

GAO

Report to the Chairman, Subcommittee
on Oversight and Investigations,
Committee on Veterans' Affairs, House
of Representatives

October 1993

VA HEALTH CARE

Restructuring Ambulatory Care System Would Improve Services to Veterans



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Human Resources Division

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October 15, 1993

The Honorable Lane Evans
Chairman, Subcommittee on Oversight
and Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

This report responds to your request concerning service delays in the Department of Veterans Affairs ambulatory care system.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, copies of this report will be sent to the Secretary of Veterans Affairs, appropriate congressional committees, and other interested parties. Other major contributors to this report are listed in appendix III.

Sincerely yours,

A handwritten signature in cursive script that reads "David P. Baine".

David P. Baine
Director, Federal Health
Care Delivery Issues

Executive Summary

Purpose

One goal of the Department of Veterans Affairs (VA) is to provide timely medical care to the nation's veterans. In recent years, some veterans have complained about delays in receiving care at VA ambulatory care facilities. Health care experts testified in 1991 before the House Committee on Veterans' Affairs that VA has not established an ambulatory care system that provides timely care. In response to these concerns, the Chairman, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, asked GAO to examine VA's ambulatory care system to (1) determine how long veterans wait for care, (2) identify factors causing service delays, and (3) recommend ways to improve efficiency and shorten veterans' waiting times in ambulatory care facilities.

Background

Veterans made over 22 million visits to VA's more than 200 ambulatory care facilities during fiscal year 1991. Of these visits, almost 4 million were to emergency/screening clinics, about 5 million were to general medicine clinics, and about 14 million were to specialty clinics.

Veterans with new or acute medical conditions initially apply for care at emergency/screening clinics. Clinic staff conduct a preliminary evaluation (triage) to prioritize the severity of illness relative to other patients who are waiting for care. Generally, veterans' conditions are considered to be emergent, urgent, or nonurgent. Nonurgent conditions are neither life- nor limb-threatening and treatment is not considered to be time sensitive; urgent and emergent conditions require more immediate care.

Emergency/screening clinics generally (1) provide physical examinations, (2) give treatment, or (3) refer patients to general medicine or specialty clinics. Veterans referred to specialty clinics, such as cardiology or orthopedics, receive care for more complex conditions in a particular body system. General medicine clinics provide care for more routine or stable medical conditions.

VA does not maintain systemwide data on veterans' waiting times. Facilities have flexibility to develop and implement local operating policies and procedures. Using a questionnaire, GAO obtained information from 215 VA ambulatory care facilities on operating policies and procedures used in emergency/screening, specialty, and general medicine clinics and veterans' waiting times. Also, GAO visited seven facilities to discuss their operating practices and explore innovative approaches being used to improve timeliness. GAO focused on ways to improve efficiency of

operations with available resources. GAO did not address such budgetary issues as staffing or space deficiencies.

Results in Brief

Veterans are too often experiencing lengthy service delays when they seek ambulatory care at VA facilities. Although waiting times varied widely, veterans with nonurgent conditions frequently waited 1 to 3 hours before a physician examined them in the emergency/screening clinics that GAO surveyed. In addition, veterans frequently waited 8 to 9 weeks to obtain appointments in the specialty clinics surveyed.

Inefficient operating practices are major factors contributing to veterans' service delays. VA's ambulatory care procedures cause many veterans with nonurgent conditions to arrive unscheduled at emergency/screening clinics and receive care on a first-come, first-served basis. This frequently results in uneven workloads for staff and overcrowding during peak hours. Also, VA's operating policies allow many veterans to receive general medical care in specialty clinics after their medical conditions have been stabilized, thereby resulting in overcrowding as other veterans with new conditions that need specialty care are referred to these clinics.

VA's reliance on local facilities to identify and address service delays has resulted in facilities trying a wide range of measures, with varying levels of effectiveness. Most facilities adjusted resources to address overcrowding, generally moving staff among service areas during peak periods. While this action may temporarily reduce service delays, it requires staffing to be continually adjusted in response to uncontrolled, fluctuating workload demands. Some facilities have achieved greater success through process changes, such as telephone assistance networks, which allow workload demands to be more efficiently managed.

VA headquarters has not provided (1) guidance on how veterans' waiting times should be measured or (2) performance goals to evaluate timeliness of services. Because systemwide goals have not been set, facilities have no benchmarks against which to compare performance.

Principal Findings

Emergency/Screening Clinics' Service Delays

Service delays stem from various causes. First, VA's ambulatory care system forces veterans with nonurgent conditions to use VA's

emergency/screening clinics regardless of their medical needs. Many veterans have needs that could be solved over the telephone, such as advice about prescriptions or previously diagnosed conditions. However, these veterans have no option but to walk in for advice.

Second, nonurgent veterans are treated on a first-come, first-served basis, rather than at a scheduled visit. As a result, they tend to arrive during peak hours, generally in the early morning, and can overwhelm clinic staff. Officials believe such uneven workloads contribute to long waits, dissatisfied veterans, and stressful working conditions. Also, VA has not systematically identified bottlenecks in service delivery or established Department-wide performance goals for key processing steps.

Most VA facilities have independently taken some steps to reduce veterans' waiting times. Some have adjusted service delivery options by evaluating processes and patient flows. For example, one facility reduced waiting times by more than 80 percent by reorganizing the processing requirements. Others have developed alternative delivery options that attempt to resolve problems by telephone or through scheduled visits to general medicine clinics. One facility reduced the volume of walk-in veterans by 18 percent after adopting a telephone assistance network. At this facility, 60 percent of nonurgent veterans waited less than 30 minutes for a physician evaluation compared with 17 percent systemwide.

Another facility restructured its ambulatory care program using primary care providers as "gatekeepers." Veterans are assigned primary care providers, who ensure continuity of care and coordinate specialty referrals. This facility decreased the number of veterans in the emergency clinic and assigned nonurgent walk-ins to primary care providers at scheduled times.

Specialty Clinics' Service Delays

Long delays frequently occur in specialty clinics because many veterans receive routine follow-up care in these clinics after their conditions are stabilized. Filling clinics' schedules with such patients contributes to long appointment waits for new patients. Also, missed appointments may extend appointment waits for many veterans. To compensate for missed appointments, facilities overbook scheduled appointments.

Facilities have tried to reduce overcrowding and long waits in specialty clinics by adjusting staff resources or clinic schedules. Some facilities have begun reviewing the medical requirements of veterans being treated

in specialty clinics. Clinics then transferred veterans needing only routine follow-up care for stable conditions to general medicine clinics. For example, one cardiology clinic reduced waits for appointments from 12 months to 4 months using this technique. Some facilities used primary care providers to coordinate specialty referrals. One facility decreased waits in specialty clinics to less than 30 days.

Recommendations to the Secretary of Veterans Affairs

GAO recommends that the Secretary of Veterans Affairs require the Under Secretary for Health to restructure the ambulatory care program to improve timeliness of services. The Under Secretary for Health should

- establish telephone assistance networks at each facility to expedite veterans' access to medical care;
- allow veterans to schedule appointments to receive care at general medicine or primary care clinics, to the maximum extent possible;
- require all facilities to develop treatment-monitoring systems that ensure all veterans referred to specialty clinics are transferred to general medicine or primary care clinics soon after their conditions are stabilized; and
- establish Department-wide performance goals for timely service delivery and gather systemwide data that will allow facilities' performances to be measured against established goals.

This report contains other recommendations not included here.

Agency Comments

GAO requested written comments from the Department of Veterans Affairs, but none were provided. However, it obtained VA's views from responsible VA officials, including the Under Secretary for Health and the deputy in charge of ambulatory care. These officials generally agreed with GAO's recommendations and stated that VA is developing a strategic planning goal to implement a managed care program. Through this program, VA will address most of GAO's recommendations. The officials also agreed that Department-wide performance goals would help promote timely service delivery and address the need to identify and disseminate innovative practices.

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Abbreviations

HMO health maintenance organization
VA Department of Veterans Affairs

Introduction

The Department of Veterans Affairs (VA) operates the largest ambulatory care delivery system in the United States, with over 200 facilities nationwide. Providing timely medical care is one goal of VA. Although VA does not centrally collect data that demonstrate the amount of time veterans wait for care, there have been recent complaints about long waits voiced by certain veterans. In addition, in 1991, health care experts testified before the House Committee on Veterans' Affairs that VA has been slow to develop an ambulatory care system where veterans can gain access quickly and have conditions diagnosed and treated in a timely manner. In response to these concerns, the Chairman, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, asked us to examine VA's ambulatory care system to (1) determine how long veterans wait for care, (2) identify factors causing service delays, and (3) recommend ways to improve efficiency and shorten veterans' waiting times.

VA's Ambulatory Care System

VA defines ambulatory care as the coordinated provision of health care to eligible outpatients. This care includes emergency care, scheduled and unscheduled primary and specialty care, preventive services, and patient educational programs. A goal of the VA ambulatory care system is to deliver the highest quality outpatient health care to the greatest number of eligible veterans in a compassionate, cost-effective, and timely manner. VA provides ambulatory care at medical centers and satellite facilities,¹ but services may be limited at some smaller facilities.

