Department of Veterans Affairs
Office of Inspector General

Review of Access to Care in the Veterans Health Administration

Veteran access to non-institutional care has improved, but VHA can do even more. Improvements are also needed in monitoring timeliness of initial care to newly enrolled veterans and providing timely elective procedures.

Report No. 05-03028-145 **May 17, 2006**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Contents

Executive Summary

Introduction

The VA Office of Inspector General (OIG) reviewed the Veterans Health Administration's (VHA) process used to ensure that all eligible veterans (veterans who are enrolled and present a clinical need) had adequate access to care. Our specific objectives were to determine whether: (1) eligible veterans had access to non-institutional care, (2) all eligible veterans who desired care were enrolled and provided timely care, and (3) eligible veterans received clinically indicated elective procedures within reasonable timeframes.

We visited five medical facilities and two Veterans Integrated Service Networks (VISNs). We interviewed 117 facility personnel who were involved in their facility's process for providing veterans with non-institutional care, enrolling veterans in VHA's health care system (HCS), and providing care in a timely manner. We reviewed medical records and analyzed workload data provided to us from the five medical facilities and nationwide data provided by VHA's Allocation Resource Center[1] and VHA's Health Eligibility Center. The review was conducted at the request of Senator Daniel K. Akaka, Ranking Member, Senate Committee on Veterans' Affairs.

Results

The Veterans Millennium Health Care and Benefits Act of 1999[2] (Act) clarified requirements for VHA to provide veterans non-institutional care, and we found that access to such care has improved. We reviewed seven non-institutional care services available to all eligible veterans if clinically necessary and found that:

- The number of medical facilities offering at least 6 of the 7 non-institutional care services increased from 4 (3 percent) of 130 facilities in fiscal year (FY) 2003 to 91 (72 percent) of 127 facilities in FY 2005.
- The numbers of veterans using at least 1 of the 7 non-institutional care services increased from 66,106 in FY 2003 to 105,570 in FY 2005—a 60 percent increase.

However, VHA can further increase veteran access to non-institutional care. Even though all enrolled veterans are eligible for non-institutional care services, some medical facilities limited access of certain non-institutional care services to only the highest priority veterans, such as those with at least a 70 percent service-connected disability. Nationwide, we found that the higher priority groups 1, 2, and 3 received more non-

[1] The Allocation Resource Center maintains national VHA databases that provide much of the support for VHA's budget development and planning.
[2] Public Law 106-117.

institutional care than the lower priority groups 5, 6, and 7 (2.8 percent compared to 1.9 percent of unique users to active enrollees). Some medical facilities were either unable or chose not to provide veterans with non-institutional care in the remote regions of their geographic areas. Additionally, VHA needs to develop metrics to assess whether its geriatric evaluation program is meeting the requirements of the Act.

These opportunities exist, in part, because VHA has not fully funded its projected workload for non-institutional care. VHA estimated that the total enrollee demand for non-institutional care in FY 2005 was an average daily census[3] of 170,403. This demand estimate included those veterans who chose to seek their care through other sources, such as Medicare and Medicaid. VHA estimated that the FY 2005 nationwide demand of enrolled veterans who would prefer to rely on the VA for non-institutional care was an average daily census of 96,255. However, VHA budgeted about $378 million[4], which was designed to achieve an average daily census of 21,863—23 percent of the estimated nationwide demand of enrolled veterans who would prefer to rely on the VA for non-institutional care. In FY 2005, VHA provided medical facilities with about $17,289 per average daily census ($378 million divided by 21,863). Using this estimate, VHA would need about $1.7 billion to meet the average daily census of 96,255 for enrolled veterans who would prefer to rely on the VA for non-institutional care and about $2.9 billion to provide non-institutional care to all enrollees. In addition, VHA's budgeting process may not provide facilities with all the funding necessary to provide medical care to priority groups 7 and 8 veterans.

We found that eligible veterans who desired care were enrolled in the VHA HCS. However, medical facilities did not establish effective controls to ensure that all newly enrolled veterans who wanted care received their care within VHA's goal of 30 days from the veteran's desired date. Medical facilities were not meeting national performance timeliness goals for providing care to newly enrolled veterans, and some veterans who stated that they wanted care did not get care. We also found that the electronic waiting list at one facility was understated, which overstated the facility's reported performance in scheduling appointments within 30 days.

Eligible veterans did not always receive clinically indicated specialty procedures within reasonable timeframes. VHA has not established a method to measure the length of time veterans wait for elective procedures; in some cases, veterans experienced excessive waiting times. For example, at one facility the average wait for elective orthopedic procedures was 212 days. While a VHA performance measure requires facility directors to track the time veterans wait for their specialty care appointments, facilities are not required to track the length of time a veteran must wait from the requests or authorizations for elective procedures until the procedures are actually performed. In addition to the lack of emphasis on this measurement, facility personnel told us about

[3] Average daily census represents the total number of outpatient encounters for non-institutional care divided by the number of days in the performance period.

[4] VHA's FY 2005 budget shows $426 million for home and community based care. Of the $426 million, about $48 million is targeted for community residential care leaving $378 million for non-institutional care.

other reasons for lengthy waits, such as physician and support staff vacancies, insufficient surgical space, and lack of colonoscopy equipment. To better assess and manage their workload and ensure veterans receive timely care, facility managers need to track the veteran's entire waiting time—not just the waiting time to the appointment.

Conclusion

VHA established policies and performance measures to ensure that eligible veterans have the opportunity to receive their care in a non-institutional setting when appropriate. As a result, veteran access to non-institutional care services has increased since FY 2003, but opportunities exist for VHA to further increase veteran access to non-institutional care. The enrollment process at the five facilities we visited complied with national enrollment policies and did not include any local barriers that prevented or discouraged veterans from enrolling. However, medical facilities need to track new enrollees to ensure that those who want care receive care. VHA needs to establish acceptable time standards and require medical facilities to measure the time veterans wait for elective procedures.

We recommended that the Under Secretary for Health:

1. (a) Continue to monitor the demand for non-institutional care services and, when possible, use available funding to accelerate medical facilities' ability to provide all required non-institutional care services to their veterans; (b) ensure that facilities have eliminated any local restrictions limiting eligible veteran access to non-institutional care; (c) expand coverage to geographic areas that currently do not offer non-institutional care services; (d) make sure facilities use the electronic waiting list to identify veterans waiting for non-institutional care; and (e) establish an effective measurement system to evaluate the extent to which geriatric evaluations are occurring.
2. (a) Direct facilities to implement a tracking mechanism to identify which newly enrolled veterans want care and make sure they receive it and (b) remind facilities of the requirement to either schedule a veteran's appointment or place the veteran on the electronic waiting list within 7 business days of the appointment request.
3. (a) Establish standardized tracking methods and appropriate performance metrics to evaluate and improve the timeliness of elective procedures and (b) implement prioritization processes to ensure that veterans receive clinically indicated elective procedures according to their clinical needs.

Comments

The Under Secretary for Health generally agreed with the findings and recommendations and provided acceptable implementation plans. VHA will continue to monitor the demand and supply of non-institutional home and community-based services and increase capacity as resources permit. The Deputy Under Secretary of Health for Operations and Management will e-mail facility directors, chiefs of staff, and nursing directions, reaffirming the guidance and expectations that non-institutional care programs are part of the VHA medical benefits package. To the extent possible, VHA will incrementally expand coverage to geographic areas that currently do not offer non-institutional care services; however, since growth is constrained by capacity as well as budget, expansion of access will continue to occur incrementally. VHA will explore increased use of Care Coordination/Telehealth Services and other creative solutions. VHA plans to issue revised directives establishing policy for use of electronic wait lists and scheduling processes. VHA will work to establish metrics to measure the extent to which geriatric evaluations are occurring and add a report on this to their monthly Performance Report. VHA's Office of Quality and Performance will develop performance metrics to evaluate timeliness of elective procedures. (See Appendix D for the full text of the Under Secretary's comments.)

The Under Secretary for Health noted that he was pleased that VHA's rapid pace of improvement in providing veteran's access to non-institutional services was acknowledged in the report. He expressed concern that since the study was limited to five facilities and two networks, it therefore might not be representative of VA access issues nationwide. Additionally, he concluded that the report focused on allocation of budget resources, even though VHA's ability to implement non-institutional programs is affected by a number of other factors that were not included in the review. Finally, the Under Secretary did not agree with our conclusion that facilities were unable to schedule veterans for appointments within 4 months as required by current policy because facilities placed some veterans on the electronic waiting list earlier. He stated that the number of patients on the electronic waiting list represents new enrollees who have been waiting more than 30 days, not 120 days.

Our conclusions in this report are in fact representative of VHA access issues nationwide. Although our site visits were limited to five facilities and two networks, our data analysis and resulting conclusions were based on nationwide workload data. Furthermore, we also believe that VHA's allocation of budget resources is a primary cause for limited access at medical facilities. From our discussions with senior leaders at the five facilities we visited and with program officials in VA Central Office, limited resources and the priority for using those resources were repeatedly given as an impediment for providing veterans with more access to care. Unavailability of private sector providers of certain services was mentioned as an impediment only at the Pacific Islands HCS and the Alaska VA HCS.

With regard to VHA concerns relating to waiting lists, we understand that facilities may choose a shorter timeframe as the criteria for when to place a veteran on the electronic waiting list. However, we did not determine and VHA did not provide us the criteria each facility uses for placing veterans on the electronic waiting list. Therefore, we used existing VHA policy that requires that all appointment requests are acted on within 7 business days by either scheduling an appointment within 4 months or placing the veteran on the electronic waiting list. Whether a 30-day or a 4-month standard is used as the criteria for placing veterans on the electronic waiting list, we still conclude that veterans included on the electronic waiting list represent veterans who are not receiving timely appointments.

The Under Secretary for Health concurred in all recommendations and submitted appropriate implementation plans for corrective action. We will follow up on planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Introduction

Purpose

The purpose of the review was to evaluate whether VHA has an effective process to ensure that all eligible veterans had adequate access to care. Our objectives were to determine whether: (1) eligible veterans had access to non-institutional care, (2) all eligible veterans who desired care were enrolled and provided timely care, and (3) eligible veterans received clinically indicated elective procedures within reasonable timeframes.

Background

Members of Senator Akaka's staff visited the Community Based Outpatient Clinic located in Maui, Hawaii. They learned during their conversations with clinicians at the VA facility that restrictions were being placed on veterans for certain non-institutional care services, which was contrary to the intent of the Act. Staff members requested our office to determine whether these restrictions were appropriate, whether certain priority groups (7, 8) were denied such services, and whether VA adequately funded services to comply with the provisions of the Act.

VHA leadership is committed to providing quality health care to veterans. The budgeting and planning for this VA health care is extremely complex. This is compounded by continuing uncertainty from year to year of the number of patients who will actually seek care from VA over time. Further complicating the budget execution process are the limitations imposed by VA's current financial management and workload measurement systems, which hinder the ability of managers to accurately measure specific program financial performance.

VHA's definition of the medical benefits package (as specified in 38 CFR 17.38) is broadly written and supports VHA's general premise that health care clinicians and managers will provide medical care that is appropriate to the needs of veterans. Therefore, VHA has the flexibility to adjust health care delivery according to locally established experiences and the best current scientific data. By not specifically identifying the medical benefit requirements of VA in a uniform manner, budgeting for the medical benefit becomes more challenging.

VHA is also challenged with determining who will seek care. The identification of those who rely upon VHA for medical care is based upon a series of assumptions that attempt to determine the likelihood that a veteran will obtain care using VHA resources. Veterans are given a priority for health care based upon the relationship of their medical condition to military service-incurred disability and, in some cases, the veteran's current income. VA experience shows that many who are enrolled at a VHA facility do not use the facility for their medical care. Thus, the system does not anticipate that all veterans

who are enrolled at a VHA facility will be provided all of their care by the VHA facility[5] or by using VHA resources. Beyond primary care, VHA provides care for enrolled priority 7 and 8 veterans only to the extent that there are funds available.

VHA's current financial management system limits the ability of managers to analyze a program's financial performance. Office of Management and Budget Circular A-127–Financial Management Systems provides that all agency financial management systems should generate reliable, timely, and consistent information necessary for meeting management's responsibilities. It also requires that management control processes are set forth to ensure that, "…reliable and timely information is obtained, maintained, reported, and used for decision making…," including prompt and appropriate recording and classifications. The OIG has repeatedly reported that VA needs an integrated Financial Management System in part to give managers the ability to analyze each program's financial performance.[6]

Our 2005 review showed that funds received from the Congress are allocated to VISNs by using the Veterans Equitable Resource Allocation (VERA) model. VHA instituted the VERA system in April 1997 to allocate funds to networks. VERA was designed to ensure the distribution of funds is equitable, based on veterans who actually use the VA health care system, rather than simply applying incrementally based budgeting. Funds are made available to the VISN for the purpose of providing veterans with the appropriate benefit. Congress directed, by language in the Senate Appropriations Report and the enactment of Public Law 106-337, that VHA enter into a contract with a federally-funded research and development center to conduct an analysis of VERA. The RAND Corporation issued a report titled, "*An Analysis of the Veterans Equitable Resource Allocation (VERA) System*," dated September 18, 2001. The contractor opined that VERA was a better alternative to incremental budgeting but recognized that VERA needed to be refined because many factors were still not considered.

