the-job training, which may have contributed to the errors we identified during our review. For example, 2,246 (68 percent) of the 3,298 schedulers who identified themselves as trainers in our nationwide survey did not know how to correctly create an appointment for a veteran who wanted an appointment as soon as possible but did not need urgent or emergent care.

Outpatient Scheduling Procedures Need Improvement Nationwide

The results of our survey confirmed that the findings we identified at the eight VHA medical facilities exist nationwide. According to 7 percent of the survey respondents, managers or supervisors directed or encouraged them to schedule appointments contrary to established procedures. Also, 81 percent of the survey respondents told us they had received no training on the use of the electronic waiting list and only 45 percent of the survey respondents had received any formal training on the use of the VistA scheduling module. Survey respondents who identified themselves as trainers often did not know the correct scheduling procedures.

Conclusion

VHA needs to improve outpatient scheduling procedures. VHA managers plan budget priorities, measure performance, and determine whether strategic goals are met, in part, by reviewing the time veterans wait for appointments and the number of veterans waiting for appointments. Inaccurate waiting time data and waiting lists compromise VHA's ability to assess and manage demand for medical care.

We recommended that the Under Secretary for Health:

1. (a) Ensure that medical facility managers require schedulers to create appointments following established procedures and (b) monitor the schedulers' use of correct procedures when creating appointments.
2. (a) Monitor consult referrals to ensure that all veterans with referrals either have scheduled appointments within 7 business days or are included on electronic waiting lists, (b) establish an automated link from the Computerized Patient Record System (CPRS) consult package to the VistA scheduling module, and (c) ensure medical facilities prohibit the use of informal waiting lists.

3. (a) Develop a standard training package for medical facilities to train schedulers on the electronic waiting list and VistA scheduling modules, (b) ensure all schedulers view the video training titled "VistA Scheduling Software: Making a Difference," and (c) require all schedulers to receive annual training on the electronic waiting list and VistA scheduling module.

Comments

The Under Secretary for Health agreed with the findings and recommendations and provided acceptable implementation plans. (See Appendix C, pages 30-38, for the full text of the Under Secretary's comments.) We will follow up on planned actions until they are completed.

The Under Secretary noted that VHA has made significant progress in improving the outpatient scheduling process. He stated that VHA's Advanced Clinic Access (ACA) initiative is an ongoing national process to implement patient-centered, scientifically based redesign principles and tools in all of its operations. According to the Under Secretary, under the ACA umbrella VHA is vigorously addressing problems with waiting times and scheduling delays and has taken steps to accurately quantify the numbers of patients on wait lists, lengths of waits, and reasons for scheduling delays. He believes that once implemented systemwide, VHA's ACA initiative in conjunction with other planned and ongoing improvements will result in needed scheduling enhancements that are consistently applied by all VHA medical facilities.

We are encouraged by VHA's efforts to improve the scheduling process. However, our review did not evaluate the implementation of the ACA initiative, and therefore, we expressed no opinion or conclusions on its adequacy. We evaluated the accuracy of the reported veterans' waiting times and facility waiting lists and our findings addressed weaknesses in the scheduling procedures used by both clinics that have implemented ACA and by clinics that have not implemented ACA. We found that the schedulers' use of incorrect procedures distorted the reported measurement of veterans' waiting times and facility waiting lists regardless of whether the clinic had implemented ACA.

(original signed by:)

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Introduction

Purpose

The purpose of the audit was to evaluate VHA's compliance with outpatient scheduling procedures to determine the accuracy of the reported veterans' waiting times and facility waiting lists. Our objectives were to determine whether: (1) schedulers followed established procedures when selecting the type of appointment and when entering the desired appointment date into VistA and (2) VHA medical facilities used effective procedures to ensure all veterans either had appointments or were identified on an electronic waiting list.

Background

Two VHA policies set requirements for priority access to medical care for veterans with service-connected disabilities.[4] The policies require that veterans with service-connected ratings of 50 percent or greater and veterans requiring care for service-connected disabilities must be scheduled for care within 30 days of the desired appointment dates. If an appointment cannot be scheduled within the 30-day time frame, VA must arrange for the veteran to receive care at another VHA medical facility or fee basis care from a non-VA provider at VA expense.

A third VHA policy establishes a goal of scheduling appointments within 30 days of the desired appointment date but not more than 4 months beyond the desired appointment date.[5] The policy requires that all appointment requests must be acted on by the medical facility within 7 business days of the request, including consult referrals to a specialist. Acting on the request involves either scheduling the requested care or placing the patient on the electronic waiting list. VHA implemented the electronic waiting list in December 2002 to provide VHA medical facilities a standard tool to capture and track information about veterans waiting for clinic appointments and primary care panel assignments.

Scope and Methodology

We visited 8 medical facilities; reviewed 1,104 medical care appointments; interviewed 247 schedulers; and used a web-based survey to capture the experiences of 15,750 schedulers nationwide related to training, supervision, and scheduling practices.

[4] VHA Directive 2002-059, "Priority for Outpatient Medical Services and Inpatient Hospital Care" (October 2, 2002) and VHA Directive 2003-062, "Priority Scheduling For Outpatient Medical Services and Inpatient Hospital Care For Service Connected Veterans" (October 23, 2003).

[5] VHA Directive 2003-068, "Process for Managing Patients when Patient Demand Exceeds Current Clinical Capacity" (December 11, 2003).

Sample of Medical Care Appointments

For the week of June 21–27, 2004, we identified a nationwide universe of 473,821 appointments, of which 38,786 (8 percent) were scheduled at the 8 medical facilities. We selected 138 scheduled appointments at each facility for a total statistical sample of 1,104 appointments. We reviewed appointment data, medical records, and consult referrals for our selected samples to determine when the appointments were scheduled, how the schedulers created the appointments, and whether the schedulers used the correct desired dates when creating the appointments. Appendix A, pages 15-17, describes our sampling methodology and results in detail.

Feedback from Schedulers

Nationwide, medical facility managers identified 29,818 employees with scheduling responsibilities. We requested that these employees complete a web-based survey designed to capture their training experiences, adequacy of supervision, and scheduling practices. During the period October 7–November 30, 2004, 15,750 (53 percent) of the 29,818 employees answered our survey. The results are shown in Appendix B, pages 18-29.

At the 8 medical facilities, 3,361 employees had scheduling responsibilities. Using the same basic questions contained in our web-based survey, we interviewed 247 employees (7 percent) as shown in Table 1.

Table 1. Number of Schedulers Interviewed

VHA Medical Facility	Total Schedulers	Number of Schedulers Interviewed
Atlanta VA Medical Center	414	35
Edward Hines Jr. VA Hospital, Chicago	425	40
Kansas City VA Medical Center	176	31
VA Boston Healthcare System	629	38
VA Greater Los Angeles Healthcare System	677	26
VA North Texas Health Care System	478	25
VA Puget Sound Health Care System	213	27
Washington, DC VA Medical Center	349	25
Totals	3,361	247

The audit was performed in accordance with *Generally Accepted Government Auditing Standards* for staff qualifications, independence, and due professional care; field work standards for planning, supervision, and evidence; and reporting standards for performance audits.