In May 1991, VA developed guidelines for hospital-based ambulatory care that require all medical centers to provide primary general medicine services as one component of ambulatory care. These services are to include, at a minimum, screening and continuing care. According to the guidelines, a primary care provider should provide a point of entry into the health care system for nonemergency care. Generally primary care providers are to maintain ongoing relationships with patients for a wide range of health problems and arrange for referral to more specialized services when greater depth of expertise in a particular area of care is needed.

VA's guidelines describe primary care as consisting of (1) access to needed services; (2) a mechanism to ensure long-term continuity of care; (3) a defined plan for preventive care; and (4) a mechanism for consultation and

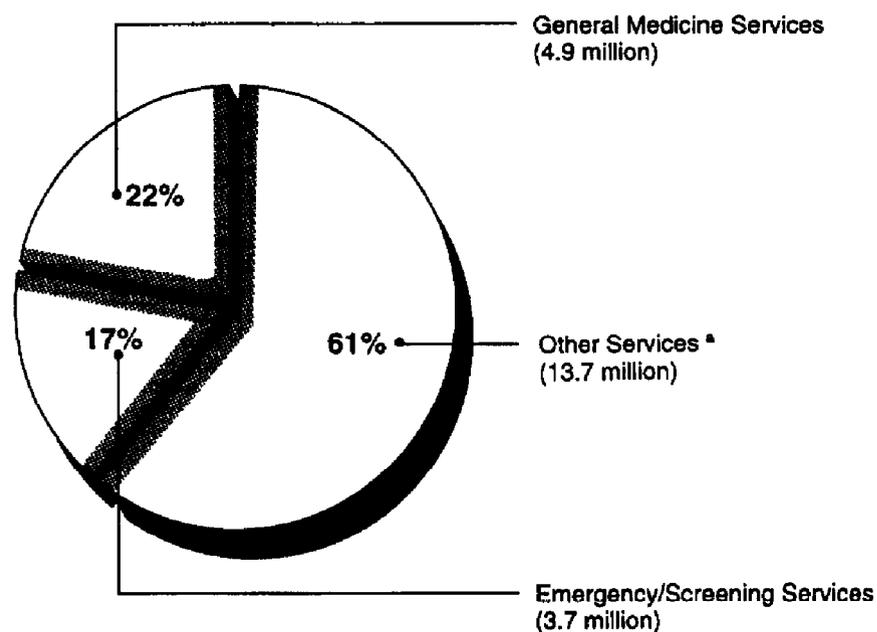
¹Satellite facilities are located an average of 80 miles from the medical center to which they are affiliated. VA also operates four independent clinics, which we refer to as satellite facilities in this report.

return of the patient to the primary care provider when specialty care has been completed; that is, coordination of care. Under VA's definition, specialists are to be used only for consultation and management of patients whose conditions require continuing expert intervention.

Types of Services

VA facilities provide a variety of ambulatory care services, such as emergency/screening, specialty, and general medicine services, to over 2 million veterans annually. We used VA's data files to estimate the distribution of different services that veterans received when they visited VA facilities. We found that, in fiscal year 1991, veterans made over 22 million visits and most were for specialty or diagnostic services. However, veterans sometimes received multiple services during one visit to a facility, as the shaded area in figure 1.1 represents.

Figure 1.1: Veterans' Visits for Ambulatory Care Services in Fiscal Year 1991



* Includes specialty and diagnostic services.

Shaded area indicates that veterans sometimes received multiple services during one visit to a facility.

Emergency/Screening
Services

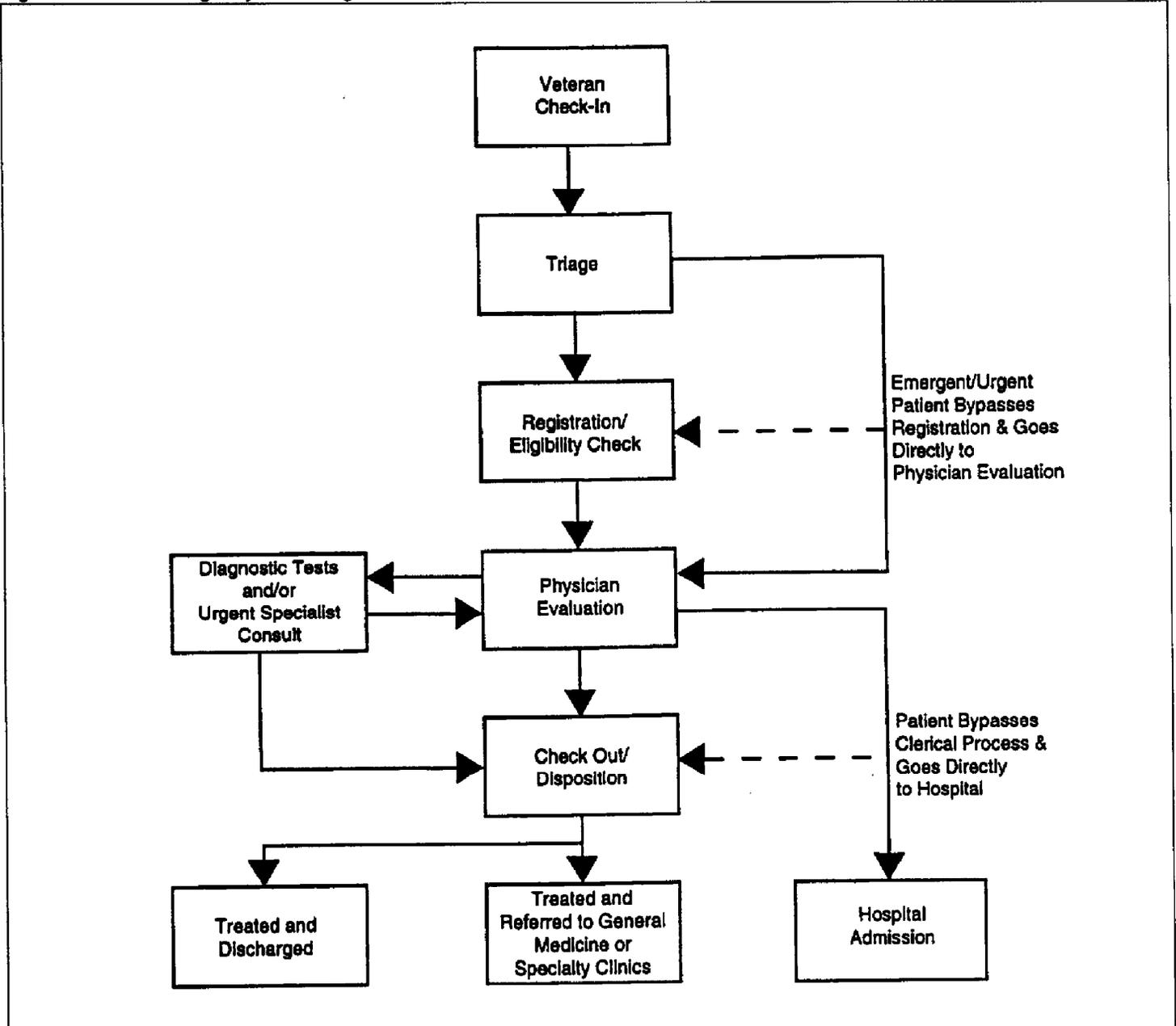
Emergency/screening clinics are the primary entry point for veterans who desire medical treatment at VA facilities. These clinics serve veterans with new or acute medical conditions, generally providing treatment or referrals to general medicine or specialty clinics. In fiscal year 1991, approximately 3.7 million outpatient visits were to emergency/screening clinics.

Generally, veterans who visit VA emergency/screening clinics go through a five-step process to obtain care: (1) check-in, (2) triage,² (3) registration/eligibility, (4) primary care physician evaluation, and (5) check-out/disposition. A patient's condition is assessed during triage and classified as either emergent, urgent, or nonurgent.³ Private emergency departments use a similar process. The VA's emergency/screening clinic process is depicted in figure 1.2 and described in detail in appendix I.

²Triage is the process of prioritizing patients by the severity of illness or injury relative to other patients who are waiting for medical care, regardless of their order of arrival.

³An emergent condition involves an illness or injury that could threaten life or limb and requires immediate attention. An urgent condition, such as a broken bone or injury requiring sutures, is one that does not threaten life or limb but needs prompt medical attention. A nonurgent condition involves neither a life- nor limb-threatening situation and does not need immediate treatment.

Figure 1.2: VA's Emergency/Screening Process for Veterans



Specialty Services

Specialty clinics provide care for specific illnesses or health problems affecting a particular body system and are used heavily by veterans. Examples of specialty clinics are cardiology, gastroenterology, neurology,

ophthalmology, and orthopedics.⁴ During fiscal year 1991, there were about 2.1 million outpatient visits for these five types of specialty services as well as 11.6 million visits for other specialty and diagnostic services.

Veterans must generally be referred to specialty clinics, usually by emergency/screening clinic physicians or inpatient physicians, at the time of discharge from a hospital. When a specialty physician evaluates a veteran, he or she may require that diagnostic or laboratory tests be performed. If necessary, the veteran is then given a follow-up appointment for the specialist to review test results, make a diagnosis, and start necessary treatments.

General Medicine Services

General medicine clinics provide routine care and treat stable conditions and common problems such as high blood pressure, arthritis, headaches, or uncomplicated infections. Veterans who are seen in the emergency/screening clinic and need scheduled diagnostic tests and further evaluation may be given their follow-up appointments in a general medicine clinic. A veteran discharged from the hospital might receive an appointment in a general medical clinic for follow-up outpatient care. When physicians in the general medical clinic diagnose patients as having severe or complex medical conditions, they are to refer the patients to specialists for more sophisticated diagnostic tests or therapeutic treatment. In fiscal year 1991, approximately 4.9 million outpatient visits were to general medicine clinics.

