DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Special Reviews and Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Concerns with Consistency and Transparency in the Calculation and Disclosure of Patient Wait Time Data

MANAGEMENT ADVISORY MEMORANDUM | MEMO #21-02761-125 | APRIL 7, 2022

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The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

The Office of Inspector General (OIG) has released this management advisory memorandum to provide information on matters of concern that the OIG has gathered as part of its oversight mission. The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Investigations.

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April 7, 2022

MANAGEMENT ADVISORY MEMORANDUM

TO: Richard A. Sauber, General Counsel
Department of Veterans Affairs (02)

FROM: Michael J. Missal, Inspector General
VA Office of Inspector General (50)

SUBJECT: Review of the Veterans Health Administration's (VHA) Calculation and Disclosure of Patient Wait Times

The OIG recognizes that ensuring veterans have timely access to health care has been an ongoing priority for VHA. In 2014, consistent with legislative mandates, VA began to publish data about patients' wait times for VHA medical appointments for each of its facilities on a dedicated website.[1] Calculating wait times is complex, and it has been challenging for VHA to consistently implement a suitable methodology that transparently and accurately reflects the amount of time patients wait for an appointment.[2]

This memorandum addresses concerns that were raised about how VHA was reporting on wait times for appointments. In June 2021, a complainant alleged that two years prior, in the fall of 2019, the then acting principal deputy under secretary for health had been informed that VHA's wait times reporting may be misleading but that VHA took no action in response. After an initial examination, the OIG determined that there was no basis to proceed with a misconduct investigation of the then acting principal deputy under secretary for health. Specifically, the OIG found no evidence of an intent or effort to mislead. Additionally, the OIG found that efforts to improve wait time disclosures had been under consideration but had been deferred by urgent priorities, including the COVID-19 pandemic. Each witness interviewed told investigators that the then acting principal deputy under secretary for health had been supportive of efforts to refine VHA's approach to measuring wait times. The complainant told OIG investigators that the then acting principal deputy under secretary for health had instructed subordinate staff to update

[1] Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), Pub. L. No. 113-146 § 206 (2014). Initially the data were reported on the VHA Patient Access Data website, and then in 2017 on a new Access and Quality in VA Healthcare (Access to Care) site. See www.accesstocare.va.gov, aimed at providing veterans with an easy way of seeing local VA wait time data.

[2] The OIG, US Government Accountability Office, VHA internal auditors, and other organizations have issued reports and recommendations to address patient wait times for VHA appointments, as well as scheduling practices, consult management, and VA's community care programs. See, e.g., VA OIG, *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15*, Rep. No. 17-00481-117, March 13, 2018; US Government Accountability Office, *Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, Rep. No. GAO-21-119SP, March 2021, at 286–88.

VA's Access to Care website disclosures to account for new methodologies, but that action had not yet been taken and inaccuracies remain.

In the course of that initial examination, however, the OIG observed that VHA has presented wait times to the public without clearly and consistently detailing the basis for their calculations. Since 2014, VHA has employed several different methodologies (particularly using different start dates) for calculating wait times reported online, as well as for determining whether wait time criteria are met for community care program eligibility.[3] The methodologies used deviated in some cases from VHA's scheduling directive and its stated wait time measures announced in the Federal Register in 2014.[4] As a result, VHA has sometimes presented wait times with different methodologies, using inconsistent start dates that affect the overall calculations without clearly and accurately presenting that information to the public. In June 2021, the then acting under secretary for health told the OIG review team that VHA has never really tackled, to his satisfaction, how VHA calculates the timeliness of access to care.

This memorandum is meant to convey information to help VA leaders determine if additional actions by VHA are necessary to accurately and transparently report wait time data.[5]

From its observations, the OIG team made these determinations:

- VHA developed standards in 2014 for how to calculate publicly reported wait times for appointments using the provider's *clinically indicated* date or the veteran's *preferred* date (defined below) as the start times.
- The inconsistent use of start dates for calculating wait times can be misleading and may result in inaccurate reporting.
- VHA has published wait time data based on start dates that are inconsistent with VHA policy and publicly stated methodologies, and the stated description of methodologies on its website may be misleading.

[3] Under current and previous legislation authorizing payment for care in the community, VHA patients may be eligible to receive care in the community based on various criteria, including wait times. As discussed later in this memorandum, a different start date was used for determining community care eligibility as it relates to the wait time standard than those used for website calculations, which can be confusing for stakeholders reading VA reports on wait times.

[4] VHA Directive 1230(5), *Outpatient Scheduling Processes and Procedures*, July 15, 2016 (amended September 24, 2021), at 3. Publication of Wait-Times for the Department for the Veterans Choice Program, 79 Fed. Reg. 65,771 (November 5, 2014).