Results and Conclusions

Issue 1: Scheduling Procedures Were Not Followed

Findings

Medical facility managers did not ensure that schedulers followed appropriate procedures when scheduling appointments. In some cases, supervisors instructed schedulers to create appointments contrary to established scheduling procedures. This resulted in medical facility managers understating reported waiting times for appointments and under reporting the number of service-connected veterans with waiting times longer than 30 days.

Schedulers Entered the Incorrect Desired Date

The VistA scheduling module measures the veteran's waiting time for each appointment by calculating the elapsed days between the desired date of the appointment and the actual date of the appointment. We reviewed the medical records for 1,104 appointments to verify the accuracy of the desired dates. If the physician annotated a specific date for the appointment, we used that date as the desired date. For example, if on February 1, 2004, the physician annotated in the medical record that he wanted to see the veteran in 6 months, we used August 1, 2004, as the desired date. For consult referrals that did not identify a specific appointment date, we used the date of the referral as the desired date.

Schedulers created appointments using the wrong desired date for 457 (41 percent) of the 1,104 appointments.[6] The average elapsed-day difference between the desired date shown in the VistA scheduling module and the desired date shown in the medical records was 46 days. For 100 (22 percent) of the 457 appointments, the schedulers entered desired dates that were earlier than the correct desired dates by an average of 42 days. Using the earlier desired dates overstated waiting times. In 277 (61 percent) of the 457

[6] The 457 appointments included 80 appointments for which the VistA scheduling module did not create desired dates. These appointments were primarily walk-in appointments and appointments made using the auto-rebook method (a system-generated appointment).

appointments, the schedulers entered desired dates that were later than the correct dates by an average of 46 days, which understated waiting times. The range of errors is summarized below:

Table 2. Effect of Incorrect Desired Dates

Difference in Elapsed Days	Number of Appointments
VistA Scheduling Module Had No Desired Date	80
Schedulers' Desired Date Earlier Than Correct Desired Date	100
Overstated by 1–10 Days	19
Overstated by 11–30 Days	41
Overstated by 31–100 Days	33
Overstated by 101–272 Days	7
Schedulers' Desired Date Later than Correct Desired Date	277
Understated by 1–10 Days	51
Understated by 11–30 Days	81
Understated by 31–100 Days	120
Understated by 101–472 Days	25
Totals	457

As the following examples illustrate, some of the errors resulted in substantial differences between reported and actual waiting times:

- On March 11, 2003, a mental health clinic at the VA Boston Healthcare System made a consult referral to a primary care clinic. On May 4, 2004, the scheduler created a primary care appointment for June 25, 2004, using not next available with a desired date of June 25, 2004. Thus, the reported waiting time was 0 days (June 25–June 25). However, the veteran actually waited 472 days from the date of the consult referral (March 11, 2003) until the date of the appointment (June 25, 2004).
- On August 5, 2003, a primary care clinic at the Atlanta VA Medical Center made a consult referral to the eye clinic for a 100 percent service-connected veteran. On October 27, 2003, a scheduler created an appointment using a desired date of June 15, 2004, and the appointment was scheduled for June 21, 2004. Thus, the reported waiting time was 6 days (June 15–June 21). However, the veteran actually waited 321 days from the date of the referral (August 5, 2003) to the date of the appointment (June 21, 2004).
- On October 2, 2003, a mental health clinic at the VA North Texas Health Care System made a consult referral to an ophthalmology clinic. On May 3, 2004, a scheduler created an appointment and used a desired date of June 21, 2004. The appointment was scheduled for June 23, 2004, resulting in a reported waiting time of

2 days. However, the veteran actually waited 263 days from the date of the consult referral (October 2, 2003) to the date of the appointment (June 23, 2004).

From our interviews with schedulers, we determined that most errors associated with the desired dates were caused by schedulers first determining the next available appointment date and then using it as the desired date. Schedulers also told us that consulting providers would review their consult referrals and the veterans' medical records to prioritize the referrals by clinical need. Based on this medical record assessment and the provider's clinic schedule, the provider then notified the scheduler when to schedule the consult. The scheduler used that date as the desired date which inappropriately eliminated any reported waiting time.

Schedulers Entered the Wrong Appointment Type

The VistA scheduling module requires that schedulers first determine the type of appointment to create. The next available option should be used when the veteran or clinician determines the care is needed as soon as possible. This option is typically used for new patients or consult referrals. If the scheduler determines the veteran does not need the next available appointment, the scheduler will identify the appointment as not next available and enter a desired date of care. Generally this option is used when the provider wants the veteran to return for a follow-up appointment (for example, an appointment in 6 months).

Schedulers created appointments using the wrong appointment types for 380 (34 percent) of the 1,104 appointments:

- For 285 (75 percent) of the 380 appointments, schedulers used the not next available appointment request type instead of the next available appointment type.
- For 95 (25 percent) of the 380 appointments, schedulers used the next available appointment request type instead of the not next available appointment type.

Incorrect Guidance from Supervisors

Schedulers told us supervisors instructed them to create appointments contrary to established scheduling procedures. Our interviews and nationwide survey results confirmed this condition:

- Of the 247 schedulers we interviewed, 65 (26 percent) determined the first available appointment date and then used that as the desired date. Our nationwide survey showed that 41 percent of the respondents were directed to determine the first available appointment date and then use that as the desired date.

- Of the 247 schedulers, 51 (21 percent) entered all appointments as not next available. Our nationwide survey disclosed that 27 percent of the respondents were directed to never use the next available appointment option.
- Of the 247 schedulers, 24 (10 percent) entered desired dates that would reduce the calculated waiting time for all appointments. Our nationwide survey found that 10 percent of the respondents believed that their leadership pressured them to keep waiting lists short, causing them to circumvent established procedures for scheduling appointments.

In addition, 7 percent of the nationwide survey respondents reported that their managers or supervisors directed or encouraged them to schedule appointments contrary to written guidance or directives.

Facilities Understated Reported Waiting Times

VHA uses the percentage of next available appointments scheduled within 30 days as one of its measures for evaluating medical facility director performance. The VHA goal is that at least 90 percent of all next available appointments are scheduled within 30 days.

Schedulers created 315 of 1,104 appointments as a next available appointment, but only 276 of the 315 appointments included a desired date.[7] The VistA scheduling module showed that 224 (81 percent) of the 276 appointments were scheduled within 30 days of the desired dates. However, after we adjusted the appointment information to show the correct desired dates and appointment types, 505 (46 percent) of the 1,104 appointments should have been classified as next available. Of the 505 appointments, only 330 appointments (65 percent) were scheduled within 30 days of the desired dates—well below the VHA goal of 90 percent and the directors' reported accomplishment of 81 percent.

We also compared the reported waiting times shown for the 276 appointments classified as next available to our recalculated waiting times based on the 505 appointments that should have been classified as next available. Although the recalculated average waiting time of 30.1 days was consistent with VHA's goal of scheduling appointments within 30 days, it was 44 percent more than the reported average waiting time of 20.9 days.