We also found that not all of the expected use of these funds is defined in detail by VHA when funds are provided to the VISNs. For example, we found that the funding for each non-institutional care program is not specifically enumerated in the funding that a VISN receives from VHA. The VISN and facility managers allocate monies to these programs based upon perceived need and other factors. The lack of specificity in the current financial management system makes it difficult to evaluate productivity. Recent attempts

[5] 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.

[6] OIG *Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2005 and 2004*, November 15, 2005.

to implement a new financial management system, the Core Financial and Logistics System, were not successful.[7]

Non-Institutional Care

The Act, passed by Congress in 1999, directed VA to provide veterans eligible for medical services with certain non-institutional care services—services that are provided to veterans in their own homes or in community settings. In response to the Act, VHA implemented policies[8] requiring medical facilities to provide non-institutional care services to all eligible veterans and to include the services in the VHA medical benefits package. The services include:

- Home based primary care.
- Purchased skilled home health care.
- Homemaker and home health aides (H/HHA).
- Adult day health care.
- Geriatric evaluation and management.
- Respite care.
- Hospice and palliative care.

In addition, VHA measures the facilities' use of care coordination and home telehealth (CCHT) services to meet the non-institutional care needs of veterans. (Descriptions of these non-institutional care services are provided in Appendix A.)

VHA does not provide its medical facilities with specific funds to be used for non-institutional care. After Congress approves the annual budget, VA financial managers distribute funds to each VISN within the three appropriations—medical administration, medical facilities, and medical services. VISN managers use the VERA system as the basis for determining and distributing the amount of funds each medical facility receives within their VISN. Each facility's non-institutional care needs then compete with the other medical service needs of the facility.

VERA allocates resources based primarily on patient workloads. Each VISN receives a funding allocation based on a predetermined dollar amount per veteran served and the complexity of the veteran's health conditions. VERA allocation rates are separated into two groups—veterans in priority groups 1 through 6 and veterans in priority groups 7 and 8. According to VHA officials, VISNs receive less funding for priority groups 7 and 8.

[7] OIG Report: *Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)*; Number 04-01371-177, August 11, 2004.
[8] VHA Directive 2001-061, *Non-Institutional Extended Care within VHA*, October 4, 2001, and IL 10-2004-005, *Under Secretary for Health's Information Letter, Non-Institutional Extended Care,* May 3, 2004.

Those two groups' veterans are generally healthier, have other options for health care through private insurance, and do not use the VA for all of their health care needs. The FY 2006 allocation rates are shown in Table 1 below:

Table 1. VERA Allocation Rates

Price Groups	Priority Groups 1-6	Priority Groups 7-8
1. Non-Reliant on VA for Care	$271	$226
2. Basic Medical, Heart, Lung, and Gastroenterology	$2,684	$1,382
3. Mental Health	$3,334	$1,901
4. Oncology and Legally Blind	$6,210	$3,100
5. Multiple Problems	$9,335	$6,553
6. Significant Diagnosis	$16,098	$12,674
7. Specialized Care	$15,160	$10,360
8. Supportive Care	$25,775	$20,278
9. Chronic Mental Illness	$32,478	$32,478
10. Critically Ill	$49,297	$40,131

Initial Care to New Enrollees

VA maintains an enrollment system consisting of eight priority groups as a tool to manage the provision of medical care to all enrolled veterans. (Appendix B has a complete description of the eight enrollment priorities.) On January 17, 2003, VA announced in the *Federal Register*[9] that all priority groups of veterans would be treated, except those classified as priority 8[10] who enrolled after January 17, 2003.

VHA's goal is to schedule all eligible new enrollees who request VA care within 30 days of their desired appointment date. However, medical facilities must schedule appointments for veterans who have a 50 percent or greater service-connection or who require care for a service-connected disability within 30 days or arrange to provide the care at another VHA medical facility, on a fee-for-service basis, or at a Defense Department sharing agreement facility at VA expense. VHA also requires that facilities either schedule veteran appointments for care within 4 months or place veterans on electronic waiting lists.

[9] 68 FR 2670, January 17, 2003.

[10] Priority 8 veterans are those who agree to pay specified co-payments and have income and/or net worth above the VA means test threshold and the Department of Housing and Urban Development geographic index.

Timeliness of Elective Specialty Procedures

VHA's performance measures for timeliness of care do not track the length of time veterans wait from when a procedure is requested or authorized until it is performed. VHA has no standardized process to capture and measure these waiting times. In September 2005, VHA chartered a task force to develop an electronic method to determine the number of veterans waiting for specialty procedures and the length of their waiting time.

We could not locate any timeliness standards within the VHA or United States medical organizations for the procedures we reviewed. However, some countries with national health systems have set timeliness goals and implemented performance measures for orthopedic surgery. For example, in Great Britain, the waiting time for hip and knee replacement surgery in 2003 was 11 to 12 months. Great Britain's National Health Service initiated an effort to reduce waiting times to no longer than 6 months for orthopedic surgery. As a result, in April 2005, the average waiting time was about 12 weeks.[11] Further, a study of published literature found some consistency across benchmarks developed specifically for hip and knee replacement of 3 to 6 months from specialist assessment to surgery. The study reported that evidence indicates that deterioration in functional health status occurs in patients waiting more than 6 months for joint replacement surgery.[12]

Scope and Methodology

We conducted our field work at five medical facilities and two VISNs:

- Pacific Islands HCS.
- Alaska VA HCS and Regional Office (Alaska VA HCS).
- New York Harbor HCS.
- Portland VA Medical Center (Portland VAMC).
- James A. Haley VA Medical Center (Tampa VAMC).
- VISN 20, Northwest Network.
- VISN 21, Sierra Pacific Network.

We interviewed 117 personnel involved in the management and operation of non-institutional care, enrollment, primary care, and specialty procedures. We analyzed workload data provided to us from the five medical facilities and nationwide data

[11] *Orthopedic Patients get Faster Treatment*, [U. K.] Department of Health Press Release, April 5, 2005.
[12] Noseworthy, T.W., *Towards Establishing Evidence-Based Benchmarks for Acceptable Waiting Times for Joint Replacement Surgery*, Report #1, July 2005 and Report #2, October 2005. University of Calgary, Alberta.

provided by the Allocation Resource Center and the Health Eligibility Center. We also reviewed veteran medical records.

Access to Non-Institutional Care Services

The Allocation Resource Center provided the unique user numbers for the following seven non-institutional care services for FYs 2003, 2004, and 2005:

- Home based primary care.
- Purchased skilled home health care.
- H/HHA.
- Contract adult day health care.
- Outpatient respite.
- Home hospice.
- CCHT.

We reviewed the number of unique users at all VHA medical facilities to determine the extent to which VHA has provided non-institutional care services to veterans. During our visits to the five medical facilities, we interviewed key personnel to determine if any local restrictions were preventing veterans from receiving non-institutional care.

Access to Initial Care

VHA's Health Eligibility Center provided a nationwide database containing information pertaining to 1,122,258 veterans who applied to the VHA for the first time during the period October 1, 2002, through June 30, 2005. We then analyzed enrollment data and interviewed enrollment personnel at the five medical facilities to determine if there were any indications that certain enrollment priority groups were discouraged from enrolling in the VHA.

For the five medical facilities we visited, we identified all new enrollees for the 1st quarter of FY 2005. For each new enrollee, we compared the date of enrollment to the date of the first medical appointment to identify if the enrollee received care and, if so, how long it took to receive the initial care. We then met with key personnel at each medical facility to evaluate the timeliness of care for selected veterans.

Timeliness of Elective Specialty Procedures

To determine whether eligible veterans received clinically indicated elective procedures within reasonable timeframes, we selected three specialty services—cardiology, orthopedic surgery, and gastroenterology. We requested system-wide data from VHA but found that it did not exist. Therefore, we requested that the five medical facilities we

visited provide lists of procedures performed during FY 2005 that were assigned the following nine current procedural terminology (CPT)[13] codes:

- 93510 (left heart catheterization).
- 33206, 33207, 33208, 33210, 33211 (pacemaker procedures).
- 27130 (total hip arthroplasty).
- 27447 (total knee arthroplasty).
- 45378 (colonoscopy).

We selected 276 elective cases from the three specialty services at the five facilities and reviewed medical records to determine the number of elapsed days from the date the clinician determined a procedure was needed to the date the procedure was performed. VHA staff at each facility validated the data. We also interviewed primary and specialty care providers at each facility.

The review was conducted in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

[13] CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services. CPT serves as an effective means for reliable nationwide communication among physicians, other health care providers, patients, and third parties.

Results and Conclusions

Issue 1: VHA Can Further Increase Veteran Access to Non-Institutional Care.

Findings

Veteran access to non-institutional care has increased over the past several years. We reviewed seven non-institutional care services available to all eligible veterans if clinically necessary and found that:

- The number of facilities offering at least 6 of the 7 non-institutional care services increased from 4 (3 percent) of 130 facilities in FY 2003 to 91 (72 percent) of 127 facilities in FY 2005.
- The number of veterans[14] using at least 1 of the 7 non-institutional care services increased from 66,106 in FY 2003 to 105,570 in FY 2005—a 60 percent increase.

However, there are opportunities for VHA to further increase veteran access to non-institutional care. Even though non-institutional care services are available to all eligible veterans, some medical facilities limited access of certain non-institutional care services to only the highest priority veterans, such as those with at least a 70 percent service-connected disability. The nationwide data showed that priority groups 1, 2, and 3 received more non-institutional care than priority groups 5, 6, and 7 (2.8 percent compared to 1.9 percent of unique users to active enrollees). Some medical facilities were either unable or chose not to provide veterans with non-institutional care in the remote regions of their geographic areas. Additionally, VHA needs to develop metrics to assess whether its geriatric evaluation program is meeting the requirements of the Act.

These opportunities to increase access exist, in part, because VHA has not fully funded its projected workload for non-institutional care. VHA budgeted about $378 million for home and community based care, which was designed to achieve an average daily census of 21,863—23 percent of the estimated nationwide demand of enrolled veterans who would prefer to rely on the VA for non-institutional care. In addition, VHA's budgeting process may not provide facilities with all the funding necessary to provide care to priority groups 7 and 8 veterans.

VHA needs to provide the necessary funding to ensure non-institutional care services are available to veterans. Eliminating local eligibility restrictions, expanding non-institutional care to include the entire geographic area of each medical facility, and establishing metrics to make sure VHA's geriatric evaluation program is meeting the

[14] We measured the unique users for each of the seven non-institutional care services we reviewed. Some users may receive more than one non-institutional care service.

requirements of the Act will help ensure that all eligible veterans receive the care they need in the setting they desire.

The Government Accountability Office Reported That Veteran Access to Non-Institutional Services Was Limited

A series of Government Accountability Office (GAO) reports, letters, and testimonies[15] published prior to FY 2004 criticized VHA for not providing a full scope of non-institutional care to veterans. In testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives, GAO reported that veteran access to non-institutional care services was limited by service gaps and facility restrictions. GAO reported that, faced with competing priorities and little guidance from headquarters, field officials chose to use available resources to address other priorities.

In part, VHA responded by issuing several policies reminding facilities that non-institutional care is available to eligible veterans as part of the VHA medical benefits package. The Under Secretary for Health's Information Letter 10-2004-005, dated May 3, 2004, identified the services that are part of the VHA medical benefits package and reminded facility staff that all VA facilities must provide or purchase these services for all enrolled, eligible veterans with a clinical need for the service.

VHA Has Not Fully Funded Its Projected Workload for Non-Institutional Care

VHA uses the Home and Community Based Care portion of the Long Term Care Model to quantify its future non-institutional care workload. VHA estimated that the total enrollee demand for non-institutional care in FY 2005 was an average daily census of 170,403. This demand estimate included those veterans who chose to seek their care through other sources, such as Medicare and Medicaid. VHA estimated that the FY 2005 nationwide demand for enrolled veterans who would prefer to rely on the VA for non-institutional care was an average daily census of 96,255, which would increase to 109,362 by FY 2013. VHA officials told us they focus only on demand for veterans who rely on the VA for non-institutional care, and they hope to eliminate the difference between nationwide demand and the targets they set by the year 2013, as shown in Table 2. VHA officials told us they never intended to meet the nationwide demand for non-institutional care immediately because the HCS's organization and infrastructure could not accommodate the rapid growth that would be necessary to do so.

[15] *VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care*, GAO-03-487, May 9, 2003; *VA Long-Term Care: Implementation of Certain Millennium Act Provisions Is Incomplete, and Availability of Noninstitutional Services Is Uneven*, GAO-02-510R, March 29, 2002; and *VA Long-Term Care: The Availability of Noninstitutional Services Is Uneven*, GAO 02-652T, April 25, 2002.