[5] This memorandum was sent to the Office of General Counsel on February 14, 2022, to provide the opportunity to review and comment. Following that period, their comments were given full consideration, and the one request for a change was noted with the full text of the response provided in appendix B. The OIG issues management advisory memoranda when exigent circumstances or areas of concern are identified by OIG hotline allegations or in the course of its oversight work, particularly when immediate action by VA can help reduce further risk of harm to veterans or significant financial losses. Memoranda are published unless otherwise prohibited from release or to safeguard protected information.

- VA implemented new access standards in 2019 for determining community care eligibility, deciding to use the date of appointment *request* as the start time.

The OIG is taking no additional steps or planning any further reporting at this time because there were no findings of intentional misconduct related to the initial allegations, and this memo serves to alert VA of the problems identified in the course of that examination.

VHA Established Methodologies for Calculating Publicly Reported Medical Facility Wait Time Data in 2014

As mentioned above, Congress passed the Veterans Access, Choice, and Accountability Act of 2014 (the Choice Act) in August of that year, which required VA to publish data about wait times for medical appointments in VHA facilities on a public website.[6] Pursuant to the Choice Act, VHA developed a methodology for calculating wait times that it reported to Congress and published in the Federal Register.[7] VHA has posted wait time data for all VHA medical facilities for primary care, specialty care, and mental healthcare appointments on a public website since 2014. Starting in 2017, VHA posted wait time data on a newer public web page. As discussed below, the start date used to calculate wait times posted on the second website for new patients was not consistent with the method for calculating wait times described in the Federal Register and the VHA scheduling directive.

To understand the inconsistencies, it is important first to understand the general process and various start dates that VHA has used and referenced in its reporting of wait times. For VHA facility appointments, a request for care is made directly by or on behalf of the veteran or by a VA care provider. A scheduler then identifies an available appointment date and time for the requested clinic in VHA's scheduling system and creates an appointment. VHA aggregates its medical facility appointment data to produce reports on the timeliness of its care. VHA's appointment-scheduling process includes several time stamps that have been variously used as start dates to measure appointment wait times. These include the following, with the boxed measures reflecting the start dates according to current VHA policy:

- **Request date:** the date on which a veteran or care provider requests an appointment (for instance, the date a consult (referral) is made by a VHA provider).[8] (Note that the date of *request* is referenced in the Choice Act and later used by VA in its regulations under the

[6] Choice Act, Pub. L. No. 113-146 § 206 (2014).

[7] Publication of Wait-Times for the Department for the Veterans Choice Program, 79 Fed. Reg. 65,771 (November 5, 2014).

[8] VHA Directive 1232(4), *Consult Processes and Procedures*, August 24, 2016 (amended December 14, 2021), defines a consult as "a request for clinical services on behalf of a patient. In VHA, consult requests are made through an electronic document in [the Computerized Patient Record System] communicating service requests and/or results." The consult request date is also referred to by VHA as the "file entry date."

VA MISSION Act of 2018 (MISSION Act) *specifically to determine community care program eligibility* related to wait times.)[9]

- **Clinically indicated date:** the date a VA healthcare provider deems an appointment "clinically appropriate" based upon the patient's needs.[10]
- **Preferred date:** "the date the patient communicates they would like to be seen. The [preferred date] is established without regard to existing clinic schedule capacity."[11]

- **Create date:** the date the appointment is created.[12] (This start date was in use before 2014 for new patients and used in practice again on its public website since 2017 for new patients.)
- **Appointment date:** the date of the appointment.[13]

The Choice Act defined VA's wait time goal as being "not more than 30 days from the date on which a veteran requests an appointment for hospital care or medical services from the Department."[14] The Choice Act also allowed VA to establish different wait time goals if it submitted the information in a report to Congress, and then published it in the Federal Register and on a website available to the public, which it did.[15] In the notice published in the Federal Register in November 2014, VA announced that the wait time data published on its public-facing website would be measured for both new and established patients from the *clinically indicated date* or *veterans' preferred date*.[16] Before that time, VHA had measured wait times (internally, but not publicly) from the *create date* for *new* patients and from the veteran's *preferred date* for *established* patients.[17]

[9] The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, Pub. L. No. 115-182 (2018). VA, "VA announces access standards for health care," January 30, 2019, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5187.

[10] This date is also sometimes called the "clinically appropriate date" or "return to clinic" date.

[11] This date is also sometimes called the "patient indicated date." Previously, VHA used the term "desired date"—the date the patient or provider wanted the patient to be seen. This term has been replaced by preferred date (when the patient wants to be seen) and clinically indicated date (when the provider wants the patient to be seen).

[12] 79 Fed. Reg. 65,772.

[13] This date is also sometimes called the "completed" date. Average wait times are retrospective and based on completed appointments. Although they can be misleading, discrepancies in how those times are reported do not, therefore, affect the time veterans had to wait for an appointment.