Facilities Under Reported Service-Connected Veterans Waiting More Than 30 Days

VHA policy requires that veterans with service-connected disabilities receive priority access to medical care. For the 320 service-connected appointments in our sample, we found that 57 (18 percent) had waiting times of more than 30 days, if the scheduler had

[7] The VistA scheduling module did not include desired dates for 39 next available appointments from walk-in appointments or appointments created using the auto-rebook method of scheduling.

used the correct desired date and appointment request type.[8] The difference in elapsed days between the reported waiting times and the actual waiting times averaged 72 days and ranged from 1 to 340 days.

Table 3. Effect of Incorrect Desired Dates on Service-connected Veterans

Number of Elapsed Days Over 30 Days	Number of Appointments Past the 30-Day Waiting Time Requirement
1–10 Days	17
11–25 Days	15
26–50 Days	12
51–340 Days	13
Total	57

Because schedulers did not use the correct scheduling procedures, medical facility directors were unaware that 2,009 service-connected veterans waited longer than 30 days from their desired dates for their appointments and, therefore, were unable to arrange for the veterans to receive their care at other VHA medical facilities or fee basis care from non-VA providers at VA expense. Based on our statistical sample, we estimate that this number could be as high as 24,463 nationwide.

Conclusion

VHA needs to provide more attention and oversight to the scheduling process. We found errors in the two key tasks of creating an appointment—a 41 percent error rate when entering the desired date and a 34 percent error rate when selecting the appointment request type. The effect of these scheduling errors can be significant. Budget decisions that consider the medical facilities' ability to timely handle patient workload will lose credibility if the performance data is not accurate. The scheduling process is designed to ensure that all veterans receive prompt medical care. Not following the required scheduling process will increase the risk that veterans do not promptly receive needed medical care.

Recommended Improvement Action 1. We recommended that the Under Secretary for Health: (a) ensure that medical facility managers require schedulers to create appointments following established procedures and (b) monitor the schedulers' use of correct procedures when creating appointments.

[8] Five of the 57 appointments were created using the auto-rebook method. Although VistA does not calculate the waiting times for appointments created using the auto-rebook method, we were able to calculate the actual waiting times by reviewing medical records.

The Under Secretary for Health agreed with the findings and recommendations and reported that VHA shares the OIG's concern about inconsistent procedures being applied among VHA medical facilities. Under the ACA umbrella, VHA is actively involved in consolidating and updating established national scheduling directives and devising a new VHA scheduling directive designed to assist the administrative staffs who are responsible for scheduling. It is anticipated that the new national guidance will be finalized for field distribution by the end of July 2005. This is part of VHA's efforts to better standardize procedures throughout the system.

VHA will continue to emphasize the requirement that all facilities implement established practices. All of the Veterans Integrated Service Network (VISN) directors and medical facility directors were provided copies of this report and the ACA Steering Committee continues to reinforce the need for medical facility compliance with existing policies during routine conference calls and mail group exchanges. All VISNs and medical facilities have designated ACA points of contact, who are actively overseeing compliance efforts. VISN and medical facility directors are required to certify quarterly whether or not their facilities are in compliance with existing requirements, and to provide explanatory comments about their compliance or non-compliance.

In addition, the VHA External Peer Review Program (EPRP) abstractors used chart reviews to compare medical record documentation with information contained in the scheduling package. This assessment provided a unique opportunity to evaluate entries in the VistA scheduling package, and identified opportunities for focused scheduler training that are being incorporated into scheduler training programs. VHA plans to continue utilizing the EPRP abstractors for regular, quarterly collection of these comparative data, beginning in July 2005.

The improvement actions are acceptable, and we will follow up on the planned actions until they are completed.

Issue 2: Waiting Lists Were Not Complete

Findings

VHA medical facility managers did not have effective procedures to ensure that all veterans seeking medical care either had an appointment within 4 months of the desired date of care or were identified and reported on the facilities' electronic waiting lists. We found medical facilities omitted veterans from their electronic waiting lists and clinics where schedulers had backlogs of consult referrals and kept informal waiting lists.

Medical Facilities Understated Their Electronic Waiting Lists

At 5 of the 8 medical facilities, schedulers did not place the associated veteran on the electronic waiting list for 24 (2 percent) of the 1,104 appointments. Schedulers used

incorrect desired dates, which resulted in a calculated waiting time of less than 4 months. The waiting time using the correct desired date was more than 4 months.

Table 4. Number Of Veterans Not On The Electronic Waiting List

Number of Elapsed Days Over 4 Months	Number of Appointments Past the 4-Month Waiting Time Requirement
1–10 Days	1
11–25 Days	4
26–50 Days	9
51–310 Days	10
Total	24

As a result, the 5 medical facilities understated their electronic waiting lists by 856 veterans. Based on our statistical sample, we estimated that the electronic waiting list could be understated by as many as 10,301 veterans nationwide.

Backlog of Consult Referrals at Clinics

At five of the eight VHA medical facilities, schedulers told us they maintained files of consult referrals that had been referred to their clinic at least 7 business days earlier, but did not create the appointments nor place the veterans on waiting lists. For example:

- At the VA Greater Los Angeles Healthcare System, we identified 888 consult referrals to 3 specialty clinics that, at the time of our visit, had no appointments and were not on an electronic waiting list. The referrals were dated May 10, 2004, almost 3 months earlier.
- At the Washington, DC VA Medical Center, a scheduler told us that before our visit on August 9, 2004, the medical facility had over 2,000 consult referrals with no appointments. Prior to our visit, schedulers worked overtime to reduce the backlog of unscheduled referrals. These referrals were dated April 12, 2004, almost 4 months earlier. None of the veterans associated with these referrals were on the electronic waiting list.
- A scheduler at the VA North Texas Health Care System told us that as of 2 weeks before our visit on August 9, 2004, her clinic had more than 200 veterans with a referral but no appointment. These veterans were not included on the electronic waiting list.

Our nationwide survey disclosed that 20 percent of the respondents had consult referrals over 7 business days old that had not been scheduled. Specifically, 15 percent had between 1 and 25 referrals over 7 business days old; 2 percent had between 26 and 50 referrals over 7 business days old; and 3 percent had over 50 referrals over 7 business

days old. The survey also showed that 31 percent of the respondents generally took more than the maximum 7 business days to schedule the referrals.

According to schedulers and supervisors we interviewed, the consult package in CPRS did not communicate with the VistA scheduling module. Schedulers must enter appointment scheduling information into both the consult package and the scheduling module as two separate tasks. However, patient appointment data was not current or consistent between the consult package and scheduling module because schedulers in specialty clinics did not always manually transfer the information between the two software packages. As a result, schedulers could not accurately or easily determine which consults needed to be scheduled for appointments and which were actually completed.

Schedulers Kept Informal Waiting Lists

According to 17 (7 percent) of the 247 schedulers we interviewed, they maintained an informal waiting list (a waiting list other than the electronic waiting list) of veterans who needed appointments. For example, at the VA Puget Sound Health Care System a scheduler maintained a database of all veterans waiting for audiology appointments, which until recently included more than 550 veterans. As of September 1, 2004, the medical facility, using fee basis providers, had arranged audiology care for all 550 veterans. Our nationwide survey found that 16 percent of the respondents had, at some time, maintained informal waiting lists.