Facilities may use different styles of operation to provide general medicine services. In some cases, general medicine services are provided in primary care clinics, where the veterans are assigned to a primary care provider who ensures continuity of care. Veterans see the same physician each time they return to the clinic. More traditionally operated general medicine clinics do not always link the veteran with the same physician, and no single physician may be responsible for the patient, which can result in episodic and fragmented care.

VA's Organization of Ambulatory Care

Within VA, the Veterans Health Administration supervises and administers all departmental medical programs. It is headed by the Under Secretary for Health (formerly the Chief Medical Director) who reports to the Secretary of Veterans Affairs. There are separate lines of responsibility for

⁴These specialties treat diseases of the heart and circulatory system, digestive system, nervous system, eyes, and bones and joints, respectively.

administrative operations and clinical programs. The Office of the Associate Chief Medical Director for Operations provides operational direction and supervision to four VA regional offices. Each regional office is headed by a director who exercises direct line supervision over directors of field facilities in his or her respective region. Among regional responsibilities are ensuring policy implementation in the field and participating in national planning. For clinical programs, the Associate Deputy Chief Medical Director for Clinical Programs is responsible for planning, developing, and recommending clinical health services policies, standards, and criteria for those programs. One of the associate deputy's deputies is directly responsible for ambulatory care and provides direction to the physicians in charge of ambulatory care at the medical center level.

Broad VA guidance for ambulatory care programs was developed in 1991, but specific program guidelines are still under development. Actual management of ambulatory care programs is decentralized, and medical centers have great latitude in their organization and operation. Medical centers with more than 50,000 annual outpatient visits place program responsibilities on an Associate Chief of Staff for Ambulatory Care. Because ambulatory care cuts across such other services as medicine, surgery, nursing, and social work, the Associate Chief of Staff for Ambulatory Care and a multidisciplinary team work together to coordinate these services and ensure full organizational integration.

Eligibility for Care

Outpatient eligibility at VA facilities is generally determined by veterans' status during military service or medical condition. Veterans are eligible to receive outpatient care for medical conditions incurred or aggravated during military service. Most veterans are also eligible for outpatient treatment of conditions unrelated to a service disability if the care is needed to (1) obviate the need for hospitalization or (2) prepare for hospitalization or complete treatment after hospitalization. VA policy calls for facility staff to make an eligibility determination each time a veteran applies for care or is scheduled for treatment in a clinic.

Before July 1988, VA was to provide outpatient medical care to all eligible veterans on a space-available basis. After July 1988, VA was mandated to provide outpatient care to certain eligible veterans, such as those seeking care for service disabilities. For other veterans, VA outpatient care remains discretionary; that is, VA may provide care according to prescribed priorities if it has sufficient resources.

Veterans' Concerns About Service Delays

In an attempt to obtain a picture of the state of VA health care, the Disabled American Veterans,⁵ in its December 1990 magazine, asked veterans about their experiences, both good and bad, with VA hospitals. Although about 375 provided complimentary responses,⁶ almost 600 responded with various complaints about the system. Delays in receiving treatment represented one of the veterans' primary complaints. Excerpts from two complaint letters read:

These days when I get ready to go to the VA I pack a lunch and take a book because I know I will have to wait for the Doctor . . . I will have to stand in line just to register to be seen . . . and I will have to wait for the administration to process me out . . .

[VA needs] . . . to find a way to get you through without waiting from 8 a.m. to 4 p.m. to see the Doctor.

Another veteran who wanted to see a dermatologist wrote that he had to wait 6 months to get an appointment. After seeing the dermatologist and taking the medication prescribed, the veteran's condition cleared up in 3 weeks.

In addition, VA conducts a survey of veterans' satisfaction with outpatient services. When veterans receive care, they can voluntarily complete this survey, which asks respondents to rate a wide range of issues, including promptness in being seen. In fiscal year 1991, approximately 181,000 veterans responded; while 67 percent of the respondents were fully satisfied with promptness, 22 percent rated promptness as fair, and 11 percent (20,000) expressed dissatisfaction with promptness systemwide. At 16 facilities, over 20 percent of the respondents were dissatisfied.

Scope and Methodology

We reviewed VA ambulatory care policies and procedures and discussed them with VA officials. In addition, we discussed performance goals for service delivery, general medicine/primary care services, and future directions for ambulatory care with VA officials. We focused on ways to improve the efficiency of facilities' operations with available resources

⁵Formed in 1920 and chartered by the Congress in 1932, the Disabled American Veterans is a nonprofit organization representing service-connected disabled veterans that provides free counseling on veterans' benefits and services.

⁶According to a Disabled American Veterans official, an estimated 3,500 to 4,000 responses were received. However, his organization did not keep a complete account of the responses. The figures above were the only data available for our analysis. Many responses were sent to various VA organizations to address the veterans' concerns before the responses were tabulated and reviewed.

and did not address such budgetary issues as staffing shortages or space deficiencies.

Because VA does not centrally compile data on waiting times for outpatient care at its facilities, we collected the necessary data at individual facilities using a questionnaire. To help identify waiting times and factors affecting delays for outpatient care we obtained information, using questionnaires, from 215 VA facilities, including 158 medical centers and 57 satellite and independent clinics. Our questions focused on how facilities delivered emergency, specialty, and primary care services to veterans (see app. II).⁷ These facilities accounted for 92 percent of the approximately 22 million outpatient visits made to VA facilities in fiscal year 1991.

To select specialties for inclusion in our questionnaire, we asked veterans' service organizations and several VA medical centers their opinions about which specialties had long waits. On the basis of their responses, we requested information about waiting times and clinic processes in our questionnaire for five types of specialties: cardiology, gastroenterology, neurology, ophthalmology, and orthopedics. Not all of the facilities operated clinics in each of these specialties; the 215 facilities reported operating 721 separate clinics in these five specialties (cardiology = 149; gastroenterology = 125; neurology = 149; ophthalmology = 156; orthopedics = 142).

We checked each returned questionnaire for completeness, consistency, and mathematical errors. Confusing or incomplete responses were clarified with the responding official through follow-up telephone calls. Many of our survey questions asked for officials' impressions of their experience of VA's ambulatory care program. These data on staffing, changes to programs, acuteness of patient illness, and waiting times reflect VA officials' perceptions.

In addition, we selected seven VA facilities for site visits because they either implemented innovative procedures in operating their ambulatory care programs or had long outpatient waiting times. Our site selection also provided coverage for each VA region. At these facilities we observed emergency/screening clinic operations and interviewed ambulatory care officials. We also reviewed medical records of veterans treated in the emergency/screening clinic during our visit to three facilities to assess the nature of the medical conditions being presented. The facilities we visited

⁷For purposes of this report, we use the words veteran and patient synonymously, although about 4 percent of the visits were by nonveterans for fiscal year 1991.

were Cleveland, Ohio; Dallas, Texas; Philadelphia, Pennsylvania; Portland, Oregon; Sepulveda, California; Tampa, Florida; and Temple, Texas.

We also used VA's data files to estimate the distribution of different services that veterans received at VA facilities in fiscal year 1991. Because some veterans received multiple services during a single visit, we counted each veteran receiving care in an emergency/screening clinic or a general medicine clinic as a separate visit to these clinics. If no services were recorded for these two clinics, we assumed the visit was for other services, such as specialty clinics or diagnostic services. In some cases, veterans could also receive multiple specialty services in one visit.

To gain some perspective on waiting times in the private sector, we compared the responses⁸ to a similar questionnaire our office sent to public (nonfederal) and private sector hospital emergency departments. To identify management practices that VA could use to improve the timeliness of its outpatient care we discussed ambulatory care operations at the following: Group Health Cooperative of Puget Sound, a health maintenance organization (HMO) based in Seattle, Washington; the Hospital of the University of Pennsylvania and Philadelphia Health Services in Philadelphia, Pennsylvania; and the University of California Medical Center in Los Angeles, California. We also discussed trends in ambulatory care with the Executive Director of the North American Primary Care Research Group in Richmond, Virginia.

We performed our work between June 1991 and July 1993 in accordance with generally accepted government auditing standards.

⁸In Emergency Departments: Unevenly Affected by Growth and Change in Patient Use (GAO/HRD-93-4, Jan. 4, 1993), we reported the responses of almost 700 hospital emergency departments to questions regarding acuteness of patient illness and waits for service.