[14] Choice Act § 101(s)(1).

[15] Choice Act § 101(s)(2); See also Wait-Time Goals of the Department for the Veterans Choice Program, 79 Fed. Reg. 62,519, 62,520 (October 17, 2014); VA, *Report to Congress on the Veterans Choice Program Authorized by Section 101 of the Veterans Access, Choice, and Accountability Act of 2014 (Pub. L. 113-146)*, October 3, 2014.

[16] 79 Fed. Reg. 65,771, 65,772.

[17] 79 Fed. Reg. 65,771.

In 2016, VHA issued a directive on appointment-scheduling processes and procedures for outpatient clinics that states,

> VHA policy requires veterans' appointments to be "scheduled timely, accurately, and consistently with the goal of scheduling appointments no more than 30 calendar days from the [clinically indicated date], or, in the absence of a [clinically indicated date], 30 calendar days from the [veteran's preferred date]."[18]

Not Adhering to the Stated Methodology to Calculate Wait Times Can Be Misleading and Inaccurate

Accuracy and transparency in reporting wait times require that VHA clearly indicates which starting point was used in its calculations. For example, the intervals between the date the care is requested, the clinically indicated date, the patients' preferred date, or when the appointment is created (all potentially different start dates), to the date the patient is actually seen may vary. This difference can vary greatly among facilities and types of care. To illustrate this point, the following is one example of a consult scheduled a number of days after it was requested.

Example 1

On June 28, a provider referred a patient to be seen in the cardiology outpatient service (the *request date*). The referring provider entered a *clinically indicated date* of June 28, meaning that the veteran should be seen as soon as possible.[19] Although a nurse practitioner in the receiving clinic reviewed the referral the next day, a scheduler did not *create* the appointment until July 21, which was 23 days after the *request date*. The appointment was scheduled for and occurred on September 2.

Figure 1 shows that, depending on the start date, the wait time for this scenario could be calculated different ways, resulting in different representations of the veteran's wait time.

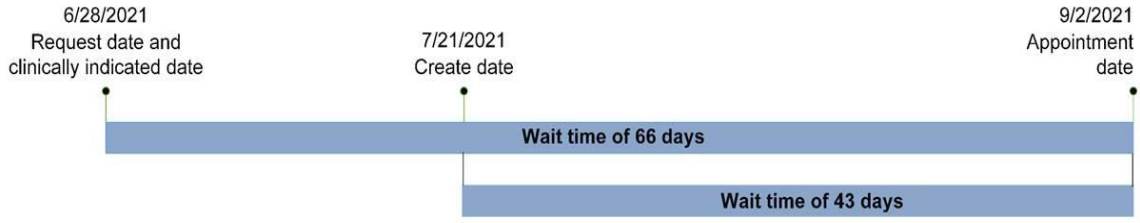


Figure 1. *Scenario illustrating different wait times for the same appointment.*
Source: OIG analysis.

[18] VHA Directive 1230(5), at 4.

[19] The clinically indicated date that is entered by the provider may not always the same as the request date. It could be a date in the future.

The different start dates being used directly affect the wait time calculations being reported. As shown in example 1, the wait time using the request date or clinically indicated date shows the 66-day wait time. In contrast, using a "create date" (as was the practice prior to 2014) would make the wait time appear to be 43 days, a difference of 23 days. In other examples drawn from VHA's data, the OIG team identified instances in which the number of days between a provider's request and the creation of the appointment were two days, five days, seven days, 20 days, and 29 days. In fewer instances, the appointment create date was the same day as the request, leaving the calculated wait time unaffected.[20] Had the appointment been requested and created on the same day in example 1 (June 28), the calculated wait time would be reflected as 66 days from both the request and create dates.

VHA Has Published Wait Time Data Based on Start Dates Inconsistent with VHA Policy and Publicly Stated Methodologies

VHA's published wait time data have not always followed VHA policy and may be misleading. While VA appeared to calculate and report wait times consistent with policy on its initial public website from 2014 until March 2021, it developed a concurrent second web page that used a different start date measure for some patients. Beginning in 2017, the wait times reported by VHA on this second, newer public web page changed for new patients and were not calculated consistent with VHA's stated method for measuring wait times announced in its November 2014 Federal Register notice and in its own directive.[21] The OIG found, consistent with its 2014 announcement, that wait times on the initial VHA Patient Access Data website were calculated using the *preferred date*.[22] In contrast, the second Access to Care website stated the best date for new patients was the *request date*.