Conclusion

VHA needs to ensure the electronic waiting list is complete and accurate. Even with the small error rate we identified, a significant number of veterans are affected. The electronic waiting list is used to gauge how well medical facilities are meeting their patient care requirements, and is also instrumental in making sure no veterans go untreated. Unreported, informal waiting lists compromise VHA's ability to assess and manage demand for medical care.

Recommended Improvement Action 2. We recommended that the Under Secretary for Health: (a) monitor consult referrals to ensure that all veterans with referrals either have scheduled appointments within 7 business days or be included on electronic waiting lists, (b) establish an automated link from the CPRS consult package to the VistA scheduling module, and (c) ensure medical facilities prohibit the use of informal waiting lists.

The Under Secretary for Health agreed with the findings and recommendations and reported that a new consult directive has been drafted to establish business rules for the management of consult requests, procedures, and other specialty service care. Also, progress is well underway to nationally implement a connection between the CPRS consult and VistA scheduling packages enabling transfers of important information. The

consult entry date is captured in the scheduling package and progress is electronically tracked through scheduling and the subsequent visit. In addition, status changes to the consult are automatically generated with alerts provided back to the providers. VHA also implemented a performance monitor that targets any consults that might still be pending resolution beyond 12 months.

The VA Office of Information is assessing additional ways to modify and effectively link the CPRS consult module to the VistA scheduling module, based on the submitted request from VHA's Consult Task Force. Work scope and completion timeframes for this project have not yet been established. This information will be shared with the OIG in upcoming activity updates.

In all follow-up communication with VISN and medical facility managers, the point will be emphasized that facilities are prohibited from using informal waiting lists. The facility points of contact for the ACA initiative will be instructed to specifically ensure that such practices are eliminated.

The improvement actions are acceptable, and we will follow up on the planned actions until they are completed.

Issue 3: Training Program Needs Improvement

Findings

VHA did not have an adequate training program for schedulers. Instead, schedulers received most of their training on-the-job from supervisors or co-workers, which may have contributed to the errors identified by our audit.

No Formal Training Package for Schedulers

VHA officials told us they had not established a formal training package for the VistA scheduling module, other than a reporting guide that discusses when to use the next available appointment. VISN 18 developed a video tape titled, "VistA Scheduling Software: Making a Difference," in response to recommendations made in our "Audit of Veterans Health Administration's Reported Medical Care Waiting Lists" (Report Number 02-02129-95, May 14, 2003). However, the tape was only distributed to employees in VISN 18. During our interviews, 71 (29 percent) of the 247 schedulers told us they had viewed the video tape even though they were not VISN 18 employees. However, 33 (46 percent) of the 71 schedulers first viewed the tape in the month preceding our visit.

VHA developed a training website about the use of electronic waiting lists that includes training materials such as manuals and reference cards. Training was conducted over the VA Intranet in October 2002, and ongoing training is available to all employees on the

VistA University website. However, our nationwide survey found that 81 percent of all respondents had received no training on the use of the electronic waiting list.

Formal Scheduler Training is Needed

Schedulers told us that on-the-job training provided by supervisors or co-workers constituted most of the training they received on the VistA scheduling module. Of the 247 schedulers, only 131 (53 percent) received some form of formal training on the VistA scheduling module. Our nationwide survey disclosed that only 45 percent of the respondents had received some form of formal training. Of the 131 schedulers who had received formal training, 86 (66 percent) were employed at 3 of the medical facilities we visited—VA North Texas Health Care System; Atlanta VA Medical Center; and the Edward Hines Jr. VA Hospital, Chicago. We defined formal training to the schedulers we interviewed by giving them examples such as viewing a video tape, discussing the scheduling module in a classroom setting, or accessing a training package on the VA Intranet.

While on-the-job training can be an integral part of any training program, it can perpetuate the bad habits or incorrect scheduling practices of the instructors. Of the 15,750 respondents to our survey, 4,032 (26 percent) provided scheduling training to their staff. As the following examples illustrate, these 4,032 schedulers gave a number of incorrect answers to the scenarios we asked them to answer:

- Of 3,298 schedulers who responded, 2,246 (68 percent) did not know how to schedule a veteran wanting an appointment as soon as possible, but did not need urgent or emergent treatment.[9] The correct procedure would be to select the next available option when creating the appointment.
- Of the 2,159 schedulers who responded, 1,329 (62 percent) trainers did not know how to schedule an appointment originating from a consult referral.[10] The correct answer would be to create the appointment using the next available appointment option.

Schedulers Were Inconsistent When Creating Appointments

As part of our survey, we presented several scenarios to the schedulers to determine if they knew the appropriate procedures for creating appointments. Based on their responses, we believe there was significant inconsistency in applying the procedures,

[9] Of the 4,032 schedulers, 734 either did not answer this question or responded that they did not schedule these types of appointments.

[10] Of the 4,032 schedulers, 1,873 either did not answer this question or responded that they did not schedule these types of appointments.

which directly contributed to the errors we identified. A summary of the schedulers' responses is shown below:

Table 5. Scheduling Scenarios

Scenario	Correct Response	Number of Responses[11]	Number of Correct Responses/ (Percent)	Number of Incorrect Responses/ (Percent)
The veteran wanted an appointment as soon as possible (not emergency or urgent).	Next available with a desired date of today.	10,567	3,265 (31%)	7,302 (69%)
The provider requested a specific time frame for a return appointment (return to clinic in 6 months).	Not next available with a desired date of 6 months in the future.	9,967	7,792 (78%)	2,175 (22%)
The provider does not specify when the veteran should be scheduled for a return appointment (return to clinic routine).	Confirm the desired date with the provider.	8,554	5,965 (70%)	2,589 (30%)
The veteran is a new consult.	Next available with a desired date of today.	6,614	2,398 (36%)	4,216 (64%)

Conclusion

VHA needs to provide a standardized training program for schedulers. Creating appointments using correct scheduling procedures is critical to ensuring that veterans receive prompt medical care and affects the director's ability to accurately assess how well the medical facility is meeting its patient care workload.

Recommended Improvement Action 3. We recommended that the Under Secretary for Health: (a) develop a standard training package for medical facilities to train schedulers on the electronic waiting list and VistA scheduling module, (b) ensure all schedulers view the video titled "VistA Scheduling Software: Making a Difference," and (c) make sure all

[11] Some of the respondents either did not answer the question or answered that the scenario did not pertain to their clinic.

schedulers receive annual training on the electronic waiting list and VistA scheduling module.

The Under Secretary for Health agreed with the findings and recommendations and reported that VHA recognizes the need to standardize minimal training requirements while still allowing opportunity for flexibility to meet individual facility needs. The Office of the Deputy Under Secretary for Health for Operations and Management has charged ACA program staff with development and roll-out by July 1, 2005, of a comprehensive VHA national education plan that will be mandatory for all individuals involved in the scheduling process. Scheduling supervisors will also be required to complete the training.