Table 2. Demand by Veterans who Rely on the VA for Non-Institutional Care Compared to VHA Target

	Average Daily Census by FY								
	FY 2005	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**
Nationwide Demand	96,255	100,436	104,130	107,214	108,382	109,077	109,165	109,440	109,362
Nationwide Target	21,863	32,800	43,738	54,675	65,613	76,550	87,487	98,425	109,362
Difference Between Demand and Target	74,392	67,636	60,392	52,539	42,769	32,527	21,678	11,015	0
Target's Percent of Demand	23	33	42	51	61	70	80	90	100

In FY 2005, VHA budgeted about $378 million for non-institutional care, which was designed to achieve an average daily census of 21,863—23 percent of the estimated nationwide demand for non-institutional care. In FY 2005, VHA provided medical facilities with about $17,289 per average daily census ($378 million divided by 21,863). Using this estimate, VHA would need about $1.7 billion to meet the average daily census of 96,255 for veterans who prefer to rely on the VA for non-institutional care and about $2.9 billion to meet the average daily census of all 170,403 enrollees needing non-institutional care.

The funds VHA distributed to facilities did not include specific funding for non-institutional care services. VISNs distribute funds to their subordinate facilities using the VERA method, which allocates resources based primarily on patient workloads. Each network receives a funding allocation based on a predetermined dollar amount per veteran served and the complexity of the veteran's health conditions. The networks then determine the amount of resources to distribute to each facility in their jurisdiction. In addition, under VERA, networks receive less for veterans enrolled in priority groups 7 and 8. For example, in FY 2006, the VISN would receive $15,160 for a priority group 5 veteran in the specialized care price group but only $10,360 for a priority group 7 veteran. According to VHA officials, VISNs receive less funding for priority groups 7 and 8. Those two groups include veterans who are generally healthier, have other options for health care through private insurance, and do not use the VA for all of their health care needs. Facilities apportion their allocated budget into fund control points to meet workload demands across all administrative and clinical programs. Fund control points are adjusted throughout the year as workload demand dictates to include non-institutional care services. VISNs use program measures, instead of program expenditures, to determine whether facilities are adequately providing non-institutional care services to veterans.

VHA should continue to monitor the demand for non-institutional services and, when possible, use available funding to accelerate the medical facilities' ability to provide all required non-institutional services to their veterans.

Veteran Access to Non-Institutional Care Has Improved Since FY 2003

Veteran access to non-institutional care has improved since FY 2003. In FY 2005, 15 of the 21 VISNs achieved at least 100 percent of their average daily census target for non-institutional care. Further, the number of facilities offering at least 6 of the 7 non-institutional care services and the numbers of veterans using at least 1 of the 7 non-institutional care services has increased since FY 2003.

Performance Measures Established in FY 2004.

Prior to FY 2004, VHA required VISNs to monitor their progress in providing non-institutional care to veterans. Beginning in FY 2004, VHA increased the emphasis on non-institutional care by establishing a performance measure to evaluate the degree to which VISNs increased their average daily census in non-institutional settings. VISN directors were given an average daily census target[16] to achieve, and their performance ratings were based on the following:

- If they met their revised target, they received an exceptional rating.
- If they met 99.5 percent of their revised target, they received a fully successful rating.
- If they met less than 99.5 percent of their revised target, they were given a less than successful rating.

In FY 2005, 15 of the 21 VISN directors received an exceptional rating, 3 were fully successful, and 3 were less than successful. VHA does not require medical facilities to measure their individual performances; instead they permit each VISN to decide whether to establish specific facility targets.

Facilities Have Increased Veteran Access to Care.

To determine whether medical facilities had increased veteran access to care, we asked the Allocation Resource Center to provide the number of unique users at each VHA facility for the following seven non-institutional care services: contract adult day health care, outpatient respite, home hospice, H/HHA, purchased skilled home health care, home based primary care, and CCHT. (Appendix C contains the number of unique veterans receiving each of the seven non-institutional care services for all VISNs and medical facilities.)

[16] Targets of VISNs varied and were revised throughout the year as additional funds were made available to them.

VHA includes six of the seven services in the medical benefits package—CCHT is not included—and requires medical facilities to measure their performance for all seven services. As shown in Table 3, we found that the number of medical facilities offering 6 of 7 non-institutional care services increased from 4 (3 percent) of 130 in FY 2003 to 91 (72 percent) of 127 medical facilities in FY 2005.[17]

Table 3. Number of Facilities Offering Non-Institutional Care Services

	Number of Facilities			Percent of Facilities		
Number of Services Offered	**FY 2005**	**FY 2004**	**FY 2003**	**FY 2005**	**FY 2004**	**FY 2003**
7	49	7	0	39	6	0
6	91	34	4	72	27	3
5	115	71	15	91	56	12
4	126	106	51	99	83	39
3	126	121	102	99	95	78
2	127	123	120	100	97	92
1	127	127	129	100	100	99
Total	127	127	130			

In addition, as shown in Table 4, medical facilities were providing more veterans with non-institutional care services. Since FY 2003, the total number of unique users has increased by 60 percent from 66,106 in FY 2003 to 105,570 in FY 2005. Each non-institutional care service we reviewed showed dramatic increases in the number of users receiving the service, ranging from a 2,275 percent increase in outpatient respite to a 19 percent increase in purchased skilled home health care.

[17] As of October 2005, VHA has 138 medical facilities. However, because VHA has consolidated some medical facilities into HCS's and workload data for other facilities is included in parent facilities, we could only obtain data for 127 facilities.

Table 4. Number of Unique Users Receiving Non-Institutional Care Services

	Number of Unique Users			Percent Increase		
Non-Institutional Care Services	**FY 2005**	**FY 2004**	**FY 2003**	**FY 2003 to FY 2005**	**FY 2004 to FY 2005**	**FY 2003 to FY 2004**
Contract Adult Day Health Care	3,527	1,614	517	582	119	212
Outpatient Respite	1,686	994	71	2,275	70	1,300
Home Hospice	2,770	1,919	1,015	173	44	89
H/HHA	22,491	16,381	11,346	98	37	44
Purchased Skilled Home Health Care	28,995	27,005	24,384	19	7	11
Home Based Primary Care	33,241	29,814	25,566	30	11	17
CCHT	12,860	5,218	3,207	301	146	63
Total	105,570	82,945	66,106	60	27	25

Veteran Access to Non-Institutional Care Was Limited by Facility Restrictions

Although VHA has achieved significant success in increasing veteran access, eliminating local restrictions would further increase veteran access to non-institutional care. Table 5 shows the services each of the five facilities offered to their veterans.

Table 5. Non-Institutional Services Provided at the Five Facilities

Non-Institutional Care Services	Pacific Islands HCS	Alaska VA HCS	New York Harbor HCS	Tampa VAMC	Portland VAMC
Contract Adult Day Health Care	Yes	No	Yes	No	No
Outpatient Respite	Yes	Yes	Yes	Yes	No
Home Hospice	Yes	Yes	Yes	Yes	Yes
H/HHA	Yes	Yes	Yes	Yes	Yes
Purchased Skilled Home Health Care	Yes	Yes	Yes	Yes	Yes
Home Based Primary Care	Yes	No	Yes	Yes	Yes
CCHT	Yes	Yes	Yes	Yes	Yes

During our facility visits, we interviewed personnel directly responsible for managing and providing non-institutional care services to veterans. In general, the primary care provider refers the veteran to the facility's social workers who determine whether the veteran meets the specific criteria for the non-institutional care service. If appropriate, the social worker then evaluates the veteran's options on how best to obtain the care—such as through the VA, Medicare, private insurance, or a private community organization. We found that all five facilities, to the extent possible, used these alternatives to provide non-institutional care to veterans. However, medical facilities do not capture workload data if the VA is not providing or paying for the care. In addition, if a facility did not offer a particular service, the facility would sometimes use another service to provide the desired care. For example, if home based primary care was not available, the veteran could receive care under the purchased skilled home health care program.

At four of the five facilities, we found local restrictions in place that limited veteran access to non-institutional care. Facility officials gave us three primary reasons for the local restrictions—budget constraints, misinterpretation of the Act, and the unavailability of certain services in the more remote regions of their primary service area. We identified no local restrictions at the New York Harbor HCS.

- The Pacific Islands HCS restricted contract adult day health care and H/HHA to highly service-connected veterans as defined by the Act (70 percent or greater),

provided no outpatient respite prior to June 2005, and offered home based primary care only to veterans living within a 50-mile radius of the Pacific Islands HCS or two of its five community based outpatient clinics—Kona and Hilo. At the time of our visit, there was a waiting list of 15 veterans for contract adult day health care and 35 veterans for H/HHA.[18]

- The Alaska VA HCS offered no contract adult day health care or home based primary care and limited H/HHA to highly service-connected veterans.
- The Tampa VAMC offered no contract adult day health care, provided no outpatient respite prior to June 2005, and offered home based primary care only to veterans living within a 30-mile radius of the Tampa VAMC or the Orlando and Vierra community based outpatient clinics. At the time of our visit, there was a waiting list of 21 veterans for home based primary care.
- The Portland VAMC offered no contract adult day health care or outpatient respite, restricted H/HHA to highly service-connected veterans, and offered home based primary care only to veterans living within a 25-mile radius (or 30 traveling minutes) away from the halfway point between the Portland and Vancouver medical facilities. At the time of our visit, there was a waiting list of 12 veterans for H/HHA and 2 veterans for home based primary care.

VHA needs to make sure that facilities eliminate any local restrictions limiting eligible veterans access to non-institutional care and, where possible, expand coverage to geographic areas that currently do not offer non-institutional care services.

Although VHA policy requires that facilities use the electronic waiting list to identify any veterans in need of and seeking non-institutional care services when budget resources are not sufficient, only the Tampa VAMC used the electronic waiting list. Instead, informal manual lists were kept. VHA needs to make sure facilities use the electronic waiting list to identify veterans waiting for non-institutional care.

Priority Group 7 Veterans Did Not Receive the Same Opportunities for Non-Institutional Care as Other Veterans

The Under Secretary for Health's Information Letter 10-2004-005 dated May 3, 2004, reminds facility staff that all VA facilities must provide or purchase non-institutional care services for all enrolled, eligible veterans in need of such services. We reviewed the extent that lower priority group veterans (priority groups 5, 6, and 7) received non-institutional care compared to the number of higher priority group veterans (priority groups 1, 2, and 3). We did not include priority groups 4 and 8 in our comparison. Priority group 4 veterans are those receiving aid and attendance or housebound benefits, or who have been determined by VA to be catastrophically disabled. Priority group 4

[18] The OIG previously reported extensive waiting lists for veterans desiring H/HHA (*Evaluation of Veterans Health Administration Homemaker and Home Health Aide Program*, Report Number 02-00124-48, December 18, 2003).

veterans have a much higher usage rate of non-institutional care services—21,609 (29 percent) of 73,461 active enrolled veterans in FY 2005. Priority group 8 veterans who did not enroll before January 17, 2003, are no longer eligible for health care services.

The nationwide data showed that priority 1 through 3 veterans received more non-institutional care than priority 5 through 7 veterans, as shown in Table 6 below.

Table 6. Comparison of Non-Institutional Care by Priority Group

Priority	FY 2005 Unique Users	Number of Active Enrollees as of June 30, 2005	Percentage of Unique Users to Active Enrollees
1	29,841	690,045	4.3
2	4,935	307,980	1.6
3	8,240	511,712	1.6
Total	43,016	1,509,737	2.8
5	31,988	1,554,243	2.1
6	387	88,107	0.4
7	2,286	164,880	1.4
Total	34,661	1,807,230	1.9

There could be acceptable explanations why there is a disparity in the extent of care provided to the lower priority groups 5, 6, and 7 veterans. For example, clinical need is not necessarily evenly distributed across all priorities and veterans enrolled in the lower priority groups often have other health care options available to them. However, based on information we obtained during our facility visits, we know that some facilities were limiting the non-institutional care provided to lower priority veterans. Eliminating local eligibility restrictions should provide some assurance that all eligible veterans are receiving their needed non-institutional care.

VHA Has Not Fully Implemented its Geriatric Evaluation Program

The Act directs the VA to provide geriatric evaluations to eligible veterans. VHA officials told us that geriatric evaluations were occurring in VHA facilities but could not provide us with objective data to support their assertion. VHA needs to implement the necessary metrics to evaluate the extent to which geriatric evaluations are occurring and provide some assurance that medical facilities are complying with the Act.

Conclusion

VHA established policies and performance measures to ensure that eligible veterans are offered non-institutional care services as required by the Act. As a result, veteran access to non-institutional care services has increased, but opportunities exist for VHA to further increase access to those services. VHA needs to continue to monitor the demand for non-institutional care services and, when possible, use available funding to accelerate medical facilities' ability to provide all required non-institutional care services to their veterans. Further, eliminating local eligibility restrictions, expanding non-institutional care to include the entire geographic area of each medical facility, making sure facilities use the electronic waiting list to identify veterans waiting for non-institutional care, and establishing metrics to make sure VHA's geriatric evaluation program is meeting the requirements of the Act will help ensure that all eligible veterans receive the care they need in the setting they desire.