The OIG did not identify a subsequent announcement in the Federal Register, or a report to Congress, that indicated VHA was changing its wait time methodology on its newer website. Therefore, when VHA stopped posting wait time data on its initial website in March 2021, it appears they were no longer complying with the Choice Act requirement to publish wait time data in accordance with the methodology it announced in the Federal Register in 2014. Moreover, as discussed below, the actual start date used for new patients on the second website beginning in 2017 was inconsistent with even its own public website information, active and accessible at the same time as the first website.

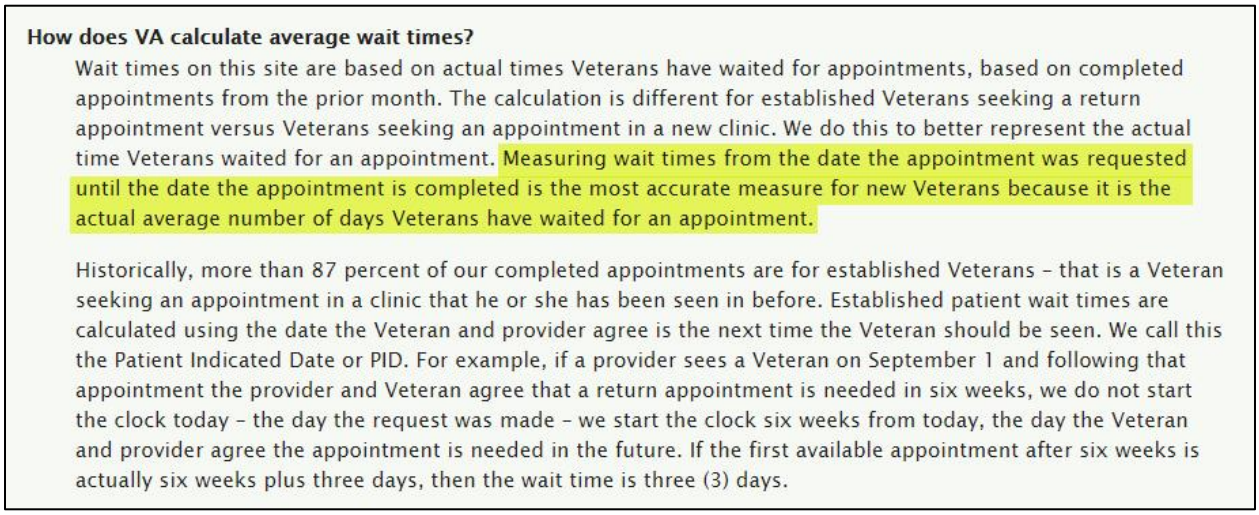
[20] The examples in this section were appointments that originated from a referral from a VHA provider, and not patient-generated requests. As discussed later, VA's scheduling systems do not automatically capture the request date for all appointments, such as the date the veteran calls to request an appointment, so there are no data to determine the extent to which the date on which a patient *requests* a new appointment may differ from the *create* date for the appointment.

[21] 79 Fed. Reg. 65,771, 65,772; VHA Directive 1230(5), at 4.

[22] "Patient Access Data," VHA, accessed July 12, 2021, https://www.va.gov/health/access-audit.asp.

Access to Care Website, Established in 2017

As the language in the figure below indicates, the second Access to Care website description of how VHA calculates average wait times for *new* patient appointments was vague. The site did, however, properly specify how VHA measured wait times for *established* patient appointments.



How does VA calculate average wait times?

Wait times on this site are based on actual times Veterans have waited for appointments, based on completed appointments from the prior month. The calculation is different for established Veterans seeking a return appointment versus Veterans seeking an appointment in a new clinic. We do this to better represent the actual time Veterans waited for an appointment. Measuring wait times from the date the appointment was requested until the date the appointment is completed is the most accurate measure for new Veterans because it is the actual average number of days Veterans have waited for an appointment.

Historically, more than 87 percent of our completed appointments are for established Veterans – that is a Veteran seeking an appointment in a clinic that he or she has been seen in before. Established patient wait times are calculated using the date the Veteran and provider agree is the next time the Veteran should be seen. We call this the Patient Indicated Date or PID. For example, if a provider sees a Veteran on September 1 and following that appointment the provider and Veteran agree that a return appointment is needed in six weeks, we do not start the clock today – the day the request was made – we start the clock six weeks from today, the day the Veteran and provider agree the appointment is needed in the future. If the first available appointment after six weeks is actually six weeks plus three days, then the wait time is three (3) days.

Figure 2. *Access to Care Website FAQ and Response to Query.*
Source: https://www.accesstocare.va.gov/Healthcare/Timeliness, accessed July 12, 2021, and again on January 11, 2022. Highlights in the figure were added by the OIG.
Note: Average wait time data are retrospective, calculated using completed appointments, and the completed appointment date is the end date of the calculation.