All VISNs received multiple copies of the video titled "VistA Scheduling Software: Making a Difference," as well as two related video training tools. A web-based version of the VistA scheduling software video has been posted on the ACA web page to facilitate scheduler training efforts systemwide.

Numerous training options, including a broad range of web-based training listed on the ACA Home Page, are currently available for schedulers, and virtually all facilities report establishment of minimal training requirements for scheduling staff. Many facilities and VISNs have developed and mandated completion of training on their local web sites and have established oversight monitors to ensure that all staff have taken the training. Refresher training is also provided at most locations on a scheduled basis or on an as-needed basis for schedulers requiring immediate assistance. Most VISNs also report that they are requiring and tracking completion of training.

The improvement actions are acceptable, and we will follow up on the planned actions until they are completed.

Appendix A

Sampling Methodology and Results

Review Universes

We identified scheduled appointments at the eight medical facilities for the week of June 21–27, 2004. The population consisted of 38,786 appointments as shown below:

Table 6. Total Scheduled Appointments

VHA Medical Facility	Total Appointments Scheduled During June 21–27, 2004	Number of Scheduled Appointments Reviewed
Atlanta VA Medical Center	4,441	138
Edward Hines Jr. VA Hospital, Chicago	3,506	138
Kansas City VA Medical Center	4,943	138
VA Boston Healthcare System	4,055	138
VA Greater Los Angeles Healthcare System	7,600	138
VA North Texas Health Care System	6,772	138
VA Puget Sound Health Care System	4,479	138
Washington, DC VA Medical Center	2,990	138
Total	38,786	1,104

Sample Design

The statistical sample included 1,104 randomly selected appointments based on a stratified sampling design at a 95 percent confidence level. The sample results and projections are limited to the 38,786 scheduled appointments in our review and do not necessarily reflect conditions for any untested populations.

Electronic Waiting List

Our review of scheduled appointments identified 24 veterans at 5 VHA medical facilities who should have been included on electronic waiting lists. Based on our sample results, we estimate that the 5 medical facilities understated their electronic waiting lists by 856 veterans (2.174 percent error rate). This projection has a confidence level of 95 percent with a lower limit of 176 and an upper limit of 1,557. We did not identify any omitted veterans at three VHA medical facilities—the Edward Hines Jr. VA Hospital, Chicago; the VA Greater Los Angeles Healthcare System; and the VA Puget Sound Health Care System.

Table 7. Veterans Not Included on the Electronic Waiting List

VHA Medical Facility	Population Size	Sample Size	Number of Veterans not Included on the Electronic Waiting List	Projected Number of Veterans not Included on the Electronic Waiting List	Confidence Interval
Atlanta VA Medical Center	4,441	138	4	129	+/- 2.755
Kansas City VA Medical Center	4,943	138	8	287	+/- 3.844
VA Boston Healthcare System	4,055	138	2	59	+/- 1.960
VA North Texas Health Care System	6,772	138	6	294	+/- 3.368
Washington, DC VA Medical Center	2,990	138	4	87	+/- 2.734
Total			24	856	

Service-Connected Veterans Waiting Longer than 30 Days

Our review identified 57 scheduled appointments for service-connected veterans that were not scheduled within VHA's goal of 30 days. Based on our sample results, we estimate that the 8 medical facilities reported that 2,009 (5.163 percent error rate) service-connected veterans were seen within 30 days when they actually waited longer than 30 days for their appointments. This projection has a confidence level of 95 percent with a lower limit of 693 and an upper limit of 3,083.

Table 8. Appointments Not Scheduled for Service-Connected Veterans Within 30 Days

VHA Medical Facility	Population Size	Sample Size	Number of Appointments Not Scheduled for Service-Connected Veterans Within 30 Days	Projected Number of Appointments Not Scheduled for Service-Connected Veterans Within 30 Days	Confidence Interval
Atlanta VA Medical Center	4,441	138	5	161	+/- 4.621
Edward J. Hines Jr. VA Hospital, Chicago	3,506	138	2	51	+/- 1.954
Kansas City VA Medical Center	4,943	138	16	573	+/- 5.267
VA Boston Healthcare System	4,055	138	12	353	+/- 3.069
VA Greater Los Angeles Healthcare System	7,600	138	4	220	+/- 2.774
VA North Texas Health Care System	6,772	138	6	294	+/- 3.368
VA Puget Sound Health Care System	4,479	138	9	292	+/- 4.056
Washington, DC VA Medical Center	2,990	138	3	65	+/- 2.376
Total			57	2,009	

Appendix B

Outpatient Scheduling Survey

Introduction

The Office of Inspector General is conducting an audit of outpatient scheduling procedures. You are invited to complete this survey to provide input which will help in assessing the current processes and with developing new procedures to assist you in doing your job and to assist veterans in receiving medical care. The survey is confidential; we ask for identifying information only to contact you if we have any questions about your responses. We estimate it will take 10 minutes to complete this survey.

Your responses to the survey will be returned electronically to the Office of the Inspector General. Individual responses will not be shared with VHA management. Your responses to the survey will assist us in identifying best practices that can be used to establish nationwide standards to improve the quality and timeliness of care provided to our nation's veterans. Thank you for your input.

Total Responses 15,750[12]

Background

	Number of Responses	Percent[13]
1. My grade level is:		
GS 3	86	1%
GS 4	419	3%
GS 5	3,590	29%
GS 6	2,243	18%
GS 7	923	7%
GS 8	413	3%
GS 9	723	6%
GS 10	300	2%
GS 11	1,108	9%
GS 12	808	6%
GS 13	360	3%
GS 14	44	1%
GS 15	109	1%
Senior Executive Service	8	1%
Title 38	1,417	11%
Total	12,551	

[12] Although there were 15,750 unique respondents to the survey, not all respondents answered each question.
[13] Percentages are rounded to the nearest whole number.

2. I schedule appointments in the following decision support system (DSS) Stop Codes:

203 (Audiology)	770	3%
303 (Cardiology)	1,040	4%
307 (Combined Gastrointestinal)	637	2%
321 (Combined Gastrointestinal)	576	2%
322 (Primary Care)	2,596	10%
323 (Primary Care)	3,132	12%
350 (Primary Care)	1,826	7%
407 (Eye Care)	1,021	4%
408 (Eye Care)	944	3%
411 (Podiatry)	1,096	4%
414 (Urology)	1,058	4%
502 (Mental Health)	1,461	5%
509 (Mental Health)	1,122	4%
510 (Mental Health)	1,133	4%
Other	8,639	32%
Total	27,051	

3. Over the course of a year, what percentage of the time do you spend scheduling appointments?

80 to 100%	2,973	19%
50 to 79%	2,009	13%
25 to 49%	1,938	13%
10 to 24%	2,800	18%
Less than 10%	5,679	37%
Total	15,399	

4. How long have you been scheduling appointments?

Less than 3 months	885	6%
3 to 6 months	773	5%
7 to 12 months	1,080	7%
13 to 24 months	1,629	11%
Over 24 months	10,978	72%
Total	15,345	

5. Do you train staff in their scheduling duties?

Yes	4,032	27%
No	10,638	73%
Total	14,670	

Training

6. Do you feel you have had adequate training to perform your scheduling responsibilities?

Yes	12,150	79%
No	3,257	21%
Total	15,407	

7. How much training on the VistA scheduling module (other than on-the-job training) have you received?

None	6,783	45%
Up to 4 hours	5,423	35%
5-8 hours	1,112	7%
9-16 hours	466	3%
More than 16 hours	1,520	10%
Total	15,304	

8. How much training on the electronic waiting list (other than on-the-job training) have you received?

None	12,270	81%
Up to 4 hours	2,314	15%
5-8 hours	278	2%
9-16 hours	100	1%
More than 16 hours	222	1%
Total	15,184	

9. Did you review the video tape entitled, "VistA Scheduling Software: Making a Difference"?

Yes	1,746	12%
No	13,230	88%
Total	14,976	

Supervision

10. When scheduling appointments, have your managers or supervisors directed or encouraged you to schedule the appointment contrary to written guidance or directives established for scheduling veterans' appointments?