Operating Practices Cause Service Delays in Emergency/Screening Clinics

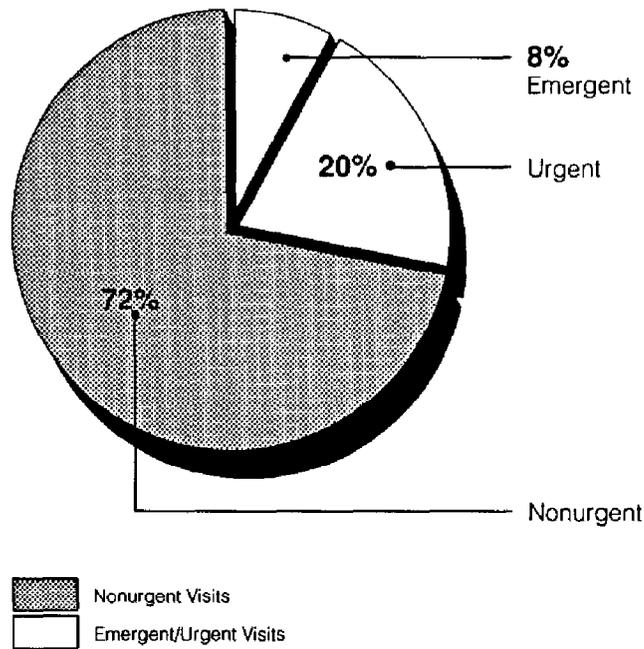
Most veterans visit VA emergency/screening clinics for nonurgent medical care and frequently wait between 1 and 3 hours for physicians to evaluate their conditions. VA's emergency/screening procedures generally require veterans with nonurgent conditions to arrive unscheduled to obtain care. This frequently results in uneven workloads for clinic staff and overcrowding of clinics during peak hours. Also, VA's lack of performance goals for measuring timely care hampers efforts to identify service delays and develop ways to improve service delivery.

Some VA facilities have developed strategies to reduce waiting times by adjusting staff resources or the flow of patients through the emergency/screening process. For example, one facility operates a telephone assistance network that frequently meets veterans' medical needs without a clinic visit. Some facilities have also shifted veterans with nonurgent conditions from the emergency/screening clinic to alternative clinics or adopted a primary care approach.

Nonurgent Veterans Encounter Long Waiting Times

VA's triage process allows medical staff in emergency/screening clinics to provide veterans access to services on the basis of the severity of their medical conditions. During fiscal year 1991, clinic staff triaged veterans about 3.5 million times at the 215 facilities surveyed. Of these, nearly three-fourths had nonurgent conditions as determined by triage decisions, as figure 2.1 shows.

Figure 2.1: Most Veterans Visited
Emergency/Screening Clinics for
Nonurgent Conditions



Because triage permitted patients with more acute conditions to receive priority treatment, veterans with emergent conditions wait considerably shorter times than those with less urgent conditions at VA emergency/screening clinics. In fact, VA personnel estimated for our survey that almost all veterans with emergent medical conditions were seen in less than 30 minutes and those with urgent conditions were usually seen in less than 1 hour. However, more than one-half the nonurgent veterans had to wait more than 1 hour and some more than 3 hours between the time triage occurred and they were evaluated by a physician. These veterans constituted the largest group by triage category. (See table 2.1.)

Chapter 2
Operating Practices Cause Service Delays in
Emergency/Screening Clinics

Table 2.1: Waiting Times for Veterans
In VA Emergency/Screening Clinics

Time waited	Number and percent of visits		
	Emergent (280,000)	Urgent (700,000)	Nonurgent (2,560,000)
Less than 30 minutes	99%	67%	17%
30 minutes, but less than 1 hour	1%	20%	29%
1 hour but less than 3 hours	0%	11%	43%
3 hours or more	0%	2%	12%

Notes: Figures may not add to 100 percent due to rounding.

Surveyed facilities estimated the percentage of emergent, urgent, and nonurgent veterans in each time range waiting from triage to physician evaluation. Data represent the systemwide average of these estimates.

Our January 1993 study of public and private sector emergency departments reported similar waits for emergent and urgent patients compared with this VA survey.¹ The public and private sector generally treated nonurgent patients sooner (35 percent of patients were seen in less than 30 minutes); however, 2 percent of patients waited more than 6 hours at these emergency departments compared with 1 percent reported in our VA survey. Another emergency department study at a 283-bed teaching hospital found the time from arrival to examination, including registration and triage, was about 15 minutes.² A similar emergency department study at a slightly larger hospital found that average waiting time from arrival to contact with the physician was about 38 minutes, although a few cases had waits of more than 2 hours.³ Some studies have shown that waiting time is viewed as a major source of dissatisfaction for nonemergent patients.⁴

¹Emergency Departments (GAO/HRD-93-4, Jan. 4, 1993).

²Carolyn H. Smeltzer, and Linda Curtis, "Analyzing Patient Time in the Emergency Department," *Quality Review Bulletin* (Nov. 1986), pp. 380-382.

³Catherine Wilbert, "Timeliness of Care in the Emergency Department," *Quality Review Bulletin* (Apr. 1984), pp. 99-108.

⁴Helen Hansagi, Barbro Carlsson, and Bo Brismar, "The urgency of care need and patient satisfaction at a hospital emergency department," *Health Care Management Review* (Spring 1992), pp. 71-75; James R. McMillan, Mary Sue Younger, and Larry C. DeWine, "Satisfaction with hospital emergency department as a function of patient triage," *Health Care Management Review* (Summer 1986), pp. 21-27; and Llewellyn E. Piper, "Waiting Time in Outpatient Care: A Study of Divergent Perspectives," *Military Medicine* (Aug. 1989), pp. 401-403.

Procedural Weaknesses Contribute to Service Delays

VA's emergency/screening process contributes to long waits for care by causing many veterans with nonurgent conditions to make unnecessary visits. Over 40 percent of the VA emergency/screening clinics do not allow veterans to schedule visits. As a result, veterans' arrivals are unevenly spread throughout the day and week, often causing overcrowding during peak hours. Also, for veterans with medical needs related to prior VA treatment, such as prescription refills, most facilities do not offer an alternative to making additional visits to the emergency/screening clinics.

Current Process Causes Unnecessary Visits

VA's emergency/screening clinic process causes many veterans with nonurgent conditions to arrive unscheduled to obtain care. However, because nonurgent conditions are not time sensitive, veterans could be scheduled at another time or have their medical needs resolved by telephone.

We visited two emergency/screening clinics that did not operate telephone assistance networks and reviewed records for 164 veterans who made visits during a judgmentally selected 24-hour period. Of the 164, 110 (67 percent) could have had their needs addressed without visiting the clinic or been seen at another time.⁵ Over one-third of the 110 veterans needed medical advice concerning existing prescriptions or refills. In other cases, veterans needed medical advice concerning test results or previously diagnosed conditions or referrals to specialty clinics.

In comparison, our review of the emergency/screening clinic records at one facility with telephone assistance (see p. 25) showed that 29 percent fewer veterans could have had their needs addressed without visiting the clinic or been treated at another time. Only 1 of 58 veterans walked in unscheduled for a prescription refill at this center, in contrast to the higher rate at facilities without telephone assistance.

During our visits we identified the following examples that illustrate how veterans with nonurgent conditions wait unnecessarily at emergency/screening clinics.

⁵We decided a patient could be seen at another time if (1) he or she wanted a prescription refill, (2) the problem existed for more than 3 days and had not become worse, (3) the patient saw a doctor recently and had a question but the condition had not become worse, or (4) a patient wanted test results. Visits were considered appropriate if they fell into the following categories: (1) admission to the hospital; (2) condition occurred within 3 days or was described as acute, such as chest pain, shortness of breath, bleeding, fever over 38.8 degrees Celsius, or broken bones; (3) condition occurred after trauma such as a car accident; or (4) directed to the emergency clinic by a doctor or by a telephone assistance nurse. These criteria were developed from guidelines endorsed by the Board of Directors of the American College of Emergency Physicians and utilized in Don P. Buesching, and others, "Inappropriate Emergency Department Visits," *Annals of Emergency Medicine* (July 1985), pp. 672-676.

- One veteran who had a chronic medical condition visited a clinic solely to have a prescription refilled. Before seeing the physician the veteran waited about 25 minutes for triage, then used another 1-1/2 hours to complete the visit. The doctor performed a brief examination and renewed the medication—services that appropriate medical staff could have resolved by telephone.
- A veteran with a skin rash was given an allergy drug (Benadryl). About 3 weeks later, he walked in and complained of an adverse reaction (feeling weak and dizzy) to the medication. After discussing the symptoms with the veteran, the emergency/screening clinic doctor changed the medication. The veteran's visit lasted 2 hours 40 minutes. This medical need also could have been resolved by telephone.
- One veteran spent 1 hour 25 minutes in the emergency/screening clinic waiting for results of a stomach X ray performed a week earlier. During this time the doctor took a brief history about why the test was performed, explained the test results, instructed the veteran to continue his current medication, and gave him a referral to a gastroenterology clinic. This service could have been provided at a scheduled visit to a general medicine clinic.
- A veteran visited the emergency/screening clinic to obtain referrals for ophthalmology and podiatry. He waited 50 minutes before he saw the doctor. During most of this time, the administrative staff was evaluating the veteran's eligibility for VA medical care. The doctor provided the referrals as requested—referrals that appropriate medical staff could have provided by telephone.

Unscheduled Visits Result in Uneven Workload

The VA process usually makes veterans applying for medical care arrive unscheduled in the emergency/screening clinic, although many of these veterans have nonurgent conditions. Because appointments are not an option, veterans' arrivals are spread unevenly throughout the day and week, causing overcrowding during peak hours. At the sites we visited, officials believed this uneven workload contributed to long waits, dissatisfied customers, and stressful working conditions.

Ninety-eight percent of respondents to our survey reported some variation in workload either throughout the week, during the day, or at both times. Daily workload fluctuation during a 5-day (Monday-Friday) period at one center ranged from a high of 163 veterans on Monday to a low of 108 on Friday. Another center that we did not visit reported an even greater variable 5-day workload during the week, ranging from 161 veterans to 87. Veterans arrive early in the morning, usually between 7:30 and 10:00 a.m.