A plain reading of the website description seems to suggest, though not clearly stated, that wait times for new patients are calculated from the *request date*, which VHA states "is the most accurate measure for new [v]eterans" because it represents the actual average days a veteran has waited for an appointment.[23] The OIG found, however, that VHA actually measured new patient appointment wait times on this website from the appointment *create date* (when the scheduler made the appointment) and not the *request date* as the website purports (such as the date a referral was made by a VHA provider). The acting assistant deputy under secretary for health for access to care informed OIG staff in June 2021 that VHA has been calculating the wait times for new patient appointments from the *create date* since the Access to Care website was created in April 2017.[24] This statement was consistent with the OIG team's validation analysis. The following table helps summarize how actual start dates used by VHA were sometimes inconsistent with what the web page said was being used, which was also different in some cases from what the Federal Register and VHA's directive stated VA would be using.

[23] The request date is different from the *clinically indicated* or *preferred* date stated as the start date in VA's directive and the Federal Register notice. Moreover, even that measure did not appear to be consistently followed.

[24] VHA's Office of Veterans Access to Care (OVAC) has been the primary national program office responsible for overseeing and directing VA's efforts to provide access to care since 2014.

Table 1. VHA Websites Publishing Wait Time Data Using Different Start Dates

VHA wait time data websites	Active years	Actual start date used for wait time calculations	Consistent with website description	Consistent with VHA policy
VHA Patient Access Data website	2014–2021	*clinically indicated date* or *veterans' preferred date*	Yes	Yes
Access and Quality in VA Healthcare (Access to Care) website	2017–present	*create date* for new patients *preferred (patient-indicated) date* for established patients	No, for new patients Yes, for established patients	No, for new patients Yes, for established patients

Source: OIG analysis of VHA's Patient Access Data website, VHA's Access to Care website and source data, and interviews with VHA officials.

Note: As mentioned earlier, VHA's publicly reported wait time data on its websites are retrospective (based on the prior month's data), and the way it is calculated does not affect the actual wait time that each individual veteran experienced.

For about four years, VA posted wait time data on two separate public websites using different start dates. When VA posted wait time data on its public Patient Access Data website from 2014 through 2021, it measured both new and established patients combined from the *clinically indicated date* or *veterans' preferred date*. When VHA began reporting its data on the new Access to Care website starting in 2017, it reverted to pre-2014 formulas.[25] That is, VHA has been using the *create date* for new patient appointments and the *preferred date* for established patients.[26]

In addition to not being in line with its scheduling directive, VHA's practice of calculating wait times for new patient appointments using the *create date* does not account for any time that may have elapsed between when a consult (referral) was requested, or its *clinically indicated date,* to the *creation* of the appointment (as depicted in example 1 earlier), which can result in a shorter wait-time calculation. Recognizing the challenges with using *create date* as the starting point, the then acting under secretary for health told the OIG team in June 2021 that he did not think that VHA should start counting from the point where a scheduler "picks up your chart and begins working with it," concluding that "it's just not fair to the veteran."

Later, in January 2019, *JAMA* published a study—authored by then current and former VA leaders and other personnel—that compared VA wait times for new patients to those in the

[25] "Access and Quality in VA Healthcare," accessed July 12, 2021, https://www.accesstocare.va.gov. According to the website, the average wait times are based on appointments completed at VA facilities during the previous month.

[26] Preferred date was previously referred to as "desired date"—the date the patient or provider wanted the patient to be seen. Preferred date is also sometimes called the "patient indicated date."

private sector.[27] The study methodology stated that the VA "[w]ait times were calculated by counting the number of days between the day that a veteran requested an appointment to the date of the appointment," and concluded that VA facilities had shorter wait times than the private sector for primary care, cardiology, and dermatology. In the course of its interviews, the OIG team received information that the then acting principal deputy under secretary for health acknowledged the study was flawed.[28] According to VA officials during interviews with the OIG team in June and July 2021, the data VA used was measured from the *create date,* which can be later than a request date stated in the article (as depicted in example 1). The OIG was unable to validate the precise methodology and underlying VA data used for the study consistent with the allegation.

VHA acknowledged on its Access to Care website that there is no national standard for measuring wait times and that making comparisons between VA and private sector wait times is difficult at best.