Recommended Improvement Action 1. We recommended that the Under Secretary for Health: (a) continue to monitor the demand for non-institutional care services and, when possible, use available funding to accelerate medical facilities' ability to provide all required non-institutional care services to their veterans; (b) ensure that facilities have eliminated any local restrictions limiting eligible veterans access to non-institutional care; (c) expand coverage to geographic areas that currently do not offer non-institutional care services; (d) make sure facilities use the electronic waiting list to identify veterans waiting for non-institutional care; and (e) establish an effective measurement system to evaluate the extent geriatric evaluations are occurring.

The Under Secretary for Health agreed with the findings and recommendations and stated that VHA will continue to monitor the demand and supply of non-institutional home and community-based services through the Long-Term Care Model and increase capacity as resources permit. However, medical facilities do not capture workload data if VA is not providing or paying for the care. In addition, if a facility did not offer a particular service, the facility would sometimes use another service in an effort to provide the desired care. As such, it is sometimes difficult to monitor the demand for all non-institutional care services.

All VA facilities are required to provide or purchase these services for all enrolled, eligible veterans in need of such services and facilities are not authorized to establish local restrictions. The VHA Deputy Under Secretary of Health for Operations and Management (DUSHOM) will, via e-mail to all facility directors, chiefs of staff, and nursing directors, reaffirm the guidance and expectations of Information Letter 10-2004-005.

To the extent possible, VHA will incrementally expand coverage to geographic areas that currently do not offer non-institutional care services. In order for VA to offer non-institutional care service in certain geographic areas, there must be a qualified private

sector provider available to contract the service. Additionally, for those services that VA provides directly, there must be a pool of suitably trained personnel available to hire in order to expand capacity. Such personnel are in short supply in many areas of the country, which is another constraint that is largely out of VA's control. However, special situations may require creative solutions. If services are not currently available through VHA in remote areas and if VHA can not purchase these services locally, because overall demand is insufficient to support, then VHA may need to devise appropriate alternatives that both meet the patient's needs and are cost effective. For instance, the DUSHOM and the VHA Office of Care Coordination will explore increased use of Care Coordination/Telehealth Services when possible to extend the geographic range of services provided.

Information Letter 10-2004-005 specifies that if the demand for non-institutional care services exceeds current capacity, waiting lists may be established. VA issued VHA Directive 2003-068 to establish policy for use of electronic wait lists and that Directive remains in effect. In May 2005, the DUSHOM distributed a memorandum to the networks instructing them to use electronic waiting lists for home based primary care and purchased skilled home health care. A revised directive is now in concurrence and we anticipate that it will be issued by May 30, 2006.

The VHA Office of Geriatrics and Extended Care will work to identify and establish metrics to evaluate the extent that geriatric evaluations are occurring. VA will add a report on the average daily census in Geriatrics Evaluation and Management programs to the monthly performance report commencing in the 3rd Quarter of FY 2006.

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

Issue 2: Facilities Need To Further Reduce Waiting Times for Enrolled Veteran Initial Care.

Findings

Staff at the five medical facilities we visited established procedures for ensuring that all eligible veterans who desired care were enrolled. However, medical facilities did not establish effective controls to ensure that all newly enrolled veterans who wanted care received their care within VHA's goal of 30 days from the veteran's desired date. Facilities were not meeting national performance timeliness goals for providing care to newly enrolled veterans. We also found that some newly enrolled veterans requested care from VHA but did not receive it.

Facilities Complied with National Enrollment Policies

VA's national enrollment policy is to treat all eligible veterans except those classified as priority group 8 veterans. At the five facilities, we met with facility enrollment personnel to determine if they were encouraged by their managers to limit or discourage veterans from enrolling for health care benefits. We found no situations where enrollment was discouraged. Instead, enrollment personnel presented themselves as hard-working and dedicated to making sure that all eligible veterans received the health care benefits they were entitled to.

To determine if there were any indications that facilities were only enrolling veterans in the highest priority groups, we also obtained the number of newly enrolled veterans by priority group from the Health Eligibility Center for FY 2003 through FY 2005 (as of June 30, 2005). As shown below in Table 7, we found that the percent of newly enrolled priority groups 5, 6, and 7 veterans has increased each year.

Table 7. Number of Newly Enrolled Veterans by Priority

	Total Number of New Enrollees			Percentage of Total Enrollment		
Priority	**FY 2005 (as of June 30, 2005)**	**FY 2004**	**FY 2003**	**FY 2005**	**FY 2004**	**FY 2003**
1	15,551	28,884	37,211	6	8	8
2	16,091	25,191	29,955	6	7	6
3	35,539	48,399	58,944	14	13	12
4	2,394	4,674	5,297	1	1	1
5	125,713	165,051	147,119	48	45	30
6	29,625	22,508	14,397	11	6	3
7	30,514	35,266	23,412	12	10	5
8	7,524	34,976	178,023	3	10	36

VHA Performance Data Show that Facilities Need To Improve Timeliness of Care

VHA's goal is to provide veterans with appointments within 30 days of their desired date. However, we found that:

- Facilities were not meeting their goal of getting newly enrolled veterans an appointment within 30 days.
- VHA patient surveys show that satisfaction with getting timely appointments was getting better but still needs improvement.

- Facilities had to put veterans on the electronic waiting list because there were no available appointments within 4 months. Further, at least one facility failed to include all veterans on the electronic waiting list, as required by VHA policy.

Facilities Were Not Meeting Their 30-Day Goal.

VHA established a performance measure in FY 2005 to evaluate how consistently facilities provided veterans their initial care within 30 days. The measure identifies the percent of veterans receiving an appointment within 30 days by comparing the oldest of either the date the veteran's appointment was created or the date the veteran was entered on an electronic waiting list to the date of the veteran's first appointment. Medical facilities must see 70 percent of new patients within 30 days to receive a satisfactory rating and 80 percent within 30 days to receive an exceptional rating.

We reviewed the FY 2005 performance measure "Wait Times for Primary Care and New Patients Seen Within 30 Days" report and found that, as shown below in Table 8, the facilities we visited did not achieve a satisfactory rating in 9 of the 20 quarters. Only the New York Harbor HCS and the Tampa VAMC consistently received satisfactory ratings or better.

Table 8. Veterans Receiving an Appointment within 30 Days

	FY 2005			
Medical Facility	**1st Quarter Percent**	**2nd Quarter Percent**	**3rd Quarter Percent**	**4th Quarter Percent**
Pacific Islands HCS	53	40	56	67
Alaska VA HCS	66	71	68	57
New York Harbor HCS	75	79	83	80
Tampa VAMC	74	72	74	84
Portland VAMC	36	62	89	97
National Average	64	65	71	76

VHA Patient Surveys Showed Satisfaction with Timely Appointments Getting Better but Still Needed Improvement.

VHA surveyed selected new patients to obtain their perceptions of their health care experiences at the medical facilities they visited. One question asked was, "Were you able to get an appointment as soon as you wanted?" Medical facilities must receive a rating of 70 percent of new patients who were satisfied with getting an appointment as soon as they wanted to receive a satisfactory rating and 80 percent to receive an exceptional rating. The survey results for FY 2003 through FY 2005 for each of the five facilities we visited and the national average is shown in Table 9. While all five facilities

improved their ratings, the facilities did not achieve a satisfactory rating in 7 of the 15 periods we reviewed. Only the New York Harbor HCS consistently received satisfactory ratings or better.

Table 9. New Patient Satisfaction Ratings

	Percent of Veterans Satisfied		
Medical Facility	**FY 2005**	**FY 2004**	**FY 2003**
Pacific Islands HCS	69.6	61.6	64.8
Alaska VA HCS	77.7	58.6	46.8
New York Harbor HCS	81.8	70.9	76.7
Tampa VAMC	90.2	80.7	66.2
Portland VAMC	79.6	77.9	64.3
National Average	84.4	80.4	70.9

Some Facilities Were Unable To Schedule Veterans Timely.

We obtained data from the national electronic waiting list as of September 30, 2005, and as of December 31, 2005, and found that four of the five facilities were not able to schedule veterans for appointments within 4 months. VHA policy[19] requires that all appointment requests are acted on within 7 business days by either scheduling an appointment within 4 months (facilities can establish a shorter timeframe) or placing the veteran on the electronic waiting list. Instead, as shown in Table 10, four facilities placed some veterans on waiting lists until available appointments could be found.

Table 10. Number of Veterans on Waiting Lists for Appointments

	Per Electronic Waiting List	
Medical Facility	**As of September 30, 2005**	**As of December 31, 2005**
Pacific Islands HCS	126	71
Alaska VA HCS	7	3
New York Harbor HCS	0	0
Tampa VAMC	1,131	233
Portland VAMC	1,489	1,709

In addition to the reported numbers on the electronic waiting list, some veterans may not have appointments or be included on the waiting list. For example, the Alaska VA HCS reported only three veterans on the waiting list as of December 31, 2005. However,

[19] VHA Directive 2003-068, *Process for Managing Patients When Patient Demand Exceeds Current Clinical Capacity*, December 11, 2003.

during our visit to the Alaska VA HCS, we identified at least 70 veterans who had been waiting up to 3 weeks to be scheduled for appointments but were not on the electronic waiting list. The scheduler told us she was waiting to schedule these patients until she could contact them and schedule an appointment within 4 months. However, by not placing the veterans on the waiting list as prescribed by VHA policy, the number of veterans on the facility's electronic waiting list is understated.[20]

Facilities Need To Monitor Whether Veterans Are Receiving Care

Medical facilities did not have an effective process to make sure that all newly enrolled veterans who applied for care received care.

For the five facilities, the Health Eligibility Center provided a list of 4,305 veterans who enrolled during the 1st quarter of FY 2005. To determine whether these veterans received their desired care, we reviewed medical records to identify the date of any initial primary or specialty care received. We found that 1,044 (24 percent) of the 4,305 veterans received no care from their date of enrollment (1st quarter of FY 2005) through the end of the FY (shown in Table 11).

Table 11. Number of Newly Enrolled Veterans Who Received No Care in FY 2005

	Number of Newly Enrolled Veterans	Pacific Islands HCS	Alaska VA HCS	New York Harbor HCS	Tampa VAMC	Portland VAMC
Total	4,305	372	270	759	1,823	1,081
Number Who Received Care During FY 2005	3,261	207	132	568	1,521	833
Percent Who Received Care	76	56	49	75	83	77
Number Who Received No Care During FY 2005	1,044	165	138	191	302	248
Percent Who Did Not Receive Care	24	44	51	25	17	23

[20] The OIG previously reported that medical facilities did not maintain accurate electronic waiting lists (*Audit of the Veterans Health Administration's Outpatient Scheduling Procedures*, Report Number 04-02887-169, July 8, 2005).

VHA has a process in place to identify if a newly enrolled veteran wants care. The enrollment package that each newly enrolled veteran completes contains VA Form 10-10EZ (revised in 2003). The form includes the question, "Do you want an appointment with a VA doctor or provider as soon as one becomes available?" However, we found that the revised forms were not always used, or the specific question was not always answered.

We understand that not all veterans who enroll want to receive their care at a VHA facility; so, with the assistance of facility personnel, we attempted to determine why the 1,044 veterans in our case review did not receive an initial primary or specialty care appointment. We found that only personnel at the New York Harbor HCS could tell us with any certainty whether a veteran wanted care. New York Harbor HCS personnel used an electronic spreadsheet to match newly enrolled veterans with patient records to identify veterans with medical appointments. Veterans who did not have scheduled appointments were contacted to determine whether they wanted care.

Staff at the other four facilities could only speculate; they opined that if the veteran did not get care, then the veteran did not want care. However, we found that was not always accurate. For example:

- At the Portland VAMC, we contacted five priority group 1 veterans who did not receive any care. One veteran told us he had been waiting 15 months since his enrollment for care. He was told when he enrolled that someone would call and schedule his initial appointment. Facility staff told us it was the responsibility of the veteran to call for an appointment and could not explain why the veteran was told otherwise. The remaining four veterans we contacted told us they did not plan to use VHA medical facilities.
- At the Alaska VA HCS, we reviewed the VA Form 10-10EZ for five veterans who did not receive care in FY 2005 and who responded affirmatively to the question, "Do you want an appointment with a VA doctor or provider as soon as one becomes available?" Of the 5 veterans who answered yes, 2 (40 percent) said they wanted care and 3 (60 percent) said they did not want care. Facility staff could not explain why the two veterans who indicated they wanted care did not receive appointments.
- At the Pacific Islands HCS, we reviewed the VA Form 10-10EZ for 13 veterans who responded affirmatively to the question, "Do you want an appointment with a VA doctor or provider as soon as one becomes available?" Of these 13, we found that 3 veterans were seen within 30 days, 3 were seen after 90 days, and 7 veterans did not receive care. Facility staff could not explain why the seven veterans were neither provided appointments for care nor included on the electronic waiting list.