At five of the seven centers we visited, 30 to 60 percent of patients arrived during this peak period.⁶ Although this behavior makes sense for individual veterans, it can overwhelm clinic staff when scores of veterans arrive during early morning hours.

Although scheduling appointments to emergency/screening clinics would help to spread workload more evenly, only 121 VA clinics (57 percent) schedule visits, according to our survey results. At the 121 clinics, the percentage of veterans routinely scheduled varied widely. Some emergency/screening clinics (5 percent) scheduled almost all patients (90 percent or more), others (38 percent) scheduled relatively few patients (10 percent or less). Overall, scheduled visits accounted for only 18 percent of all visits to emergency/screening clinics at the 121 clinics.

Also, facilities' scheduling practices varied widely. For example, at one facility we visited that scheduled appointments to the emergency/screening clinic, the veteran skipped the administrative step but joined the queue and waited along with unscheduled arrivals to see a physician. While scheduling appointments may have helped control the uneven workload for these facilities, veterans may not be realizing the full advantages of having a scheduled appointment.

Lack of Performance Goals Undermines VA's Management Oversight

Assessing the timeliness of service delivery at individual facilities is difficult because VA has not established appropriate performance goals. Some facilities measured only the total time of a veteran's visit, while others have developed more elaborate measures, but these efforts varied widely systemwide.

Methods of Measuring Waiting Times Varied by Clinic

VA requires facilities to conduct quarterly time studies, but does not describe the parameters to be measured. As a result, study methodologies usually vary among facilities. Many facilities only measure the total elapsed time a veteran spends at an emergency/screening clinic. However, this is not a very helpful measure because delays can occur at any step in the process. Many VA emergency/screening clinics do not review two of the more critical waiting times that affect patient satisfaction—the time veterans wait to (1) be triaged and (2) be examined by a doctor. About 46 and 78 percent, respectively, of facilities did not review these times.

⁶Five centers provided data for periods of either 1 week or 1 month.

In response to one of our survey questions we received information from two types of time studies: one type used a standard VA computer program that measures elapsed time,⁷ while another type measured intermediate steps. Both types of studies varied in what was included. For example, some studies included the time from check-in to check-out after necessary diagnostic tests and treatments were completed and prescriptions had been filled, others did not include all of these elements. Other studies measured the time to perform triage and the physician's evaluation, but did not measure the intervening waits. A few evaluated waiting times only for patients admitted to the hospital.

VA Has Not Established Goals for Timely Treatment of Veterans by Physicians

VA headquarters has a goal for timely patient triage but it does not have a goal for timely service delivery for the start of physician evaluation in emergency/screening clinics. However, some emergency/screening clinics have developed internal goals to measure timely service delivery, but these varied widely from clinic to clinic.

VA's triage goal is for 95 percent of all walk-in patients to be evaluated by a health care professional within 10 minutes of initial contact. Preliminary screening of patients ensures that the most seriously ill or injured patients receive care first. A little more than half the facilities reported monitoring this step. In addition, only 3 of 15 time studies (from 1991 and 1992) provided us showed that the triage standard was met. One reason some facilities could fail to meet the standard is because they conducted the registration/eligibility checks before triage. Data provided to us show that the registration step can take upwards of 1 hour to complete, and, thus, these facilities are not meeting the one time standard that is in place.

Twelve facilities that sent us time studies had instituted internal goals for assessing timely care in their emergency/screening clinics. However, goals varied among facilities. For example, one emergency/screening clinic established that a patient visit should be completed within 2 hours; at others, 3 or 4 hours was the requirement. Another's goal was that unscheduled patients be provided service by a health care professional within 1 hour of arrival at the emergency/screening clinic. Finally, one facility required that a review be conducted for delays of 6 hours. However, 8 of the 12 facilities did not achieve their established goals as disclosed by studies conducted during 1991 and 1992, which facilities provided to us.

⁷VA's standard computer program records a veteran's check-in and check-out times.

One emergency/screening clinic we visited had not developed goals against which to measure its performance. Officials at the clinic told us that if they start receiving complaints from veterans about lengthy waits they investigate the situation.

Facilities' Efforts to Reduce Veterans' Waiting Times

Individual VA facilities have taken various management actions to reduce veterans' waiting times. These efforts included adjustments to facility resources and existing service delivery processes, or providing alternative service delivery options. Two facilities reported conducting quality management projects to reduce waiting times. A few facilities implemented telephone assistance networks that reduced the number of unscheduled visits to the emergency/screening clinic.

Adjusting Staff Resources

Management at some VA facilities tried to solve overcrowding and long waits in the emergency/screening clinic by adjusting staff resources. Adjustments included (1) scheduling staggered shifts in anticipation of peak workload periods, (2) reassigning staff if workload exceeded the anticipated number, (3) expanding clinic hours, or (4) hiring more staff.

More than 70 percent of the facilities responded to our survey that they scheduled staggered emergency/screening clinic shifts to make more VA employees available during peak workload periods. Forty-six and 60 percent of facilities reassigned nurses and clerks, respectively, from other duties to the emergency/screening clinic during anticipated peak workload, while about 40 percent reassigned physicians. When the number of patients seeking care exceeded the number anticipated by the staffing schedule, the majority of the facilities reported that they reassigned physicians, nurses, and clerks to the emergency/screening clinic.

Some facilities reported that they expanded emergency/screening clinic hours. Almost half the facilities hired more physicians or support staff for the emergency/screening clinic.

Adjusting Existing Service Delivery Processes

A few facilities reported using a quality management approach to develop strategies for addressing long waits. At these facilities, VA officials and staff assessed the clinic operating process, reorganized patient flow, and decreased patient waiting times. These approaches demonstrate the importance of monitoring intermediate waiting times in the

emergency/screening clinic in order to identify bottlenecks in the process. For example:

- Through team meetings one facility decided on changes that included hiring a triage nurse instead of having the facility physicians combine triaging with treating nonurgent patients, and instituting a “one-stop” registration process. These changes reduced check-in and triage processing times at the emergency/screening clinic by 81 percent.
- At another emergency/screening clinic personnel flow-charted patient flow through their facility and identified bottlenecks, such as a 46-minute wait for veteran check-in and more than a 1-hour wait for triage. The team redesigned its intake process to minimize veterans’ waits. After 3 months, the total waits for these services dropped to less than 10 minutes.

Providing Alternative Service Delivery Options

In addition to adjusting staff resources and improving the workflow in the emergency/screening clinics, some facilities provided alternative service delivery options for veterans to access care. Some facilities used a telephone assistance network, coordinated veterans’ visits with a primary care provider, operated alternative clinics, or provided priority treatment to service-connected veterans. Most of these approaches shifted the veteran out of the emergency/screening clinic and into a scheduled clinic.

Telephone Assistance

Twelve percent of the VA facilities we surveyed reported having telephone assistance networks. These networks enable some patients to resolve their medical problems over the telephone or schedule appointments, if necessary. Telephone assistance networks may also reduce veterans’ waits for care. For example, at one facility with a high-volume telephone assistance network 60 percent of its nonurgent veterans saw a physician in less than 30 minutes, another 20 percent saw a physician within 1 hour.

Telephone advice is a recognized form of assistance used in the private sector, where patient telephone calls are answered by a health care professional. A nonurgent caller receives advice about his or her medical condition; if the caller’s condition is diagnosed emergent, the patient is advised to go to the hospital immediately. However, as one study reports,⁸ most callers do not suffer from emergent or urgent conditions that require immediate care.

⁸Pamela J. Knowles, and Richard O. Cummins, “ED medical advice telephone calls: Who calls and why?” *Journal of Emergency Nursing* (Nov./Dec. 1984), pp. 283-286.

Chapter 2
Operating Practices Cause Service Delays in
Emergency/Screening Clinics

The Portland VA medical center has had a telephone assistance network in operation since 1989. According to Portland officials, telephone assistance has increased veterans' satisfaction and lowered waiting times in the emergency/screening clinic by reducing unscheduled patient workload. Sixty percent of nonurgent veterans waited less than 30 minutes for a physician evaluation compared with 17 percent systemwide. Many of the approximately 130 veterans who call Portland's telephone assistance lines each day have their problems resolved without having to visit the center.

Based on a 1-day review of emergency/screening clinic medical records at the Portland center, only 2 percent of walk-in patients requested prescription refills compared with 25 percent at two facilities without telephone assistance networks. While other factors may have influenced the number of prescription refill requests at this facility, Portland officials believe that the telephone assistance network decreased the number of veterans who walked in for refills. Eighteen months after starting the telephone assistance network, emergency/screening clinic workload had decreased by about 18 percent.

The telephone assistance network allowed Portland to control its work flow by

- sending nonurgent patients to a scheduled general medicine evaluation clinic;
- having a pharmacist refill prescriptions over the telephone;
- using a designated clinic nurse from a specialty clinic, if the patient was already enrolled there, to provide advice on his or her medical condition and schedule any necessary appointments; and
- notifying the emergency/screening clinic of the impending arrival of an acutely ill patient.