VA Implemented New Access Standards for Community Care Eligibility in 2019 That Also Calculate Wait Times Differently from Publicly Reported Average Wait Times

The Choice Act established the framework for increasing veterans' access to care in the community. The MISSION Act continued veterans' ability to seek care locally, with some adjustments to eligibility requirements.[29] According to VA regulations under the MISSION Act, effective June 2019, a veteran is eligible for community care if VA cannot schedule an appointment internally for the veteran within 20 days of the date of *request* for primary care, mental health care, and noninstitutional extended care services or within 28 days of the date of

[27] Madeline Penn, BS, BA; Saurabha Bhatnagar, MD; SreyRam Kuy, MD, MHS; Steven Lieberman, MD; Shereef Elnahal, MD, MBA; Carolyn Clancy, MD; David Shulkin, MD, "Comparison of Wait Times for New Patients Between the Private Sector and United States Department of Veterans Affairs Medical Centers," *JAMA Network Open* 2, no. 1 (2019), https://doi.org/10.1001/jamanetworkopen.2018.7096. The study focused on new patient appointment wait times in primary care, dermatology, cardiology, and orthopedics, and concluded that VA's wait times have improved from 2014 to 2017 and that VA facilities have shorter wait times than the private sector across a range of specialties. The study assessed wait times at VA medical centers in 15 major metropolitan areas in fiscal years 2014 and 2017.

[28] In the General Counsel's response to this memorandum, VHA suggested one edit to this sentence to clarify the then acting principal deputy under secretary for health "recognized the study had flaws because of the inherent difficulty in finding a single set of accurate data for these wait times." (See appendix B for the VA comments, including that the named individual "did not believe that the study was based on inaccurate or false information, which is the implication of the wording.") The OIG did not revise the referenced sentence because it was the wording used in information provided to the OIG from a source other than the then acting principal deputy under secretary for health.

[29] MISSION Act of 2018, Pub. L. No. 115-182 (2018); VA, "VA announces access standards for health care," January 30, 2019, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5187. The access standards are one of six criteria for community care eligibility under the MISSION Act that entitle veterans to receive care outside of VHA facilities to meet their needs.

request for a specialty care appointment (unless the veteran and provider have agreed to a later date).[30]

When determining an individual veteran's eligibility for community care based on wait time, VHA schedulers are required to identify the wait time from the *request* to the next available *appointment date* in real time. Staff can do this on an individual, case-by-case basis by viewing the clinic availability when the appointment is requested. VHA's Office of Community Care guidebook instructs facility staff to determine whether a veteran is eligible for community care on an individual basis, using the "file entry date" of the consult (request date) and looking for the first available appointment in the relevant clinic schedule.[31] VHA officials told the review team that staff are not to use average wait times to determine community care eligibility.[32]

As previously discussed, VHA calculates and reports average patient wait times on its most current website based on the prior month's completed appointments (retrospective), using the *create date* for new patients and the *preferred date* for established patients as the start times, which are different from the *request dates* that staff are to use in real time (forward-looking) for determining community care eligibility related to how long a patient must wait to see a provider (see table 2 below). For a timeline that summarizes the various wait time methodologies, see also appendix A.

[30] 38 C.F.R. § 17.4040. See also Veterans Community Care Program, 84 Fed. Reg. 26,310 (June 5, 2019).

[31] *VHA Office of Community Care Field Guidebook*, Chapter 2: Eligibility, Referral, and Scheduling. The OCC Field Guidebook is continually updated based on guidance provided by VHA. The guidebook assists staff with obtaining care for patients in the community.

[32] The complainant did not question VA's process of assessing wait times for purposes of eligibility determinations. Therefore, the OIG did not evaluate whether VA staff were accurately determining community care eligibility as part of this review. Rather, VA's community care access standards for wait times were examined to help demonstrate the confusion caused by having different start dates for different purposes.

Table 2. VHA's Two Purposes in Calculating Wait Times

Wait time purpose	Wait time date range used
Website reporting, in aggregate	*Create date* to appointment date (new patients) *Preferred date* to appointment date (established patients)
Community care eligibility determinations	*Request date* to next available appointment date

Source: OIG analysis of VHA's Access to Care website and VA regulations, and interviews with VHA officials.
Note: As discussed earlier, although request date is listed on the VHA website as what is "most accurate," the create date was actually used for new patients.

VHA Has Used a Different Methodology for Website Reporting Than for Community Care Purposes Due in Part to Data Collection Limitations

According to VHA officials, they have used the *create date* to calculate average wait times for new patient appointments because it is the cleanest data point they consistently have available. VHA officials further explained that the agency does not have an automated way to gather the request date for all appointments. For example, VA's scheduling systems do not automatically capture the date the veteran calls to request an appointment. To capture this data point to systematically calculate aggregate, retrospective wait times, VHA would need facility staff to manually enter that information.

However, VHA's scheduling system does automatically capture the request date when it comes from a VA provider's referral or order, and the clinically indicated date (when entered by the provider), in addition to the date the scheduler created the appointment in the system. Therefore, depending on which start date VHA ultimately uses to calculate wait times, personnel may have access to some of the needed information.

Regardless of the methodology used, VHA should clearly describe it and any limitations in the publication of wait time data. That methodology should also be reported to Congress and published in the Federal Register and should be consistent with VA directives or other guidance, which may require revisions to those authorities.