Yes	1,110	7%
No	14,166	93%
Total	15,276	

11. Do you believe the supervision you receive regarding scheduling appointments is adequate to perform your duties?

Yes	12,478	82%
No	2,721	18%
Total	15,199	

12. Have you ever been directed to never use the next available appointment option when scheduling appointments?

Yes	4,183	27%
No	11,051	73%
Total	15,234	

13. Have you ever been directed to determine when the next appointment slot is open before you enter the desired appointment date?

Yes	6,192	41%
No	8,959	59%
Total	15,151	

14. Do you feel there is pressure from your leadership (including your immediate supervisors) to keep the waiting list times short causing you to circumvent the established procedures for scheduling appointments?

Yes	1,469	10%
No	13,597	90%
Total	15,066	

Scheduling Practices

15. Do you ever determine when the next appointment slot is open before you enter the desired appointment date?

Yes	8,741	58%
No	6,431	42%
Total	15,172	

16. Do you ever use the next available appointment option when scheduling appointments?

Yes	8,113	53%
No	7,102	47%
Total	15,215	

17. How many consult referrals do you have over 7 business days old that have not been scheduled?

None	9,971	80%
1 to 25	1,903	15%
26 to 50	248	2%
More than 50	342	3%
Total	12,464	

18. Do or did you use the electronic waiting list?

Yes	1,073	7%
No	14,190	93%
Total	15,263	

19. Do or did you maintain an informal waiting list (such as a paper copy on your desk)?

Yes	2,433	16%
No	12,754	84%
Total	15,187	

20. Have you ever cancelled or rescheduled the appointments of nonservice-connected veterans in order to schedule the appointments of service-connected veterans?

Yes	803	5%
No	14,422	95%
Total	15,225	

21. If you receive patients as referrals from other clinics (consult referrals), generally how soon are you able to schedule their appointments? This question applies only to scheduling appointments, not how long it takes to actually see the patient.

Within 1 business day of receiving the referral	2,739	27%
Within 7 business days of receiving the referral	4,346	42%
Within 30 business days of receiving the referral	2,491	24%
More than 30 business days after receiving the referral	744	7%
Total	10,320	

For the following questions, we have modified the question by bolding and italicizing the correct procedure for each scheduling scenario.

Questions 22 through 28

When scheduling appointments how would you enter an appointment under the following circumstances? Please answer with the procedures that you currently use.

22. The veteran wants an appointment as soon as possible, but does not need urgent or emergent treatment.

Answer no to the prompt "Is this a next available appointment request"? and use the next open time slot as the desired date. (The next open time slot can be determined by either: (i) staff and/or provider knowledge of their clinic schedules; (ii) review of a hard copy schedule; or (iii) using the scheduling package to find the next open time slot, backing out of the scheduling package, and then restarting the appointment search).	3,056	29%
Answer no to the prompt "Is this a next available appointment request"? and use today (the date you are creating the appointment) as the desired date.	1,288	12%
Answer no to the prompt "Is this a next available appointment request"? and enter the desired date specified by the provider (for example, t+6m for a return to clinic (RTC) in 6 months).	1,689	16%
Answer yes to the prompt "Is this a next available appointment request"? find open time slot and create appointment.	3,265	31%
Contact the provider to determine the specific instructions for the patient's return visit.	1,269	12%
Total	10,567	

23. The provider requests a specific timeframe for a return appointment (for example, the provider notes return to clinic in 6 months).

Answer no to the prompt "Is this a next available appointment request"? and use the next open time slot as the desired date. (The next open time slot can be determined by either: (i) staff and/or provider knowledge of their clinic schedules; (ii) review of a hard copy schedule; or (iii) using the scheduling package to find the next open time slot, backing out of the scheduling package, and then restarting the appointment search).	1,040	10%
Answer no to the prompt "Is this a next available appointment request"? and use today (the date you are creating the appointment) as the desired date.	374	4%
Answer no to the prompt "Is this a next available appointment request"? and enter the desired date specified by the provider (for example, t+6m for a RTC in 6 months).	7,792	78%
Answer yes to the prompt "Is this a next available appointment request"? find open time slot and create appointment.	476	5%
Contact the provider to determine the specific instructions for the patient's return visit.	285	3%
Total	9,967	

24. The provider does not specify when the veteran should be scheduled for a return appointment (For example, the provider notes "return to clinic routine" or leaves this blank).

Answer no to the prompt "Is this a next available appointment request"? and use the next open time slot as the desired date. (The next open time slot can be determined by either: (i) staff and/or provider knowledge of their clinic schedules; (ii) review of a hard copy schedule; or (iii) using the scheduling package to find the next open time slot, backing out of the scheduling package, and then restarting the appointment search).	985	12%
Answer no to the prompt "Is this a next available appointment request"? and use today (the date you are creating the appointment) as the desired date.	342	4%
Answer no to the prompt "Is this a next available appointment request"? and enter the desired date specified by the provider (for example, t+6m for a RTC in 6 months).	583	7%
Answer yes to the prompt "Is this a next available appointment request"? find open time slot and create appointment.	679	8%
Contact the provider to determine the specific instructions for the patient's return visit.	5,965	70%
Total	8,554	

25. Appointment cancelled by patient, and the patient wants to be rescheduled.

Answer no to the prompt "Is this a next available appointment request"? and use the next open time slot as the desired date. (The next open time slot can be determined by either: (i) staff and/or provider knowledge of their clinic schedules; (ii) review of a hard copy schedule; or (iii) using the scheduling package to find the next open time slot, backing out of the scheduling package, and then restarting the appointment search).	4,038	38%
Answer no to the prompt "Is this a next available appointment request"? and use today (the date you are creating the appointment) as the desired date.	1,567	15%
Answer no to the prompt "Is this a next available appointment request"? and enter the desired date specified by the provider (for example, t+6m for a RTC in 6 months).	1,161	11%
Answer yes to the prompt "Is this a next available appointment request"? find open time slot and create appointment.	3,192	30%
Contact the provider to determine the specific instructions for the patient's return visit.	804	7%
Total	10,762	