Primary Care

While 171 of the 215 VA facilities we surveyed (80 percent) told us that they operated some or all of their general medicine clinics using primary care, the percentage of patients enrolled varied widely. Some VA facilities coordinated veterans' unscheduled visits for nonurgent conditions with primary care providers. The level of coordination for such first contact care varied at the facilities we visited:

- Three made some attempt to coordinate first contact care. Generally, veterans could decide whether to wait for their primary care provider or have the emergency/screening clinic doctor evaluate their condition (if

nonurgent). Otherwise, the coordination effort was only for veterans already enrolled in primary care.

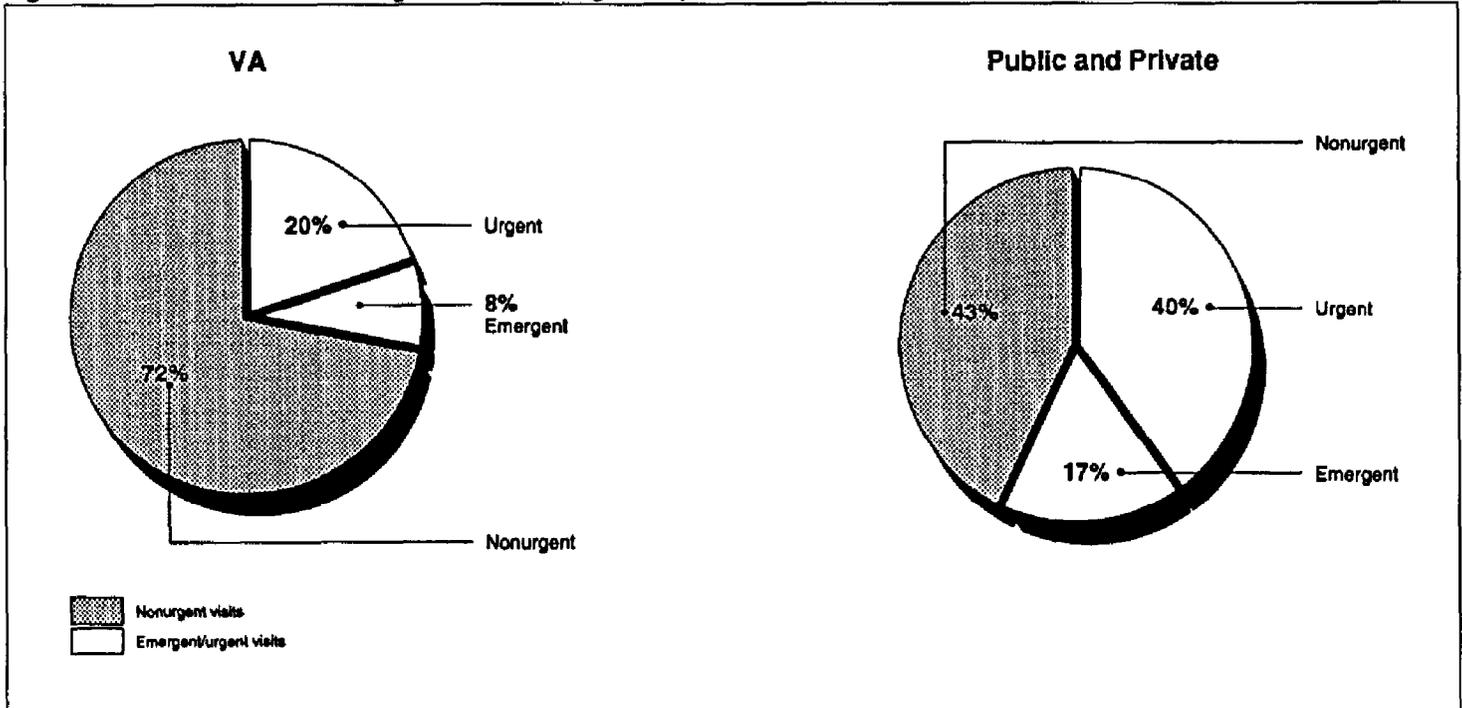
- Two fully coordinated a veteran's first contact with the facility with a primary care provider. If veterans with new nonurgent conditions walked in, they were treated by the physician who would continue as their primary care provider. If already enrolled veterans walked in, they were sent to their assigned primary care provider.

Using this coordinated approach, one facility decreased the number of nonurgent veterans who walked in to the emergency clinic. Veterans were assigned to primary care providers, and if the veterans walked in with nonurgent conditions, they were given a scheduled appointment with their primary care provider that day. These veterans could also use the telephone assistance network to schedule appointments with their primary care provider.

Linking a veteran with a primary care provider when the patient initially applies for care is a first step in establishing continuity of care and can decrease unnecessary visits to emergency/screening departments. A large number (85 percent) of the 171 facilities that operated primary care said that primary care clinics improved continuity of care. One facility official believes that this occurs because patients are more satisfied when they see the same physician every visit.

Patients assigned to primary care went to VA emergency/screening clinics less frequently at 60 percent of the 171 facilities. However, veterans' use of emergency/screening clinics remained high when compared with other public and private sector emergency departments, as figure 2.2 shows.

Figure 2.2: VA Estimates of Nonurgent Visits Are High Compared With Public and Private Sector



Note: Number of visits for VA = 3.7 million; estimated number of visits for public and private emergency departments = 99.6 million.

Our study of public and private emergency departments found that the major factor causing a 43-percent usage rate by nonurgent patients was that those patients did not have a primary care provider.⁹ Another study in one community showed that emergency department use decreased with increasing availability of primary care physicians.¹⁰

In some segments of the private sector, such as health maintenance organizations, primary care physicians act as gatekeepers who control patients' access to emergency department visits. A primary care physician coordinates and manages the patient's care from the time care is first needed through treatment and follow-up. HMOs generally require members to seek medical care first from their primary care physician. Primary care physicians also coordinate care for individuals who seek emergency care.

⁹Emergency Departments (GAO/HRD-93-4, Jan. 4, 1993).

¹⁰John Hilditch, "Changes in Hospital Emergency Department Use Associated with Increased Family Physician Availability," *The Journal of Family Practice* (1980), Vol. 11, No. 1, pp. 91-96.

Many HMOs require members who are not in life-threatening situations to obtain permission from the primary provider before an emergency department visit.

Alternative Clinics

About 30 percent of the emergency/screening clinics we surveyed dedicated a pharmacist solely to refill prescriptions. At one facility we visited, the pharmacy operated a separate prescription refill clinic. Patients needing only prescription refills were sent directly to this clinic without having to go through the regular emergency/screening clinic. In addition, about 40 percent of facilities opened a scheduled general medicine clinic for nonurgent patients.

Some Service-Connected Veterans Given Priority

VA regards service-connected veterans as its premier customers and promulgates through its regulations the priority order in which such veterans are to receive medical care. However, emergency/screening clinics have considerable discretion when applying these priorities and some VA emergency/screening clinics further prioritized nonurgent veterans after triage using this service-connected classification.

Thirty-four percent of the 215 facilities surveyed prioritized nonurgent veterans using the service-connected or nonservice-connected classification. Service-connected veterans with nonurgent conditions made about 345,000 visits to these centers in fiscal year 1991. At one facility we visited, veterans were triaged and then nonurgent veterans were further divided into two groups: service-connected and nonservice-connected. Service-connected veterans with nonurgent conditions were then treated before nonservice-connected veterans with nonurgent conditions.

By comparison, 59 percent of the facilities surveyed used only medical severity to determine priority of care; nonurgent veterans were treated in order of arrival without consideration of their service-connected or nonservice-connected status. As a result, service-connected veterans with nonurgent conditions were treated on a first-come, first-served basis during 520,000 visits in fiscal year 1991.

Conclusions

Veterans with nonurgent conditions are too often experiencing lengthy service delays when they seek care at VA emergency/screening clinics. Inefficient operating practices result in needless overcrowding as too many veterans with nonurgent medical conditions walk in to

emergency/screening clinics during peak hours because alternative means of accessing medical services are not available.

Currently, facilities have considerable discretion in addressing potential service delays. Some facilities have done little, while others have tried a wide range of measures with some success. VA headquarters has not provided (1) guidance on how facilities should measure veterans' waiting times and (2) performance goals to compare timeliness of services and assess the need for further improvements. Veterans' waiting times could be significantly reduced at some facilities if VA top management helped facility management to implement the best practices currently in place at other facilities.

Many facilities adjusted resources to address overcrowding, generally moving staff among service areas during peak periods. While this approach may help reduce service delays, it requires staffing to be continually adjusted in response to fluctuating workload demands. Moreover, shifting staff may potentially disrupt services in other areas or have little effect on waiting times, depending on the staff's familiarity with clinics' operating policies and procedures.

Facilities that adjusted processes appear to have achieved greater success through greater management control over workload demands, thus reducing waiting times. For example, some implemented mechanisms, such as telephone assistance networks, to resolve veterans' nonurgent medical concerns without having the veterans make unscheduled emergency/screening clinic visits. Others scheduled nonurgent patients' visits instead of requiring them to arrive unscheduled at the emergency/screening clinic. VA facilities have generally used two scheduling strategies: some scheduled veterans in emergency/screening clinics, while others scheduled them into general medicine clinics. The latter appears preferable, especially when linked to telephone networks. This is because physicians who are familiar with veterans' medical histories could be available to respond to their needs.