VHA officials told us there was no specific requirement to monitor veterans who were not receiving care. Instead, the emphasis is placed on making sure that veterans who receive care get it within the specified timeframes.

Conclusion

The enrollment process at the five facilities we visited complied with national enrollment policies and did not include any local barriers that prevented or discouraged veterans from enrolling. Making sure medical facilities track all veterans who want care, fully implementing a requirement to monitor the time new patients spend waiting for their initial appointments, and either scheduling a veteran's appointment within 4 months or placing the veteran on the electronic waiting list within 7 business days should help medical facilities better achieve VHA's goal of providing veterans with appointments within 30 days of their desired date.

Recommended Improvement Action 2. We recommended that the Under Secretary for Health: (a) direct facilities to implement a tracking mechanism to identify which newly enrolled veterans want care and make sure they receive it and (b) remind facilities of the requirement to either schedule a veteran's appointment or place the veteran on the electronic waiting list within 7 business days of the appointment request.

The Under Secretary for Health agreed with our findings and recommendations and stated that the DUSHOM will issue a new directive on scheduling processes and procedures to establish use of electronic waiting lists as a vehicle for communicating new enrollee desire for an appointment to a scheduling clerk. When a newly enrolled or newly registered patient requests clinical care, enrollment/registration staff will immediately enter the name of the patient into electronic waiting lists for the clinic and preferred location requested. In addition, enrollment/registration staff will document that the patient is newly enrolled/registered in the comments section of electronic waiting lists. Schedulers in all clinics at all locations will review electronic waiting lists daily to determine if a newly enrolled or newly registered patient has requested care in their clinic.

The DUSHOM will issue a revision of VHA Directive 2003-068 and a new directive on scheduling processes and procedures, which will require staff to act within seven calendar days to schedule or place all requests for outpatient services on electronic waiting lists. Furthermore, the new scheduling directive will require individuals and supervisors with responsibilities for scheduling outpatient services to complete nationally developed training modules to assure compliance with business rules related to registration, enrollment, scheduling, consult management and use of electronic waiting lists. The training will emphasize the requirement to schedule or place the veteran on electronic waiting lists within seven calendar days.

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

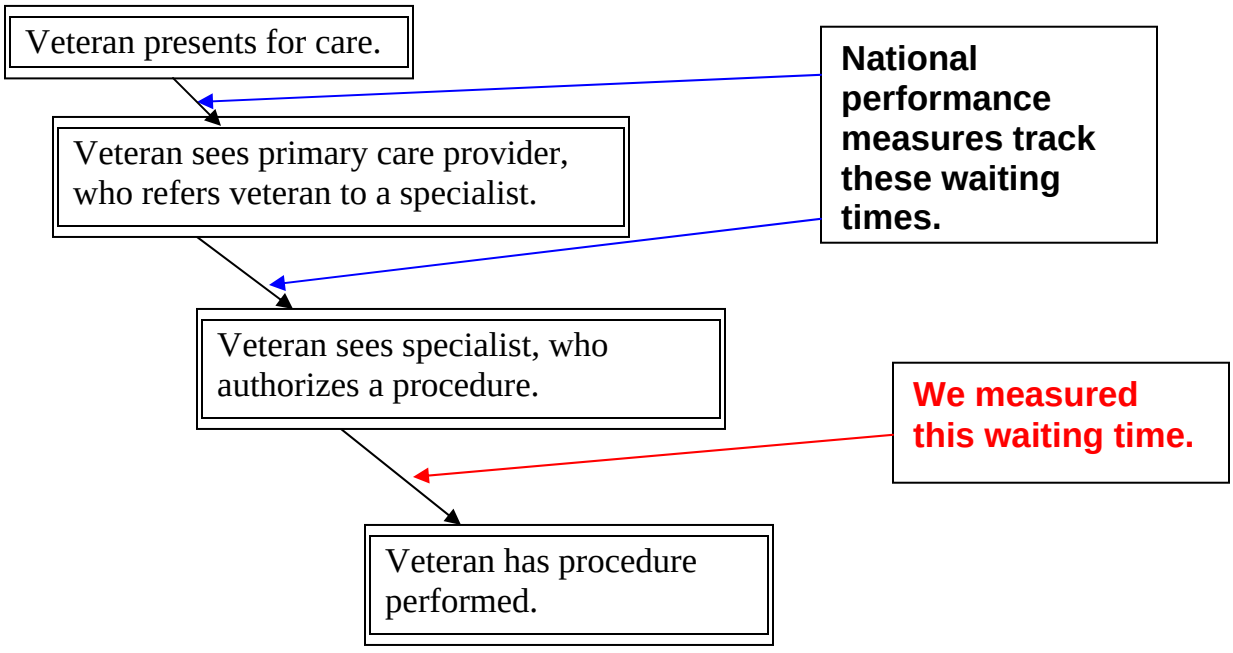
Issue 3: Medical Facilities Need To Measure and Decrease Waiting Times To Obtain Elective Procedures.

Findings

We found that eligible veterans did not always receive clinically indicated specialty procedures within reasonable timeframes. VHA has not established a method to measure the length of time veterans wait for elective procedures. While a VHA performance measure tracks the time veterans wait for their specialty care appointments, facilities are not required to measure the length of time from the request or authorization for elective procedures until the procedures are performed. In some cases, veterans had excessive waiting times. For example, at the Portland VAMC, the average wait for elective orthopedic procedures was 212 days. In addition to the lack of emphasis on this measurement, reasons for lengthy waits included physician and support staff vacancies, insufficient space, and lack of colonoscopy equipment. Facility managers need to measure waiting times to better assess and manage their workload and ensure that veterans receive timely care.

VHA Does Not Measure Waiting Time To Obtain Specialty Procedures

The current national performance measures for timeliness of access to care do not measure the waiting time to obtain specialty procedures, as indicated in the flow chart below.



We found that neither VHA nor the five facilities we visited maintained standardized lists of patients waiting for their procedures. Generally, the nurses or schedulers at the facilities maintained informal, manual waiting lists for their specific areas.

In September 2005, in response to our inquiry, VHA chartered a task force to develop an electronic method to determine the number of veterans waiting for specialty procedures and the length of waiting time. Once this information is standardized and tracked, facilities will be better able to assess and assign appropriate resources to provide timely procedures. Metrics affect organizational behavior, and the current performance measures have been successful in improving timeliness of primary and specialty care appointments. VHA should expand its performance measures for access to care to include the timely provision of clinically indicated elective procedures.

Waiting Time To Obtain Elective Specialty Procedures Was Excessive

Because VHA did not have national or facility data regarding waiting times for elective procedures, we reviewed selected procedures that had been performed and then measured the elapsed days since the specialist ordered the procedure. We limited our review to three specialty services: orthopedic surgery, cardiology, and gastroenterology. We obtained a list of procedures with nine different CPT codes (45378, 93510, 33206, 33207, 33208, 33210, 33211, 27130, and 27447) performed during FY 2005. In total, we reviewed 276 elective cases from the three specialty services at the five facilities we visited. We also interviewed 31 primary and specialty care providers to solicit their perspectives regarding the timeliness of veterans obtaining procedures.

Two of the facilities we visited—Pacific Islands HCS and Alaska VA HCS—refer most veterans to other Federal facilities for elective orthopedic surgery. Alaska VA HCS also refers all of their elective heart catheterizations to other Federal facilities. We were able to review data from veterans referred from the Pacific Islands HCS to other VHA facilities, but the Alaska VA HCS was unable to provide similar data. Managers at the Alaska VA HCS told us that workload generated as a result of those referrals was captured in the other facilities. The logistics of scheduling these patients at another facility and arranging transportation over large geographic distances (such as from Guam to Palo Alto or from Fairbanks to Seattle) may result in delays.

Veterans with urgent or emergent medical conditions, such as chest pain or fractures, received appropriate high priority specialty care at (or through referral from) all five facilities visited. However, it was unclear how clinicians prioritized veterans whose medical conditions were stable but whose health and quality of life would benefit from elective procedures, such as joint replacements and screening colonoscopies.

We found that some veterans experienced lengthy waits for elective specialty procedures, as shown in Table 12 below.

Table 12. Waiting Times To Obtain Elective Specialty Procedures

	Pacific Islands HCS	Alaska VA HCS	New York Harbor HCS	Tampa VAMC	Portland VAMC	Total
Cardiology	**20**	**0**	**19**	**19**	**20**	**78**
Range in days	4-350		6-185	9-138	7-90	4-350
Average days	63		31	42	21	39
Gastroenterology	**20**	**20**	**20**	**20**	**20**	**100**
Range in days	8-533	12-126	1-96	6-126	14-113	1-533
Average days	135	61	53	39	59	69
Orthopedic	**20**	**19**	**20**	**19**	**20**	**98**
Range in days	14-379	25-309	7-172	12-225	37-282	7-379
Average days	182	104	71	99	212	134
Total	60	39	59	58	60	276

Cardiology Procedures.

Of the 78 cardiology procedures reviewed, 7 veterans (9 percent) waited longer than 90 days. Veterans at the Pacific Islands HCS waited the longest for their procedures—on average 63 days. One example is a 56-year-old veteran who lives on Guam and presented to her primary care provider with a history of coronary artery disease, symptoms of shortness of breath on exertion, and chest pressure. She waited 100 days for her cardiac catheterization procedure (June 20 to September 27, 2005).

Gastroenterology Procedures.

Of the 100 gastroenterology procedures we reviewed, 20 veterans (20 percent) waited longer than 90 days. Veterans at the Pacific Islands HCS waited the longest for their procedures—on average 135 days. OIG previously reviewed the timeliness of colonoscopies in VHA and made similar observations, including that patients with symptoms and/or positive screening tests were not always prioritized ahead of patients requesting routine screening colonoscopies. Timely diagnostic colonoscopies for patients

with symptoms or positive screening results are essential for optimum early detection and treatment. VHA agreed to set timeframes for this important diagnostic test to occur.[21]

Orthopedic Surgeries.

Of the procedures we reviewed, VHA clinicians appeared to have the most difficulty providing elective joint replacement surgery in a timely manner. Of the 98 total orthopedic surgeries we reviewed, 54 veterans (55 percent) waited longer than 90 days for surgery, and 33 of these waited longer than 180 days. Veterans at the Portland VAMC waited the longest for their surgery—on average 212 days. One veteran, a 54-year-old male, had a degenerative condition of his right hip called avascular necrosis and had right hip replacement surgery in 1997. He came to the Portland VAMC in June 2004 complaining of left hip pain. In September 2004, an imaging study showed early signs of left hip avascular necrosis. Clinicians prescribed narcotic pain medications and joint injections. In June 2005, the veteran discussed the option of left hip replacement with orthopedic clinic staff. During the discussion, staff explained that the operation might be several years away due to the size of the wait list and the fact that the veteran was not service-connected. Staff suggested that he consider non-VA options; however, he had no private or state insurance and was not Medicare-eligible. The veteran's sister reported that, on July 13, 2005, he took an intentional overdose of pain medication and died. As a result of this case, the facility added two orthopedic physician assistants, initiated recruitment for a staff orthopedic surgeon, and increased operating room time for orthopedic surgery. However, as of January 11, 2006, 383 patients were still on a waiting list for orthopedic surgery.

The Pacific Islands HCS, Alaska VA HCS, and Portland VAMC attempted to manage the demand for elective orthopedic surgery by designating two groups of veterans:

- Those with disabilities rated as greater than 50 percent service-connected or service-connected for their orthopedic related conditions (priority group 1 veterans).
- Those with non service-connected disabilities or disabilities rated as less than 50 percent service-connected.

The intent was that, assuming similar clinical conditions, those veterans in the first group would be scheduled for surgery before the veterans in the second group. However, we found that this process was not consistently followed. For example, at the Portland VAMC and the Pacific Islands HCS, we identified 14 and 10 priority group 1 veterans, respectively, who waited longer than 90 days for orthopedic surgery, compared with the other three facilities where only one or two priority group 1 veterans waited more than 90 days. Some veterans in our sample who complained of extreme pain from arthritic hips or knees waited much longer for joint replacement surgery than other veterans with

[21] *Colorectal Cancer Detection and Management in VHA Facilities*, Report No. 05-00784-76, dated February 2, 2006.

similar complaints, regardless of service-connection. We compare the following two veterans at the Portland VAMC as an illustration. One veteran was 48 years old and the other was 53 years old. Both had complained of constant hip pain for several years. Both were examined by orthopedic surgeons, diagnosed with avascular necrosis, and determined to need hip replacement surgery. The 48-year-old was 70 percent service-connected in priority group 1 and waited 254 days for surgery, while the 53-year-old was in priority group 5 and waited only 50 days.

While no VHA standards exist for optimal timeframes, it is our opinion that more than 3 to 6 months is an unacceptable time interval for obtaining clinically indicated elective procedures. VHA should set timeliness goals and clear prioritization criteria for elective procedures. Veterans with clinical needs for elective procedures should not wait much longer in one part of the country than another.