Although used for different purposes, VHA's two approaches to calculating wait times and the use of different measurements (as described in table 2) appear to have created confusion. For example, in a September 2019 testimony, VHA's then executive-in-charge seemingly relied on average wait time data to opine on achieving community care eligibility wait time standards.[33] In response to a member's question about whether VA's access standards for community care are achievable and working, the executive-in-charge stated, "I would say yes, they are achievable

[33] *Hearing on MISSION Critical: Care in the Community Update*, *Before the House Committee on Veterans' Affairs*, 116 Cong. (September 25, 2019).

and have been achieved for the most part. In mental health, the 20-day access standard, 139 of our 141 sites are meeting the 20-day access standard."

In the course of its interviews, the OIG team received information that suggested the statistics relating to VHA facilities meeting mental health wait times were calculated from the *create date*. This was consistent with the OIG's validation analysis. Using the create date for average wait times is different than the community care wait time eligibility measurement, and may not capture the full amount of time a veteran has waited for an appointment to the extent that there was a delay in scheduling, as shown in example 1.

During a July 2019 testimony, Congress asked why VHA did not measure wait times from the *request date*.[34] VHA's acting assistant deputy under secretary for health for access to care answered, "If the veteran calls and the appointment is made that day . . . that is the same measurement." This statement is accurate if the appointment was created the same day it was requested. But when those dates are different (as shown in example 1), then measuring from the create date would not include the additional time the veteran waited between when the appointment was requested and when it was created.

To avoid similar pitfalls in presenting its wait time data, VHA should consider using a consistent methodology that is accurately described, which will also help VHA communicate those methods more transparently in the future. As discussed in the following section, VHA has recognized this need and has been contemplating changes, but other urgent priorities have delayed progress.

Since 2019, VHA Has Been Discussing Aligning VHA Wait Time Calculations with Community Care Access Standards, but No Changes Have Been Made to Date

VHA officials told the OIG team that leaders have been discussing the possibility of updating their public reporting wait time methodology to be consistent with how they determine community care eligibility since the fall of 2019.

On October 1, 2019, OVAC personnel sent a detailed process map to VHA leaders illustrating how the various dates affect wait time methodologies. The internal document identified that the current wait time metric for new patient appointments was from the *create date* to the appointment date and noted the following two options for future appointment wait time metrics:

1. Start the wait time from the file entry date, when the provider requested the referral.
2. Start from the patient indicated date.

[34] *Hearing on True Transparency? Assessing Wait Times Five Years After Phoenix*, *Before the House Committee on Veterans' Affairs*, 116 Cong. (July 24, 2019).

In December 2019, VHA leaders briefed congressional staff regarding concerns about how VHA has struggled with scheduling referrals quickly in the past. Leaders clarified how VHA was calculating its wait time data and plans for going forward. During the briefing, VHA discussed a new initiative intended to reduce the time from request date to create date. According to the briefing document, the meeting included a discussion of the "measurement of publicly reported specialty care wait times" and a high-priority initiative to align "publicly reported specialty care wait times with MISSION Act."[35]

The December 2019 briefing document further showed that the previous method used to measure average wait times was the time between the create date and appointment date, but in the future VA instead would measure the *request date* to *create date* to *appointment date*.[36] In July 2021, VHA officials acknowledged that they were still discussing the matter, and that no changes had been made. Officials further explained to the OIG team that they had not been able to prioritize addressing these issues due to more urgent concerns, particularly the COVID-19 pandemic.

Officials also informed OIG staff in June and July 2021 that wait time discussions were resumed and leaders were strongly considering updating the data for the public website. However, VHA leaders indicated that this change is not merely a "flip of the switch" due to challenges of collecting consistent data points.

Conclusion

The OIG recognizes the tremendous pressure VA has been facing in meeting the unprecedented and significant challenges posed by the pandemic and the complexities in consistently reporting wait times, and hopes the information in this memorandum will help advance its efforts.

As the OIG communicated to VA in July 2021, the staff that conducted the initial examination did not identify evidence to substantiate misconduct by the then acting principal deputy under secretary for health related to wait time reporting and improvements. No evidence of an intent or effort to mislead were found in regard to the wait time reporting allegations. However, the OIG observed during its review that VHA has been inconsistent and also not fully compliant with the Choice Act as well as the VHA directive in how it calculates wait times, and imprecise in how it has disclosed and explained its publicly reported wait time data.[37] VHA's efforts to improve the accuracy in its reporting of the timeliness of veterans' access to care are dependent on the consistency of its calculations of wait times and its transparency regarding which methodologies and data sources have been used, together with any limitations.

[35] VHA, "8 Corners Data Update," PowerPoint presentation, December 10, 2019.

[36] This document calls the create date the "scheduled" date and the appointment date the "completed" date.