Facilities' efforts to shift the focus of general medicine clinics toward a primary care approach also have great potential for reducing waiting times. This is because veterans can be assigned to primary care providers who assume responsibility for serving the veterans' general health care needs. These providers can be used to treat a veteran at the initial visit for a new condition, rather than having the veteran walk in to the emergency/screening clinic, where a physician does a brief evaluation and

then refers the veteran to another physician for general medical or specialty care. Those veterans who were assigned a primary care provider used the emergency/screening clinic less frequently, thereby relieving some of the overcrowding.

Recommendations to the Secretary of Veterans Affairs

We recommend that the Secretary require the Under Secretary for Health to restructure the ambulatory care system to improve timeliness of customer service and facilitate veterans' access to services. Specifically, the Under Secretary for Health should

- establish telephone assistance networks at each facility, so that veterans' access to medical care can be better facilitated;
- allow veterans to schedule appointments to receive care at general medicine or primary care clinics, to the maximum extent possible;
- survey VA facilities to identify innovative practices that are used to effectively reduce waiting times and incorporate the best practices into existing operating policies and procedures;
- establish performance goals for timely service delivery and gather systemwide data that will allow facilities' performance to be measured against the established goals. When performance does not meet or exceed goals, facilities should be required to evaluate the cause(s) and implement corrective actions to improve timeliness of service delivery.

Agency Comments

We requested written comments from the Department of Veterans Affairs, but none were provided. However, we obtained VA's views from responsible VA officials, including the Under Secretary for Health and the deputy in charge of ambulatory care.

In general, these officials agreed with the recommendations presented in this chapter. They stated that several of the recommendations will be addressed through VA's strategic plan, the goal of which is to implement a managed care program. This program was developed from a primary care concept and will include telephone networks and allow veterans to schedule appointments. These officials also agreed that Department-wide performance goals would help promote timely service delivery and address the need to identify and disseminate innovative practices.

Operating Problems at Specialty Clinics Cause Service Delays

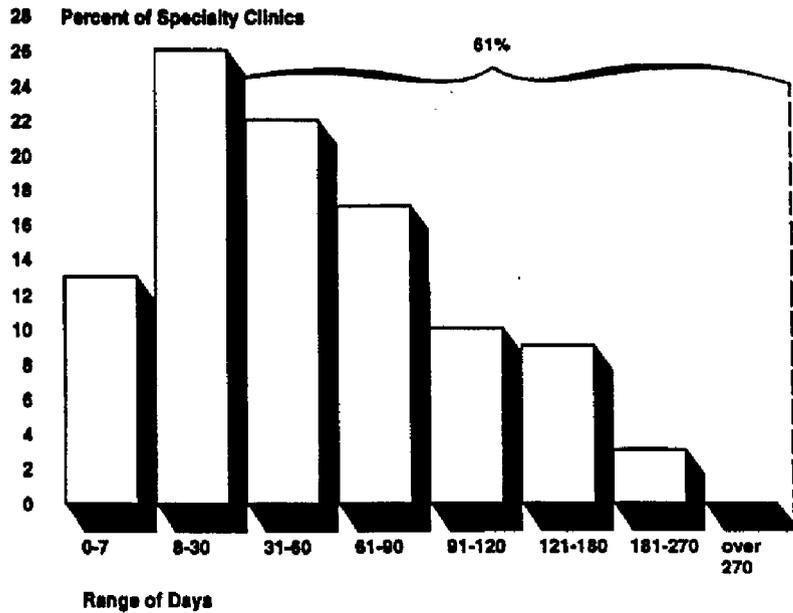
Veterans needing specialty medical services frequently experienced long delays in scheduling appointments at the 721 specialty clinics we surveyed.¹ Delays occurred because many veterans were continuing to receive general medical care in specialty clinics after their conditions had stabilized. Also, veterans frequently failed to notify clinic staff when they were unable to keep scheduled appointments. As a result, other veterans might have been precluded from shortening their waiting times by using the unkept appointments. As with VA's emergency/screening clinics, a lack of performance goals and monitoring measures for timely care affects efforts to identify service delays and improve performance. To reduce waiting times, some facilities have adjusted resources, while others have developed new patient treatment procedures.

Veterans Encounter Long Waits to See Specialists

At the 721 clinics we surveyed, waiting times for appointments averaged 62 days. VA staff at some facilities told us that if a veteran's condition was urgent and an evaluation was needed before the next available appointment the clinic would overbook the schedule to see the patient sooner. While some clinic waits were less than 7 days, the majority had waits of more than 30 days, and a few clinics exceeded 270 days, as figure 3.1 shows.

¹The 721 specialty clinics provide cardiology, gastroenterology, neurology, ophthalmology, and orthopedic services at the 215 VA facilities we surveyed.

Figure 3.1: Waiting Times at Most of the 721 Clinics Surveyed Were More Than 30 Days



Long waits for appointments impact other parts of the health care system. For example, most facilities we surveyed reported that the amount of time patients wait for appointments in specialty clinics exacerbates overcrowding in emergency/screening clinics because veterans return to those clinics rather than waiting for appointments in specialty clinics. In addition, over 40 percent of facilities responded that the anticipated amount of time patients would have to wait for appointments in specialty clinics contributes to physicians' hospitalizing patients rather than having them wait for appointments.

Procedural Weaknesses Contribute to Service Delays

VA's specialty clinics' operating procedures contribute to long waits for care. At facilities we visited, many veterans were receiving appointments for general medical care in specialty clinics. This can delay new patients from obtaining an earlier appointment. In addition, veterans missing appointments and VA's overbooking practices further exacerbate waiting times.

Overcrowding Exacerbated by Veterans' Receiving Medical Care From Specialists

Specialty clinics frequently treated patients who had stable conditions that could have been treated by a generalist, according to VA officials at facilities we visited. For example, at one facility we visited, a veteran was initially diagnosed in the cardiology clinic as having mild congestive heart failure. After starting treatment, he continued to be given appointments every 6 months to the cardiology clinic for routine monitoring of his condition. Such routine follow-up care can be provided by either a specialist or a generalist. Using a generalist physician for routine monitoring would free up specialists for veterans needing new evaluations.

Specialty referral policies regarding limitations on who could make referrals or how long referred patients remained under the specialists' care are also contributing factors to overcrowding in specialty clinics. Five of the facilities we visited did not limit who could make specialty referrals. In addition, most facilities we visited did not require the specialist to return a referred patient to a primary care clinic when his or her condition stabilized and the patient needed only general medical care. However, 73 percent of survey respondents said that they suggest that specialists review patients to determine if they can be reassigned to primary care. The VA official in charge of ambulatory care told us that very few facilities have been able to incorporate control of specialty referrals so that specialists treat only those veterans requiring specialty services.

Private sector providers, such as HMOs, use primary care physicians as gatekeepers who control and coordinate referrals to specialists. Under the primary care concept, patients usually must receive approval from their primary care physician before making an appointment with a specialist.² Often, a simple telephone call to the primary physician is sufficient to obtain approval for some referrals such as eye examinations. The primary care physician may also have to approve additional visits recommended by specialists. After treatment by a specialist, patients usually return to their primary care physician for monitoring of their condition. Savings accrue because services are provided by generalists who usually cost less than specialists. Continuity of care is enhanced because the patient primarily receives care from one physician rather than visiting multiple specialists. Circumventing the primary provider's role may lead to fragmentation, unnecessary services, and duplication of care.

²Eighty-five percent of HMOs place restrictions on patients' self-referral to specialists, and approximately half of these require the patient to visit the primary care provider before consultation is allowed. See John M. Eisenberg, "The Internist as Gatekeeper: Preparing the General Internist for a New Role," *Annals of Internal Medicine* (1985), Vol. 102, pp. 537-543.

Excessive No-Shows

Veterans frequently failed to visit specialty clinics on their scheduled appointment day without notifying VA. We calculated an overall no-show rate of about 17 percent during the second quarter of fiscal year 1992 for the 721 specialty clinics we surveyed. VA acknowledges that missed appointments pose problems for ambulatory care administrators and clinicians. No-shows create additional appointment and test rescheduling requirements and inefficiencies for providers and clerical staff.

One facility we surveyed studied no-shows and found that the most common reason veterans failed to keep an appointment was that they forgot about it (29 percent). However, most of the facilities we visited had not studied why veterans failed to report for appointments.

VA procedures may contribute to veterans' failure to notify clinics that they will not be able to keep scheduled appointments. Some clinics did not schedule an appointment with the veteran during the initial screening visit or the prior visit but rather notified the veteran by mail. In addition, some facilities did not routinely remind veterans of the scheduled appointments. As a result, veterans may have been unaware that they had appointments. For example, one facility we visited scheduled almost all patients by mail and did not have an appointment reminder process in place. An internal study of the scheduling process found that some patients were not receiving appointment notices and, thus, these veterans did not know that they had an appointment, resulting in no-shows.

In addition, VA's process for rescheduling appointments for no-shows may contribute to the overall problem. When veterans miss appointments, 60 percent of VA facilities automatically reschedule the appointment without contacting the patient. Thus, veterans who miss appointments take slots on two occasions when only one is needed. This fills the clinic schedule and can extend appointment waits for other veterans.

Excessive Overbooking Contributes to Service Delays

One technique most facilities use to compensate for no-shows is overbooking; that is, they make more appointments than the normal schedule would allow. While overbooking is an acceptable tool if the no-show rate remains at a predictable level, it causes overcrowding on days when more patients than predicted keep their appointment.