Common Barriers to Timely Care

We interviewed the chiefs of cardiology, gastroenterology, and orthopedic surgery services, as well as a number of primary care providers, to gain their perspectives on the timeliness of elective procedures. Although the five facilities varied greatly in size and capacity, the reasons for delays given by these providers were consistent and fell into four themes:

- Physician vacancies and difficulty recruiting specialty physicians.
- Lack of support staff, such as nurses, physician assistants, and anesthesiologists.
- Insufficient space, including inpatient beds and operating rooms.
- Lack of equipment, such as scopes and data processors for colonoscopies.

Some barriers to timely care were unique to one or two facilities. For example, some orthopedic surgery for Alaska VA HCS veterans occurs in operating rooms at the sharing agreement military hospital at Elmendorf Air Force Base. We were told that delays were experienced when procedures scheduled to be performed at Elmendorf were cancelled due to military deployments. These veterans had to be re-prioritized and worked into the referral lists to the VA Puget Sound HCS, which is based in Seattle. Some of these cases were referred to community providers at VA expense, depending on veteran condition and availability of fee basis funds. Staff at the Pacific Islands HCS told us that similar delays have occurred in some services provided by the Tripler Army Medical Center in Honolulu.

Conclusion

Facilities could better assess and manage their workload if they consistently measured the number of veterans needing elective procedures and the length of waiting times for the

procedures to be performed. Facilities need to use clear, consistent criteria for prioritizing veterans on waiting lists for elective procedures.

Recommended Improvement Action 3. We recommended that the Under Secretary for Health: (a) establish standardized tracking methods and appropriate performance metrics to evaluate and improve the timeliness of elective procedures and (b) implement prioritization processes to ensure that veterans receive clinically indicated elective procedures according to their clinical needs.

The Under Secretary for Health agreed with our findings and recommendations and stated that the Office of Quality and Performance (OQP) is in the process of developing performance metrics for wait times that will ensure that elective procedures are accomplished in a timely fashion according to a patient's clinical needs. In addition, OQP is establishing timeliness of access measures for orthopedic procedures for knees and hips, which is expected to be completed in the 4th Quarter of FY 2007. As discussed in VHA's response to OIG Draft Report, Healthcare Inspection: Colorectal Cancer Detection and Management in VHA Facilities, Project No. 2005-00784-HI-0109, patient care services has developed a draft policy on colorectal cancer screening and diagnosis, which will set performance and timeliness expectations. This policy will be issued by August 2006. Additionally, the DUSHOM, acting through the Advanced Clinic Access Measurement Sub-Committee, chartered a task force to examine processes and procedures for scheduling surgical procedures and use of the surgery/operating room software in order to develop recommendations on how to most effectively schedule and monitor elective surgical procedures.

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

Appendix A

Description of Non-Institutional Care Services

Home Based Primary Care. Home based primary care is a VA-operated home care service in which VA staff provide comprehensive longitudinal, interdisciplinary primary care in the homes of veterans with complex medical, behavioral, and psychosocial conditions. While coordinating and avoiding duplication of services, home based primary care may be combined with purchased skilled home health care if the needs are beyond routine frequency or intensity of visits.

Purchased Skilled Home Health Care. Skilled home health care services are in-home services provided by qualified personnel that include skilled nursing, physical therapy, occupational therapy, speech therapy, and social work services. Care includes clinical assessment, treatment planning, treatment provision, patient and family education, health status monitoring, reassessment, referral, and follow-up.

Homemaker and Home Health Aides. H/HHA services are personal care and related support services that enable frail or disabled veterans to live at home. Only trained personnel who have successfully completed a competency evaluation and are employed by an agency may provide these services under the general supervision of a nurse. Homemaker services may include assistance with Activities of Daily Living that are essential for maintaining a safe and sanitary environment in the areas of the home used by the patient. Some of the available services are: light housekeeping; meal preparation and assistance with eating; shopping; escorting to appointments; bathing; toileting; dressing; aid in ambulating; aid in exercising; and routine health monitoring.

Contract Adult Day Health Care. Contract adult day health care consists of health maintenance and rehabilitative services provided to frail veterans in an outpatient setting. Care is provided in a protective setting during part of a 24-hour day. Individualized programs of care are delivered by health professionals and support staff, with an emphasis on helping participants and their caregivers to develop the knowledge and skills necessary to manage the patient's care requirements in the home. Its predominant focus is a therapeutic one, directed at persons with disabling conditions and medical disorders, thus distinguishing adult day health care from social day care.

Geriatric Evaluation and Management. Geriatric evaluation and management is a specialized program of services provided by an interdisciplinary team of health care professionals in either an inpatient or outpatient setting. The geriatric evaluation component consists of a multidimensional evaluation on a targeted group of older patients. The management component consists of the development of a comprehensive plan throughout the patient's continuum of care.

Outpatient Respite Care. Respite care services are personal care and supportive services delivered in the home, nursing home, adult day care center, or assisted living facility, for the express purpose of temporarily relieving the unpaid caregiver of caregiving duties. Respite care services may include various VA provided services and non-VA purchased services. Respite care remains distinct in that the focus and purpose of respite care is to provide relief for the caregiver. Respite care services are limited to 30 days per year from all settings in which respite is provided.

Home Hospice Care. Hospice is the final stage of the care continuum in which the primary goal of treatment is comfort rather than cure for patients with advanced life-limiting disease. Community hospice agencies provide these services that emphasize relief of suffering and maintenance of functional capacity as long as possible through comprehensive management of all the needs of the patient. They also provide support for the patients' family or other caregivers, including bereavement support following the death of the patient.

Care Coordination and Home Telehealth. CCHT is the ongoing monitoring and assessment of patients via telephone connection. CCHT provides VA staff with a continuous connection to monitor patients and provide clinical services from the convenience of their place of residence, support caregivers in their difficult roles, and prevent unnecessary and inappropriate utilization of resources. Care coordinators facilitate referrals for appropriate non-institutional care services, serving as a link between such services and the VA HCS.

Appendix B

Description of Enrollment Priorities

Priority Group 1. Veterans with service-connected conditions rated 50 percent or more disabling.

Priority Group 2. Veterans with service-connected disabilities rated 30 or 40 percent disabling.

Priority Group 3. Veterans who are former prisoners of war, who are awarded the Purple Heart, who have service-connected conditions rated 10 or 20 percent disabling, who are discharged from active duty for a disability incurred or aggravated in the line of duty, or who are awarded special eligibility classification under 38 U.S.C. Section 1151.

Priority Group 4. Veterans who are receiving aid and attendance or housebound benefits or veterans who have been determined by VA to be catastrophically disabled.

Priority Group 5. Non-service-connected veterans and 0 percent non-compensable service-connected veterans whose income and net worth are below the established dollar threshold, veterans in receipt of VA pension, and veterans eligible for Medicaid.

Priority Group 6. All other eligible veterans who are not required to make a co-payment for their medical care, including World War I and Mexican Border War veterans; compensable 0 percent service-connected veterans; veterans solely seeking care for disorders associated with exposure to a toxic substance, radiation, or for disorders associated with service in the Gulf War, or for illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.

Priority Group 7. Veterans whose income is above the VA Means Test and Financial Assessment threshold but below the applicable Geographic Index threshold.

- Group 7a are non-compensable 0 percent service-connected veterans.
- Group 7c are non-service-connected veterans.

Priority Group 8. Veterans not included in priority groups 4, 6, or 7 who are eligible for care only if they agree to pay the medical care co-payment.

- Group 8a is 0 percent non-compensable service-connected veterans.
- Group 8c is non-service-connected veterans and veterans who are not eligible for enrollment. These veterans are eligible for care of non-service-connected conditions on a humanitarian emergency basis and for care of service-connected conditions.

- Group 8e is 0 percent non-compensable service-connected veterans who applied for enrollment after January 16, 2003.

- Group 8g is non-service-connected veterans who applied for enrollment after January 16, 2003.

Appendix C

Non-Institutional Care Services by VISN and Facility

Table 13: Non-Institutional Care Services Offered by VA Facilities in Network 1, Boston, MA (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS								
	Bedford	Boston	Connecticut HCS	Manchester	Northampton	Providence	Togus	White River Junction	Totals
Home Based Primary Care	179	34	337	310	0	117	429	0	1,406
Purchased Skilled Home Health Care	1	337	341	146	101	86	375	168	1,555
H/HHA	127	9	56	115	88	39	226	39	699
Contract Adult Day Health Care	58	27	8	34	24	0	12	65	228
Outpatient Respite Care	2	1	9	0	9	1	17	2	41
Home Hospice	3	12	17	10	1	6	6	2	57
CCHT	2	3	467	2	2	16	26	1	519

Table 14: Non-Institutional Care Services Offered by VA Facilities in Network 2, Albany, NY (FY 2005) [22]

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS					
	Albany	Bath	Canandaigua	Syracuse	Western New York HCS	Totals
Home Based Primary Care	348	399	313	872	571	2,503
Purchased Skilled Home Health Care	-	-	-	-	473	473
H/HHA	-	-	-	-	1,117	1,117
Contract Adult Day Health Care	-	-	-	-	123	123
Outpatient Respite Care	-	-	-	-	7	7
Home Hospice	-	-	-	-	26	26
CCHT	228	106	46	121	211	712

[22] Dashes indicate that the data at the Allocation Resource Center could not be obtained for the medical facility. The workload data for these facilities are included with the Western New York HCS.

Appendix C

Table 15: Non-Institutional Care Services Offered by VA Facilities in Network 3, Bronx, NY (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS					
	Bronx	Hudson Valley HCS	New Jersey HCS	New York Harbor HCS	Northport	Totals
Home Based Primary Care	267	417	371	362	184	1,601
Purchased Skilled Home Health Care	23	16	108	216	47	410
H/HHA	5	50	923	1,005	142	2,125
Contract Adult Day Health Care	0	16	106	25	20	167
Outpatient Respite Care	0	0	0	6	33	39
Home Hospice	19	1	15	48	4	87
CCHT	17	40	120	8	24	209

Table 16: Non-Institutional Care Services Offered by VA Facilities in Network 4, Pittsburgh, PA (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS										
	Altoona	Butler	Clarksburg	Coatesville	Erie	Lebanon	Philadelphia	Pittsburgh HCS	Wilkes Barre	Wilmington	Total
Home Based Primary Care	0	255	43	76	135	142	200	521	64	80	1,516
Purchased Skilled Home Health Care	106	36	130	50	136	17	105	423	87	52	1,142
H/HHA	95	115	202	162	185	180	144	345	96	96	1,620
Contract Adult Day Health Care	23	0	5	79	16	43	34	0	3	53	256
Outpatient Respite Care	18	4	4	30	15	25	0	32	9	8	145
Home Hospice	7	3	31	3	4	1	6	22	10	7	94
CCHT	6	9	11	26	34	72	85	97	41	41	422

Table 17: Non-Institutional Care Services Offered by VA Facilities in Network 5, Baltimore, MD (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS			
	Martinsburg	Maryland HCS	Washington, DC	Totals
Home Based Primary Care	0	546	235	781
Purchased Skilled Home Health Care	62	167	91	320
H/HHA	146	462	183	791
Contract Adult Day Health Care	32	389	91	512
Outpatient Respite Care	1	9	11	21
Home Hospice	14	38	30	82
CCHT	73	83	135	291

Table 18: Non-Institutional Care Services Offered by VA Facilities in Network 6, Durham, NC (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS								
	Asheville	Beckley	Durham	Fayetteville	Hampton	Richmond	Salem	Salisbury	Totals
Home Based Primary Care	281	0	187	0	83	103	0	71	725
Purchased Skilled Home Health Care	120	143	278	278	169	504	156	291	1,939
H/HHA	150	99	135	73	135	126	159	160	1,037
Contract Adult Day Health Care	76	0	13	34	26	44	132	106	431
Outpatient Respite Care	5	11	33	51	2	5	10	83	200
Home Hospice	28	9	14	23	9	4	19	26	132
CCHT	16	7	32	14	18	15	16	37	155

Table 19: Non-Institutional Care Services Offered by VA Facilities in Network 7, Atlanta, GA (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS								
	Augusta	Birmingham	Central Alabama HCS	Charleston	Columbia	Decatur	Dublin	Tuscaloosa	Totals
Home Based Primary Care	242	155	396	322	112	151	0	136	1,514
Purchased Skilled Home Health Care	150	279	114	370	389	296	89	55	1,742
H/HHA	177	46	83	183	203	139	107	105	1,043
Contract Adult Day Health Care	6	0	0	16	31	17	0	2	72
Outpatient Respite Care	26	5	5	3	8	0	6	72	125
Home Hospice	15	63	23	49	44	61	8	7	270
CCHT	61	99	64	35	91	76	52	50	528

Table 20: Non-Institutional Care Services Offered by VA Facilities in Network 8, Bay Pines, FL (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS						
	Bay Pines	Miami	North Florida/South Georgia HCS	San Juan	Tampa	West Palm Beach	Totals
Home Based Primary Care	292	486	748	420	996	142	3,084
Purchased Skilled Home Health Care	356	184	950	39	468	75	2,072
H/HHA	135	124	540	7	109	235	1,150
Contract Adult Day Health Care	0	0	10	0	0	30	40
Outpatient Respite Care	9	0	17	0	2	10	38
Home Hospice	20	48	98	0	57	8	231
CCHT	454	641	1,202	837	538	328	4,000