[37] The Choice Act requires VA to publish wait times in accordance with the methodology reported to Congress and published in the Federal Register.

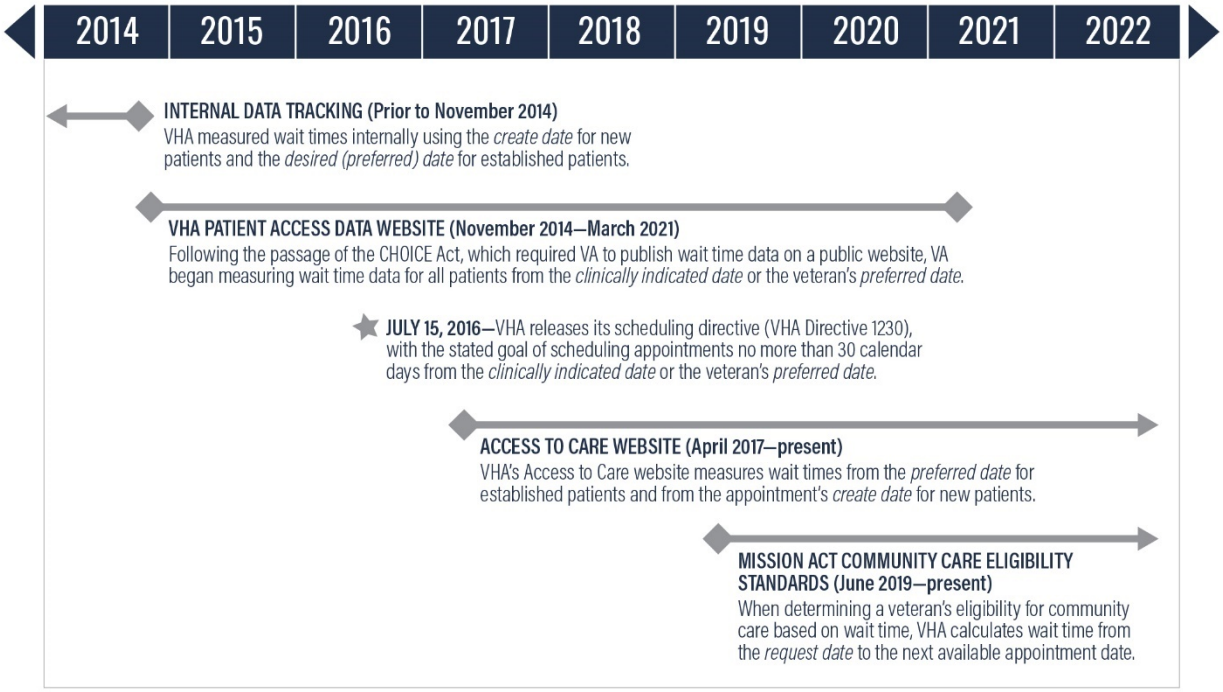
Requested Action

The OIG requests that VA inform the OIG what action, if any, is taken to address the issues identified in this memorandum regarding wait time calculation methodologies and related reporting.

VA Comments and OIG Response

VHA suggested one edit to this memorandum regarding the then acting principal deputy under secretary for health's account of the 2019 JAMA study methodology for reporting VA wait times. The OIG did not revise the referenced sentence as requested because the sentence accurately reflects the wording used in information provided to the OIG from a source other than the then acting principal deputy under secretary for health. The VHA edit was proposed to clarify that the then acting principal deputy under secretary for health "recognized the study had flaws because of the inherent difficulty in finding a single set of accurate data for these wait times." The VA response further commented that the "person identified by title in the draft did not believe that the study was based on inaccurate or false information, which is the implication of the wording." The full text of VA's response is included as appendix B.

Appendix A: Timeline of VHA's Use of Various Methodologies for Calculating Patient Wait Times



Source: OIG analysis.

Appendix B: VA Comments

Department of Veterans Affairs Memorandum

Date: March 10, 2022

From: General Counsel (02)

Subj: Draft OIG Management Advisory Memorandum: Concerns with Consistency and Transparency in Calculation and Disclosure of Patient Wait Time Data

To: Acting Deputy Assistant Inspector General, Office of Special Reviews (56)

1. Veterans Health Administration (VHA) has a single suggested edit the draft report referenced above.

2. On page 9 in the first full paragraph in line 8 the report references that the "then acting principal deputy under sec for health acknowledged the study was flawed…"

   VHA recommends this be changed to "then acting principal deputy under sec for health recognized that the study had flaws because of the inherent difficulty in finding a single set of accurate data for these wait times."

The person identified by title in the draft did not believe that the study was based on inaccurate or false information, which is the implication of the wording. Acceptance of this edit would, he believes, reflect more accurately his thinking.

(Original signed by)

Richard A. Sauber

cc:

Inspector General (50)

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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