26. If you schedule appointments for any specialty clinics and receive a consult referral.

Answer no to the prompt "Is this a next available appointment request"? and use the next open time slot as the desired date. (The next open time slot can be determined by either: (i) staff and/or provider knowledge of their clinic schedules; (ii) review of a hard copy schedule; or (iii) using the scheduling package to find the next open time slot, backing out of the scheduling package, and then restarting the appointment search).	1,842	28%
Answer no to the prompt "Is this a next available appointment request"? and use today (the date you are creating the appointment) as the desired date.	616	9%
Answer no to the prompt "Is this a next available appointment request"? and enter the desired date specified by the provider (for example, t+6m for a RTC in 6 months).	949	14%
Answer yes to the prompt "Is this a next available appointment request"? find open time slot and create appointment.	2,398	36%
Contact the provider to determine the specific instructions for the patient's return visit.	809	12%
Total	6,614	

27. Patient does not want first time slot offered, requests the next day.

Answer no to the prompt "Is this a next available appointment request"? and use the next open time slot as the desired date. (The next open time slot can be determined by either: (i) staff and/or provider knowledge of their clinic schedules; (ii) review of a hard copy schedule; or (iii) using the scheduling package to find the next open time slot, backing out of the scheduling package, and then restarting the appointment search).	3,709	36%
Answer no to the prompt "Is this a next available appointment request"? and use today (the date you are creating the appointment) as the desired date.	2,204	21%
Answer no to the prompt "Is this a next available appointment request"? and enter the desired date specified by the provider (for example, t+6m for a RTC in 6 months).	1,680	16%
Answer yes to the prompt "Is this a next available appointment request"? find open time slot and create appointment.	1,917	19%
Contact the provider to determine the specific instructions for the patient's return visit.	765	7%
Total	10,275	

28. Appointment cancelled by clinic, patients need to be rescheduled.

Answer no to the prompt "Is this a next available appointment request"? and use the next open time slot as the desired date. (The next open time slot can be determined by either: (i) staff and/or provider knowledge of their clinic schedules; (ii) review of a hard copy schedule; or (iii) using the scheduling package to find the next open time slot, backing out of the scheduling package, and then restarting the appointment search).	3,336	33%
Answer no to the prompt "Is this a next available appointment request"? and use today (the date you are creating the appointment) as the desired date.	1,215	12%
Answer no to the prompt "Is this a next available appointment request"? and enter the desired date specified by the provider (for example, t+6m for a RTC in 6 months).	1,165	12%
Answer yes to the prompt "Is this a next available appointment request"? find open time slot and create appointment.	2,857	28%
Contact the provider to determine the specific instructions for the patient's return visit.	1,534	15%
Total	10,107	

Appendix C

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: May 19, 2005

From: Under Secretary for Health

Subject: **Audit of Veterans Health Administration's Outpatient Scheduling Procedures**

To: Assistant Inspector General for Auditing (52)

1. I have reviewed the referenced draft report and concur in the findings and recommendations. VHA is committed to assuring that key clinic scheduling improvements become operational in all of our facilities and we will continue to advance our ongoing, systematic efforts to achieve that goal. A plan of corrective action to your recommendations is attached. The Deputy Under Secretary for Health for Operations and Management also plans to send a memo to all VISN Directors that addresses expectations in follow-up to issues addressed in your report. This correspondence will be provided to you in our first quarterly action plan update.

2. While the report accurately identifies recognized inconsistencies among facilities in implementing established outpatient scheduling procedures, we are disappointed that you failed to even allude to the significant steps VHA has taken, particularly over the past year, to implement a key initiative that directly impacts scheduling issues in question. The Advanced Clinic Access (ACA) project is an ongoing national process to implement patient-centered, scientifically based redesign principles and tools in all of its operations. These successfully tested principles result not only in improved access, but also in improved patient, staff and provider satisfaction, as well as in improved quality, improved efficiency and decreased cost. Under the ACA umbrella,

VHA is vigorously addressing problems with wait times and scheduling delays. We have taken steps to accurately quantify numbers of patients on wait lists, length of waits and reasons for scheduling delays. In addition, we are making notable progress in the move to standardize appointment scheduling processes and to manage wait lists.

3. Structured organizational support has been established to guide, oversee and measure initiative progress. An ACA Steering Committee and its sub-committees, comprised of representatives from all VHA organizational levels, provide overall direction. ACA points of contact have been designated in all VISNs and medical facilities, and lines of communication are being expanded to assure systematic sharing of information. In this regard, the ACA Steering Committee launched an ACA Outlook email group in March 2004. This group consists of approximately 600 members, most of whom are directly involved in scheduling activities. In addition to routine, daily communication, the group participates in regularly-scheduled monthly conference calls that feature "best practices" presentations by individual VISNs and medical facilities that are targeted specifically at the educational needs of clinic administrative support staff.

4. VHA is also revising and consolidating existing national directives dealing with clinic scheduling (i.e., VHA Directive 2003-068: Process for Managing Patients When Patient Demand Exceeds Current Clinical Capacity; VHA Directive 2003-062: Priority Scheduling for Outpatient Medical Services and Inpatient Hospital Care for Service Connected Veterans; and VHA Directive 2002-059: Priority for Outpatient Medical Services and Inpatient Hospital Care). In addition, a VHA work group has been charged with development of a national directive to provide step-by-step guides for scheduling management. It is anticipated that these directives will be finalized for field distribution by the end of July 2005. Since July 2004, all facility and network directors have been required to certify compliance with existing directives. Managers are conscientiously providing important feedback about roadblocks they encounter,

particularly in relation to out-of-date software and the frequent connection incompatibilities between the Computerized Patient Record System (CPRS) consult package and the VistA scheduling module. This problem was also highlighted by OIG.

5. We agree that such software inadequacies represent a barrier to successful implementation of our ACA initiative, and VHA program managers are working closely with the Office of Information (OI) to remedy the situation. In August 2004, a VHA Consult Task Force was created to address disconnects among the consult package, the scheduling package, and the electronic wait list. Based on their recommendations, the OI is in the process of designing enhancements to establish the needed links. Further analysis is currently being conducted to refine the work scope and define timelines for completion of this project. We will share progress with you in this regard in upcoming action plan status updates.

6. VHA recognizes the need for qualified, well trained administrative staff. We have required all facilities to carefully inventory specific staff that is currently performing the scheduling function, and to identify and act upon procedural inefficiencies. The new scheduling directive will provide further guidance about recommended scheduler competencies, position descriptions, performance reviews, etc. A most compelling challenge is the high turnover rate among the clerical staff that is critical to the successful scheduling of appointments for our veterans. VHA is working hard to systematically address this issue.

7. Finally, we reiterate our priority commitment to assuring that all clinic schedulers have access to needed training and educational opportunities to assist them in fulfilling their responsibilities. Much improvement in this area has already been accomplished, but additional challenges remain. We address some of our planned and ongoing training initiatives in the attached action plan, as well as the methods we plan to apply in monitoring the effectiveness of such efforts. We note in particular our

national education plan for schedulers and scheduling supervisors, anticipated for completion by early July 2005.