Appendix C

Table 21: Non-Institutional Care Services Offered by VA Facilities in Network 9, Nashville, TN (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS						
	Huntington	Lexington	Louisville	Memphis	Mountain Home	Tennessee Valley	Totals
Home Based Primary Care	0	190	178	619	0	0	987
Purchased Skilled Home Health Care	446	207	270	92	217	288	1,520
H/HHA	468	71	37	118	278	392	1,364
Contract Adult Day Health Care	14	0	0	0	12	9	35
Outpatient Respite Care	22	9	15	0	0	7	53
Home Hospice	22	87	39	21	21	11	201
CCHT	115	56	98	75	115	81	540

Table 22: Non-Institutional Care Services Offered by VA Facilities in Network 10, Cincinnati, OH (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS					
	Chillicothe	Cincinnati	Cleveland	Columbus	Dayton	Totals
Home Based Primary Care	207	210	1,829	172	415	2,833
Purchased Skilled Home Health Care	0	271	157	867	278	1,573
H/HHA	197	103	946	59	471	1,776
Contract Adult Day Health Care	5	113	35	60	58	271
Outpatient Respite Care	0	0	0	3	0	3
Home Hospice	1	24	64	7	15	111
CCHT	112	51	86	149	86	484

Table 23: Non-Institutional Care Services Offered by VA Facilities in Network 11, Ann Arbor, MI (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS							
	Ann Arbor HCS	Battle Creek	Danville	Detroit	Indianapolis	Northern Indiana	Saginaw	Totals
Home Based Primary Care	0	252	240	258	409	432	130	1,721
Purchased Skilled Home Health Care	82	10	12	147	257	176	77	761
H/HHA	151	285	153	191	315	396	141	1,632
Contract Adult Day Health Care	5	85	40	11	15	27	17	200
Outpatient Respite Care	32	18	9	1	45	14	29	148
Home Hospice	44	5	4	22	86	19	21	201
CCHT	0	106	129	54	159	20	30	498

Table 24: Non-Institutional Care Services Offered by VA Facilities in Network 12, Chicago, IL (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS							
	Chicago HCS	Hines	Iron Mountain	Madison	Milwaukee	North Chicago	Tomah	Totals
Home Based Primary Care	255	785	0	0	639	261	0	1,940
Purchased Skilled Home Health Care	115	201	89	91	186	4	25	711
H/HHA	262	96	9	115	72	5	24	583
Contract Adult Day Health Care	28	50	0	6	28	23	0	135
Outpatient Respite Care	0	4	2	13	2	0	0	21
Home Hospice	10	2	2	23	18	1	11	67
CCHT	3	17	0	13	21	2	20	76

Table 25: Non-Institutional Care Services Offered by VA Facilities in Network 15, Kansas City, MO (FY 2005) [23]

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS							
	Columbia	Kansas City	Eastern Kansas HCS	Marion	Poplar Bluff	St. Louis	Wichita	Totals
Home Based Primary Care	250	0	0	0	146	613	0	1,009
Purchased Skilled Home Health Care	-	440	-	-	-	573	-	1,013
H/HHA	-	332	-	-	-	208	-	540
Contract Adult Day Health Care	-	5	-	-	-	80	-	85
Outpatient Respite Care	-	63	-	-	-	41	-	104
Home Hospice	-	40	-	-	-	61	-	101
CCHT	3	15	7	17	0	1	9	52

Table 26: Non-Institutional Care Services Offered by VA Facilities in Network 16, Jackson, MS (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS										
	Alexandria	Central Arkansas	Fayetteville	Gulf Coast HCS	Houston	Jackson	Muskogee	New Orleans	Oklahoma City	Shreveport	Total
Home Based Primary Care	147	284	153	189	252	244	152	209	163	146	1,939
Purchased Skilled Home Health Care	150	255	351	48	362	172	106	70	162	366	2,042
H/HHA	37	128	134	89	280	109	5	1	46	58	887
Contract Adult Day Health Care	12	0	0	3	30	7	43	26	17	18	156
Outpatient Respite Care	1	6	69	13	15	59	32	121	26	25	367
Home Hospice	12	53	37	0	32	23	28	22	43	1	251
CCHT	34	39	0	0	0	30	0	0	54	37	194

[23] Dashes indicate that the data at the Allocation Resource Center could not be obtained for the medical facility. The workload data for Columbia, Wichita, and the Eastern Kansas HCS are included with Kansas City. The workload data for Marion and Poplar Bluff are included with St. Louis.

Appendix C

Table 27: Non-Institutional Care Services Offered by VA Facilities in Network 17, Dallas, TX (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS			
	Central Texas HCS	North Texas HCS	South Texas HCS	Totals
Home Based Primary Care	0	568	419	987
Purchased Skilled Home Health Care	15	163	330	508
H/HHA	264	178	163	605
Contract Adult Day Health Care	1	47	26	74
Outpatient Respite Care	0	0	3	3
Home Hospice	0	1	75	76
CCHT	204	266	211	681

Table 28: Non-Institutional Care Services Offered by VA Facilities in Network 18, Phoenix, AZ (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS							
	Amarillo HCS	El Paso HCS	New Mexico HCS	Northern Arizona	Phoenix	Southern Arizona	West Texas HCS	Totals
Home Based Primary Care	0	0	341	0	296	317	0	954
Purchased Skilled Home Health Care	45	68	20	254	1,058	439	1	1,885
H/HHA	4	105	291	66	87	375	1	929
Contract Adult Day Health Care	3	11	6	69	71	38	0	198
Outpatient Respite Care	0	1	6	0	28	9	0	44
Home Hospice	18	7	11	2	12	34	0	84
CCHT	120	0	0	0	13	382	0	515

Appendix C

Table 29: Non-Institutional Care Services Offered by VA Facilities in Network 19, Denver, CO (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS						
	Cheyenne	Denver	Fort Harrison	Grand Junction	Salt Lake City	Sheridan	Totals
Home Based Primary Care	64	305	0	0	367	0	736
Purchased Skilled Home Health Care	180	739	33	22	415	89	1,478
H/HHA	207	527	2	10	340	72	1,158
Contract Adult Day Health Care	0	25	0	0	7	3	35
Outpatient Respite Care	0	1	1	0	24	4	30
Home Hospice	3	36	9	1	2	0	51
CCHT	163	169	115	162	374	277	1,260

Table 30: Non-Institutional Care Services Offered by VA Facilities in Network 20, Portland, OR (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS								
	Anchorage	Boise	Portland	Puget Sound HCS	Roseburg	So Oregon Rehab Clinic	Spokane	Walla Walla	Totals
Home Based Primary Care	0	0	437	343	6	0	0	0	786
Purchased Skilled Home Health Care	296	216	557	341	69	23	28	11	1,541
H/HHA	59	191	39	287	1	11	92	48	728
Contract Adult Day Health Care	0	0	0	25	0	0	23	0	48
Outpatient Respite Care	1	9	0	42	0	2	33	0	87
Home Hospice	26	19	79	77	8	0	10	5	224
CCHT	0	31	622	2	47	1	2	58	763

Appendix C

Table 31: Non-Institutional Care Services Offered by VA Facilities in Network 21, San Francisco, CA (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS						
	Fresno	Honolulu	N California HCS	Palo Alto HCS	Reno	San Francisco	Totals
Home Based Primary Care	151	179	604	780	702	279	2,695
Purchased Skilled Home Health Care	36	107	190	140	111	319	903
H/HHA	8	29	124	102	92	98	453
Contract Adult Day Health Care	4	6	10	34	11	73	138
Outpatient Respite Care	3	3	0	0	0	3	9
Home Hospice	8	10	35	19	31	6	109
CCHT	29	3	38	24	36	28	158

Table 32: Non-Institutional Care Services Offered by VA Facilities in Network 22, Long Beach, CA (FY 2005)

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS					
	Greater Los Angeles	Loma Linda	Long Beach	San Diego	Southern Nevada HCS	Total
Home Based Primary Care	961	0	707	565	188	2,421
Purchased Skilled Home Health Care	446	479	56	223	280	1,484
H/HHA	111	275	59	73	0	518
Contract Adult Day Health Care	5	1	0	54	0	60
Outpatient Respite Care	1	28	0	0	3	32
Home Hospice	65	30	1	0	61	157
CCHT	259	161	113	111	127	771

Appendix C

Table 33: Non-Institutional Care Services Offered by VA Facilities in Network 23, Minneapolis, MN (FY 2005) [24]

Non-Institutional Care Service	Number of Veterans in Each Service by Facility or HCS								
	Black Hills HCS	Central Iowa HCS	Fargo	Iowa City	Minneapolis	Nebraska/ Western Iowa HCS	Sioux Falls	St Cloud	Totals
Home Based Primary Care	134	160	0	96	471	36	110	96	1,103
Purchased Skilled Home Health Care	219	-	566	-	893	1,601	305	339	3,923
H/HHA	108	-	178	-	475	718	105	152	1,736
Contract Adult Day Health Care	1	-	9	-	145	50	11	47	263
Outpatient Respite Care	13	-	9	-	15	122	6	4	169
Home Hospice	7	-	17	-	50	63	11	10	158
CCHT	0	5	0	0	25	0	2	0	32

[24] Dashes indicate that the data at the Allocation Resource Center could not be obtained for the medical facility. The workload data for the Central Iowa HCS and Iowa City are included with the Nebraska/Western Iowa HCS

Appendix D

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: May 4, 2006

From: Under Secretary for Health

Subject: **OIG Draft Report, Review of Access to Care in the Veterans Health Administration, Project No. 2005-03028-R5-0229 (EDMS 347693)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the recommendations. I am pleased that you acknowledge the Veterans Health Administration's (VHA) rapid pace of improvement in providing veteran's access to non-institutional services.

2. While recognizing the progress being made, I think it is important to understand the limitations of the information used in your report as well as the limitations inherent in the narrowness of the original request. Your study was limited to five facilities and two networks. Consequently, your findings may not be representative of VA access issues nationwide. Additionally, your report focuses almost solely on allocation of budget resources. VHA's ability to implement non-institutional programs is affected by a number of other factors that were not included in your review.

3. For instance, VHA provides many of the non-institutional services through contracts with private sector providers. In order for VHA to offer a service in a given geographic area, there must be a contractor available who meets VA standards and who is willing to contract with VA to provide the service. Even for those services that VHA provides directly, enough suitably trained personnel must be available in order to expand capacity, which is often difficult to accomplish due to the shortage of such providers in many parts of the country. The rate of expansion of non-institutional services will continue to be directly affected by the availability of such resources

as well as those cited in your report. In addition, veterans may come to VA for these services, but ultimately due to their needs and availability of services they may actually receive care not from VA but through federal, state or local agencies identified by VA for them. Once the veteran enters into such care VA is not able to track them, so there is a segment of the demand that is being met, but not by VA. Finally, the long-term care model projections will be revised in 2006, which will also affect the projected demand for non-institutional growth.

4. In addition, your report suggests that facilities were unable to schedule veterans for appointments within four months as required by current policy because facilities placed some veterans on the electronic waiting list (EWL). This is not a correct conclusion because facilities have the option to place a patient on the EWL at any point in time (i.e. before the four month waiting period). The number of patients on the EWL that you cite in your report represents new enrollees on the EWL who have been waiting more than 30 days, not 120 days. The VHA policy cited by the OIG requires facilities to place patients on the EWL if an appointment can not be scheduled within four months, but does not preclude them from putting them on the EWL prior to four months.

5. Thank you for the opportunity to review the draft report. VHA's complete plan of corrective action is attached. The plan provides a summary of specific initiatives that appropriately addresses each of the report's recommendations. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5) at (202) 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 OIG Report:

OIG Recommendations

Recommended Improvement Action 1. We recommended that the Under Secretary for Health: (a) continue to monitor the demand for non-institutional care services and, when possible, use available funding to accelerate medical facilities' ability to provide all required non-institutional care services to their veterans; (b) ensure that facilities have eliminated any local restrictions limiting eligible veterans access to non-institutional care; (c) expand coverage to geographic areas that currently do not offer non-institutional care services; (d) make sure facilities use the electronic waiting list to identify veterans waiting for non-institutional care; and (e) establish an effective measurement system to evaluate the extent geriatric evaluations are occurring.

Recommended Improvement Action 1(a): Continue to monitor the demand for non-institutional care services and, when possible, use available funding to accelerate medical facilities' ability to provide all required non-institutional care services to their veterans.

Concur **Target Completion Date:** On going In Process

VHA will continue to monitor the demand and supply of non-institutional home and community-based services through the Long-Term Care Model and increase capacity as resources permit. In general, the process for managing and providing non-institutional care services to veterans in the field is that the primary care provider refers the veteran to the facility's social workers who determine whether the veteran meets the specific criteria for the non-institutional care service. If appropriate, the social worker then evaluates the veteran's options on how best to obtain the care, such as through VA, Medicare, private insurance, or a private community organization. However, medical facilities do not capture workload data if VA is not providing or paying for the care.

In addition, if a facility did not offer a particular service, the facility would sometimes use another service in an effort to provide the desired care. For example, if home based primary care was not available, the veteran could receive some elements of this care under the purchased skilled home health care program. As such, it is sometimes difficult to monitor the demand for all non-institutional care services. However, VHA will continue to assess and request necessary funding to ensure non-institutional care services can be made available to eligible veterans in response to demand. To illustrate that VA is building capacity, a table comparing enrolled veteran demand for non-institutional care and 2003-2005 actual Average Daily Census (ADC) with percentage growth compared to demand is included in Appendix A. A second table also provides actual ADC data from 1995 to demonstrate growth in non-institutional care services.

Recommended Improvement Action 1(b): Ensure that facilities have eliminated any local restrictions limiting eligible veterans access to non-institutional care.

Concur **Target Completion Date:** April 30, 2006
Planned

On May 3, 2004, VHA issued Information Letter 10-2004-005, Under Secretary for Health's Information Letter on Non-Institutional Extended Care specifying services, including non-institutional care programs, that are part of the VHA medical benefits package. All VA facilities are required to provide or purchase these services for all enrolled, eligible veterans in need of such services. The information letter serves as a reminder that in those facilities where such services are not now available, or have limited availability, efforts must be made to establish or expand them. Furthermore, facilities are not authorized to establish local restrictions. The VHA Deputy Under Secretary of Health for Operations and Management (DUSHOM) will, via e-mail to all facility directors, chiefs of staff, and nursing directors, reaffirm the guidance and expectations of Information Letter 10-2004-005.

Recommended Improvement Action 1(c): Expand coverage to geographic areas that currently do not offer non-institutional care services.

Concur **Target Completion Date:** Ongoing
In Process

To the extent possible, VHA will incrementally expand coverage to geographic areas that currently do not offer non-institutional care services. However, since growth in these programs is constrained by capacity as well as budget, expansion of access will continue to occur incrementally. In order for VA to offer non-institutional care service in certain geographic areas, there must be a qualified private sector provider available to contract the service. Obviously, VA can not control this component of capacity. As such, it would be unfair to characterize VHA medical facilities as choosing not to provide veterans with non-institutional care in certain geographic areas. Additionally, for those services that VA provides directly, there must be a pool of suitably trained personnel available to hire in order to expand capacity. Such personnel are in short supply in many areas of the country, which is another constraint that is largely out of VA's control. However, special situations may require creative solutions. If services are not currently available through VHA in remote areas and if VHA can not purchase these services locally, because overall demand is insufficient to support, then VHA may need to devise appropriate alternatives that both meet the patient's needs and are cost effective. For instance, the DUSHOM and the VHA Office of Care Coordination will explore increased use of Care Coordination/Telehealth Services when possible to extend the geographic range of services provided.

Recommended Improvement Action 1(d): Make sure facilities use the electronic waiting list to identify veterans waiting for non-institutional care.

Concur **Target Completion Date:** Ongoing
In Process

Information Letter 10-2004-005, Under Secretary for Health's Information Letter on Non-Institutional Extended Care specifies that if the demand for non-institutional care services exceeds current capacity, waiting lists may be established. VA issued VHA Directive 2003-068, Process for Managing Patients when Patient Demand Exceeds Current Clinical Capacity, to establish policy for use of electronic wait lists. That Directive remains in effect. In May 2005, the DUSHOM distributed a memorandum to the networks instructing them to use EWL for Home-Based Primary Care and Purchased Home Health Care. A revised directive is now in concurrence and we anticipate that it will be issued by May 30, 2006.

Recommended Improvement Action 1(e): Establish an effective measurement system to evaluate the extent geriatric evaluations are occurring.

Concur **Target Completion Date:** June 30, 2006
In Process

The VHA Office of Geriatrics and Extended Care will work to identify and eliminate any local eligibility restrictions, and establish metrics to evaluate the extent that geriatric evaluations are occurring. VA will add a report on the average daily census in Geriatrics Evaluation and Management (GEM) programs to the Monthly Performance Report commencing in the 3rd Quarter of Fiscal Year (FY) 2006.

Recommended Improvement Action 2. We recommended that the Under Secretary for Health: (a) direct facilities to implement a tracking mechanism to identify which newly enrolled veterans want care and make sure they receive it and (b) remind facilities of the requirement to either schedule a veteran's appointment or place the veteran on the electronic waiting list within 7 business days of the appointment request.

Recommended Improvement Action 2(a): Direct facilities to implement a tracking mechanism to identify which newly enrolled veterans want care and make sure they receive it.

Concur **Target Completion Date:** September 30, 2006
In Process

The DUSHOM will issue a new directive on scheduling processes and procedures to establish use of EWL as a vehicle for communicating new enrollee desire for an appointment to a scheduling clerk. When a newly enrolled or newly registered patient requests clinical care, enrollment/registration staff will immediately enter the name of the patient into EWL for the clinic and preferred location requested. In addition, enrollment/registration staff will document that the patient is newly enrolled/registered in the comments section of EWL. Schedulers in all clinics at all locations will review EWL daily to determine if a newly enrolled or newly registered patient has requested care in their clinic.

Additionally, the DUSHOM, acting through the Advanced Clinic Access (ACA) Measurement Sub-Committee, chartered the ACA Taskforce at the end of FY 2005 to examine processes and procedures for scheduling surgical procedures and use of the Surgery/OR software in order to develop recommendations on how to most effectively schedule and monitor elective surgical procedures.

Recommended Improvement Action 2(b): Remind facilities of the requirement to either schedule a veteran's appointment or place the veteran on the electronic waiting list within 7 business days of the appointment request.

Concur **Target Completion Date:** September 30, 2006
In Process

The DUSHOM will issue a revision of VHA Directive 2003-068, Process for Managing Patients when Patient Demand Exceeds Current Clinical Capacity, and the new directive on scheduling processes and procedures, which will require staff to act within seven calendar days to schedule or place all requests for outpatient services on EWL. Furthermore, the new scheduling directive will require individuals and supervisors with responsibilities for scheduling outpatient services to complete nationally developed training modules to assure compliance with business rules related to registration, enrollment, scheduling, consult management and use of EWL. The training will emphasize the requirement to schedule or place the veteran on EWL within seven calendar days.

Recommended Improvement Action 3. We recommended that the Under Secretary for Health: (a) establish standardized tracking methods and appropriate performance metrics to evaluate and improve the timeliness of elective procedures and (b) implement prioritization processes to ensure that veterans receive clinically indicated elective procedures according to their clinical needs.

Recommended Improvement Action 3(a): Establish standardized tracking methods and appropriate performance metrics to evaluate and improve the timeliness of elective procedures.

Concur **Target Completion Date:** September 30, 2007
In Process

An ongoing VHA initiative relevant to this recommendation is the External Peer Review Program (EPRP). The EPRP is a VHA-wide effort coordinated by the Office of Quality and Performance (OQP) to provide medical facilities with diagnostic and procedure-specific quality of care information in order to improve the overall level of patient care. Currently, the program collects information on nearly all hip and knee replacement cases for all VHA facilities performing such procedures. In the 1st Quarter of FY 2007, OQP will incorporate additional data elements into the EPRP abstraction to assess the feasibility of determining which cases are truly "elective", e.g., not necessitated by fracture or infection. Of those cases determined to be elective, OQP will assess the feasibility of determining the time period between the providers' identification for the need of a procedure and its completion. If the abstraction is feasible, OQP will begin calculating the median and range of time intervals for each facility in the 3rd Quarter of FY 2007.

Furthermore, OQP is coordinating with VHA's Office of Patient Care Services (PCS) to collect and evaluate data relating to wait times for orthopedic and joint replacement surgery. After thorough evaluation, OQP and PCS will collaborate to publish guidelines and performance metrics for wait times for orthopedic and joint replacement surgery.

Additionally, in regards to VHA performance measurement of colorectal cancer screening, OQP has developed a comprehensive data collection instrument that was tested in 4th Quarter of FY 2005 and is being used in 2006 to capture data regarding colorectal cancer screening, specialty referral, testing, follow-up, and treatment. The data collection pilot that took place in the 4th quarter of FY 2005 resulted in a number of instrument improvements, but as anticipated, the data volume was deemed too small to draw any significant conclusions. However, OQP expects the volume of cases reviewed to increase as it continues to capture data throughout the remainder of 2006. OQP anticipates that it will be able to assess gaps and opportunities for improvement by the end of the 3rd Quarter of FY 2006 and provide the field with this preliminary information in the 4th quarter of FY 2006. The Performance Management Workgroup (the committee charged with selecting and recommending performance measures for VHA) will review the data analysis during the 4th Quarter of FY 2006 and will consider recommendation of measures for inclusion in the 2007 Performance Measures Plan. OQP anticipates the implementation of both performance measures and supporting indicators in 2007.

In addition, OQP is utilizing the EPRP to identify a small sample of veterans who have not undergone screening by fecal occult blood testing (FOBT) in the past year but have had a colonoscopy performed within the previous ten years. In the 1st Quarter of FY 2007, OQP will explore the feasibility of determining whether or not these colonoscopies were elective (i.e., for colorectal cancer screening) and the time period between the decision to undergo colonoscopic colon cancer screening and completion of the colonoscopy. If the abstraction is feasible, OQP will begin calculating the median and range of time intervals for the VA system in the 3rd Quarter of FY 2007. It is important to note, however, that since only a small number of cases are likely to meet the criteria of no FOBT in the past year, but a colonoscopy within the past ten years, only an estimate of national level performance will be possible from the data abstracted by EPRP. In addition, OQP is establishing timeliness of access measures for orthopedic procedures for knees and hips, which is expected to be completed in the 4th Quarter of FY 2007.

Recommended Improvement Action 3(b): Implement prioritization processes to ensure that veterans receive clinically indicated elective procedures according to their clinical needs.

Concur **Target Completion Date:** November 30, 2006
In Process

OQP is in the process of developing performance metrics for wait times that will ensure that elective procedures are accomplished in a timely fashion according to a patient's clinical needs. In addition, OQP is establishing timeliness of access measures for orthopedic procedures for knees and hips, which is expected to be completed in the 4th Quarter of FY 2007.

Additionally, as discussed in VHA's response to OIG Draft Report, Healthcare Inspection: Colorectal Cancer Detection and Management in VHA Facilities, Project No. 2005-00784-HI-0109, PCS has developed a draft policy on colorectal cancer screening and diagnosis, which will set performance and timeliness expectations. This policy will be issued by August 2006.

Appendix A

Enrolled Veteran Demand for Non-institutional Care Compared to Actual ADC
(in ADC)

	2003	2004	2005
Demand for VA-sponsored Care	85,578	91,324	96,255
Actual ADC*	18,363	19,752	24,974
VA Increase from Prior Year	5.1%	7.6%	26.4%

*ADC for the following non-institutional care programs: home-based primary care, purchased skilled home health care, VA/contract adult day health care, H/HHA, home respite, and home hospice. 2005 includes care coordination. ADC does not include community residential care

NON-INSTITUTIONAL LONG-TERM CARE*, AVERAGE DAILY CENSUS 1995-2005

Fiscal Year	ADC	ADC Growth from Previous Year	% Growth from Previous Year
1995	6,596	-	-
1996	6,678	82	1.2%
1997	10,176	3,498	52.4%
1998	11,706	1,530	15.0%
1999	13,407	1,701	14.5%
2000	14,111	704	5.3%
2001	16,150	2,039	14.4%
2002	17,465	1,315	8.1%
2003	18,363	898	5.1%
2004	19,752	1,389	7.6%
2005	24,974	5,222	26.4%
	Non-Institutional ADC Growth From 1995-2005: 278.6%		

* Excludes CRC in all years and includes impact of care coordination beginning in 2005.

OIG Contact and Staff Acknowledgments

OIG Contact	William Withrow, (816) 426-7100
Acknowledgments	Daisy Arugay Joseph Janasz Gilbert Melendez Ken Myers Carla Reid Larry Reinkemeyer Julie Watrous

Appendix F

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Veterans Benefits Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Directors, Veterans Integrated Service Networks 1-23
Director, Alaska VA Healthcare System and Regional Office (463/00)
Director, James A. Haley VA Medical Center (673/00)
Director, VA New York Harbor Healthcare System, (630/00)
Director, VA Pacific Islands Healthcare System (459/00)
Director, Portland VA Medical Center (648/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Quality of Life and Veterans Affairs
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction and Veterans Affairs
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Daniel K. Akaka, Hillary Rodham Clinton, Daniel K. Inouye, Mel Martinez, Lisa Murkowski, Bill Nelson, Charles E. Schumer, Gordon H. Smith, Ted Stevens, Ron Wyden
U.S. House of Representatives: Neil Abercrombie, Jim Davis, Carolyn B. Maloney, David Wu, Don Young

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.