8. In summary, we believe that once implemented systemwide, VHA's ACA initiative, in conjunction with other planned and ongoing improvements, will result in needed scheduling enhancements that are consistently applied by our facilities. Although your auditors concentrated on the focused request of our Secretary to assess VHA's compliance with established outpatient scheduling procedures, we feel that the report would have been more balanced if you also acknowledged VHA's significant efforts at improvement. An uninformed reader would be led to believe that identified scheduling inefficiencies remain unaddressed, and this is clearly not the case.

9. Thank you for the opportunity to comment on this report. We look forward to sharing our ongoing progress with you. If you require additional information, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at 565-7638.

(original signed by:)

Jonathan B. Perlin, MD, PhD, MSHA, FACP

Attachments

Under Secretary for Health Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendations in the Office of Inspector General's Report:

OIG Recommendations

Recommended Improvement Action 1. We recommended that the Under Secretary for Health: (a) ensure that medical facility managers require schedulers to create appointments following established procedures and (b) monitor the schedulers' use of correct procedures when creating appointments.

Concur **Target Completion Date:** July 2005 and Ongoing

OIG did not acknowledge VHA's extensive efforts to systematically implement a key new initiative, known as Advanced Clinic Access (ACA), that is designed to reduce waiting times and wait lists by improving clinic efficiencies and reducing unnecessary demand. Under the ACA umbrella, VHA is actively involved in consolidating and updating established national scheduling directives and devising a new VHA scheduling directive designed to assist the administrative staff who are responsible for scheduling activity. It is anticipated that the new national guidance will be finalized for field distribution by the end of July 2005. This is part of VHA's efforts to better standardize procedures throughout the system.

VHA will continue to emphasize the requirement that all facilities implement established practices, since we share OIG's concern about inconsistent procedures being applied among our facilities.

All of the VISN directors and medical facility directors have been provided with copies of OIG's report, and the ACA Steering Committee continues to reinforce need for facility compliance with existing policies during routine conference calls and mail group exchanges. All VISNs and medical

facilities have designated ACA points of contact, who are actively overseeing compliance efforts. As also noted in our cover memo, VISN and medical center directors are required to certify quarterly whether or not the facilities are in compliance with existing requirements, and to provide explanatory comments about their compliance or non-compliance.

In addition, as part of the full spectrum of wait time analysis, a special review was performed in late Fiscal Year 2004, utilizing the VHA External Peer Review Program (EPRP) process. EPRP abstractors used chart review to compare medical record documentation with information contained in the scheduling package. This assessment provided a unique opportunity to evaluate entries in the scheduling package, and identified opportunities for focused scheduler training that are being incorporated into scheduler training programs. We plan to continue utilizing the EPRP abstractors for regular, quarterly collection of these comparative data, beginning in July 2005.

Recommended Improvement Action 2. We recommended that the Under Secretary for Health: (a) monitor consult referrals to ensure that all veterans with referrals either have scheduled appointments within 7 business days or are included on electronic waiting lists, (b) establish an automated link from the CPRS consult package to the VistA scheduling module, and (c) ensure medical facilities prohibit the use of informal waiting lists.

Concur **Target Completion Date:** July 2005 and Ongoing

Software inadequacies, including incompatibilities between the consult package in CPRS and the VistA scheduling module, have created obstacles in managing consult referrals. Through coordinated efforts with the Office of Information, we are working to resolve software problems. Progress is well underway to nationally implement a consult-scheduling connection package created by the Washington, D.C. VAMC and the tracking routine created by VISN 3 through conversion to Class 1 software. The consult-scheduling connection shared by these two applications is basically a

cross-walk that associates each type of consult with a particular stop code as tracked in the current scheduling package.

The Washington, D.C. routine creates a connection between the consult and scheduling packages, enabling transfers of important information. The consult entry date is captured in the scheduling package and progress is electronically tracked through scheduling and the subsequent visit. In addition, status changes to the consult are automatically generated, with alerts provided back to the providers.

The VISN 3 routine provides information on all consults completed within the last thirty days of date run, including date completed, and all information about associated clinic appointments. It also provides information on all consults that are still pending resolution. Application of this new software, which is anticipated by July 2005, should greatly enhance the ability of facilities to monitor the timeliness of consult referrals.

During the first quarter, FY 2005, VHA also implemented a performance monitor that first confirms whether or not the CPRS consult software is being utilized to generate and process consults. Consults are resolved through electronically signed progress notes in CPRS. All negative responses must be addressed, tracked and reported on each subsequent quarterly monitor report. The monitor also targets any consults that might still be pending resolution beyond 12 months. These cases are tracked through completion. The consult cycle is updated quarterly to reflect current workload demand. VHA's quarterly target goal for old consults is 97 percent completion. Our average completion rate for the first quarter of FY 2005 was 95 percent, with 12 VISNs reporting a greater than 97 percent completion rate.

A new Consult Directive has also been drafted to establish business rules for the management of consult requests, procedures and other specialty service care. We will incorporate into both the Consult Directive and Scheduling Directive a requirement that all consults and outpatient procedure requests be generated using the CPRS

consult/procedure package, with scheduling completed using the VISTA appointment management scheduling software.

The Office of Information is assessing additional ways to modify and effectively link the CPRS consult module to the VISTA scheduling module, based on the submitted request from VHA's Consult Task Force. Work scope and completion timeframes for this project have not yet been established. This information will be shared with OIG in upcoming activity updates.

In all follow-up communication with network and facility managers, the point will be emphasized that facilities are prohibited from using informal waiting lists. The facility points of contact for the ACA initiative will be instructed to specifically assure that such practices are eliminated.

Recommended Improvement Action 3. We recommended that the Under Secretary for Health: (a) develop a standard training package and provide that package to medical facilities for their use in training schedulers on the electronic waiting list and VistA scheduling modules, (b) ensure all medical facilities provide the video training titled "VistA Scheduling Software: Making a Difference" to their schedulers, and (c) make sure all schedulers receive annual training on the electronic waiting list and VistA scheduling module.

Concur **Target Completion Date:** July 2005 and Ongoing

Numerous training options, including a broad range of web-based training listed on the ACA Home Page, are currently available for schedulers, and virtually all facilities report establishment of minimal training requirements for scheduling staff. Many facilities/VISNs have developed and mandated completion of training on their local web sites and have established oversight monitors to assure that all staff have taken the training. Refresher training is also provided at most locations on a scheduled basis or on an as-needed basis for schedulers requiring immediate assistance. Most VISNs also report that they are requiring and tracking completion of training. All VISNs received multiple copies of the

referenced "VISTA Scheduling Software: Making a Difference," as well as two related video training tools.

A web-based version of the VistA Scheduling Software video has been posted on the ACA web page to facilitate scheduler training efforts systemwide.

We recognize the need to standardize minimal training requirements, while still allowing opportunity for flexibility to meet individual facility needs. The Office of the Deputy Under Secretary for Health for Operations and Management has charged ACA program staff with development and roll-out by July 1, 2005, of a comprehensive VHA national education plan that will be mandatory for all individuals involved in the scheduling process. Scheduling supervisors will also be required to complete the training.

Appendix D

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Appendix E

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