Excessive overbooking exacerbates waits on the day of the appointment. Of the 721 specialty clinics we surveyed, about 70 percent responded that they compensated for no-shows by overbooking. Veterans could also be

overbooked if a physician decided a patient's condition needed to be assessed sooner than the next available appointment. VA's average overbooking rate was about 21 percent (the number of overbooked patients divided by the total number of patients seen) for the specialty clinics we surveyed during the second quarter of fiscal year 1992. However, this overbook rate is higher than the historical no-show rate. The amount of overbooking varied by clinic.

Without overbooking, appointment waits would have been even longer, according to facility officials. Overbooking may improve appointment availability overall, if fewer veterans than anticipated miss their appointment. However, overcrowding and long waits for care can occur on the day of the appointment if the no-show rate is lower than expected.

VA has a policy that veterans should normally not wait more than 30 minutes after their appointment time before they receive scheduled specialty clinic treatment, examination, or service. Clinics that overbook may not be able to meet this standard. The VA Inspector General studied the length of time veterans wait after they arrive for an appointment at one medical center. The Inspector General reported³ that overbooking resulted in long waits for patients on the day of the appointment. For example, the Inspector General found that the ophthalmology clinic at one facility overbooked 56 percent of its appointments during one average clinic day. This resulted in the last veteran waiting 2 hours 20 minutes from his appointment time until he was seen.

VA's Lack of Performance Goals Makes Assessment of Appointment Availability Difficult

As with emergency/screening clinics, VA does not have performance goals that set acceptable waits for specialty clinics' appointments. Two facilities reported to us that they developed their own goals, although these varied. For example, one facility's goal was that veterans should not have to wait more than 60 days for a specialty clinic appointment; another set more than 3 months as unacceptable.

In addition, VA does not require facilities to monitor and report appointment availability. Most facilities track appointment availability but report this information no further than to the specialty chiefs, the medical center director, or both, according to our survey responses. As a result, these data are not currently available on a systemwide basis, which limits VA's ability to identify problem areas needing management attention.

³The VA Inspector General, Final Report, Audit of VA Medical Center, Report No. 2R6-FO3-151 (Dallas, Texas, June 1992).

In October 1991, VA began collecting data on appointment availability for new patients for three clinics (cardiology, ophthalmology, and general medicine). These data were part of VA's Quality Improvement Checklist, developed to measure important areas of quality and provide facility managers with comparison data from the national system. These specialty clinics were selected because experience showed they are good indicators of waits in other ambulatory care clinics. VA officials estimate that enough data will be available from these surveys for comparison and analysis in the fall of 1993. VA should be able to use these results to focus attention on areas needing improvement.

Facilities' Efforts to Reduce Waiting Times

Facilities are addressing overcrowding and long waits for appointments in specialty clinics in different ways. Some facilities have adjusted clinic schedules, changed patient treatment policies, coordinated specialty care using primary care physicians, or given priority to service-connected veterans.

Resource Adjustments

Managers at VA specialty clinics tried to improve specialty clinics' operations by adjusting staff resources or rearranging clinic schedules. Over 50 percent of facilities expanded the hours of specialty clinics' operations and hired more staff. Also, over 50 percent held separate clinic sessions for new patients. One center we visited continuously monitored appointment availability and adjusted the clinic scheduling plan if appointment availability worsened.

New Patient Treatment Policies

Some of the facilities we visited had started to review the medical records of patients enrolled in specialty clinics to identify those with routine problems. Patients so identified were discharged from the specialty clinic and transferred to either general medicine clinics or primary care clinics for continued care.

For example, after reviewing medical records, urology clinic staff at one facility transferred 300 routine patients to general medicine. Another facility's cardiology clinic staff transferred about 20 percent of the patients to its primary care clinic. For example, patients with mild congestive heart failure were stabilized by medication in the specialty clinic and subsequently transferred to general medicine clinics where primary care physicians could monitor continuing medication therapy. Waiting time for

appointments dropped from about 12 months to 4 months in this cardiology clinic.

At another facility we visited, if the cardiologist identified patients receiving care in the cardiology clinic, the general medicine clinic, or in another specialty clinic he or she would discharge the patients from the cardiology clinic unless the condition was too complicated for a noncardiologist to manage. The veterans would be followed by another physician in the general medicine clinic or the other specialty clinic.

Some Facilities Coordinate Specialty Care

Some VA facilities are shifting control over specialty referrals from specialty clinics to general medicine and making the primary care provider responsible for coordinating all necessary specialty care. Two facilities we visited coordinated specialty referrals by allowing only primary care providers to make referrals unless emergency situations arose.

One of these facilities placed major emphasis on developing a primary care model that focuses on continuity of care and provides an ambulatory care educational experience to residents as well. At this facility all veterans are assigned to a primary care provider who will also see assigned veterans who arrive unscheduled with a nonurgent condition. The primary care provider is responsible for making referrals to specialists, although other physicians could also make referrals, if necessary. Waiting times for appointments in most specialty clinics had dropped to less than 30 days, because primary care providers were making fewer referrals than physicians under the prior general medicine clinic system where veterans were not assigned specific doctors. This facility is discussing ways to give primary care providers complete control of specialty referrals by having them approve continued specialist treatment. This would be similar to a private HMO's use of a primary care provider as gatekeeper.

Appointment Reminder Techniques

About 63 percent of facilities reminded most of the scheduled patients of their appointments. These reminders were sent by mail. Very few (5 percent) of the facilities reminded patients of their scheduled appointments by telephone. One facility we visited had instituted a reminder system whereby veterans were notified using a postcard about 10 days before scheduled appointments. This facility reported that its no-show rate had dropped significantly since this reminder system was started.

Some Clinics Provided Priority to Service-Connected Veterans

As in emergency/screening clinics, some specialty clinics decided to give service-connected veterans priority as a way to improve appointment availability. About 26 percent of the facilities give priority to nonurgent service-connected patients when scheduling specialty clinic appointments.

In some cases, nonservice-connected veterans were not treated in specialty clinics experiencing long waits for appointments but could continue to receive care in less crowded specialties at that facility. One facility we visited had a policy that selectively limited access to specialty clinics with long waiting times for appointments. Specialists and administrative staff implemented this policy by not scheduling appointments for nonservice-connected veterans in specialties with waits of more than 30 days unless a veteran's condition warranted overbooking.

While these actions may ease the overcrowding problem at some specialty clinics, they may also cause some confusion among veterans as well as inconsistencies in service delivery. For example, a nonservice-connected veteran with nonurgent conditions was referred to both neurology and ophthalmology clinics at one facility but only received an appointment in ophthalmology. This facility's neurology clinic had a 60-day wait for the next available appointment in February 1992, and since the nonservice-connected veteran's condition did not need care within 30 days, he would not be given an appointment. However, that same veteran could obtain an appointment in ophthalmology, because its appointment wait was under 30 days at that time.

Conclusions

Veterans are often experiencing excessive waiting times when scheduling appointments in specialty clinics. As with VA's emergency/screening clinics, inefficient operating practices were major factors contributing to service delays.

VA has not adequately encouraged specialty clinics to address service timeliness. No goals have been set and facilities are not required to monitor appointments. Without such goals, managers have no performance measures to determine the adequacy of service.

Specialty clinics have a significant no-show rate that could contribute to long waits for appointments. Most facilities we visited had done little to determine reasons for no-shows. However, facilities can only reduce no-shows by identifying the underlying reasons why veterans fail to keep appointments so that appropriate corrective actions can be taken.

Automatically rescheduling appointments or overbooking are techniques that address the symptoms rather than the causes of the problem.

Some facilities have taken steps to reduce waiting times. For example, some clinics identified patients who needed only routine medical services and transferred them to general medicine clinics. Through these efforts, the specialty clinics significantly reduced workload and in some cases veterans' waiting times. The existence of primary care clinics in most facilities provides an opportunity for expanding this practice systemwide.

Recommendations to the Secretary of Veterans Affairs

We recommend that the Secretary require the Under Secretary for Health to revise operating policies and procedures for treating veterans in specialty clinics in order to improve the timeliness of services, especially for those veterans needing specialty evaluation of new medical conditions. Specifically, the Under Secretary for Health should

- require all facilities to review the medical needs of veterans currently being served in specialty clinics and transfer those veterans needing only general medical care to general medicine or primary care clinics for necessary service;
- require all facilities to develop treatment-monitoring systems that ensure that all veterans subsequently referred to specialty clinics are transferred to general medicine or primary care clinics in a timely manner after their conditions are stabilized such that only general medical services are needed;
- require all facilities to survey veterans to determine why they missed appointments and develop steps to counteract these no-shows and, thereby, reduce clinics' reliance on overbooking. VA should then disseminate to all facilities the best practices that are being used to reduce adverse effects of no-shows on waiting times and incorporate these best practices into existing policies and procedures; and
- establish performance goals for timely service delivery and gather systemwide data that will allow facilities' performance to be measured against the established goals. When performance of specialty clinics does not meet the goals, facilities should be required to evaluate the cause(s) and implement corrective actions to improve timeliness of services.

Agency Comments

VA officials generally agreed with our recommendations for improving VA's specialty clinic operations. VA's initiative to enact primary care will facilitate the transferring of veterans from specialty to general medicine

Chapter 3
Operating Problems at Specialty Clinics
Cause Service Delays

clinics, as well as the development of a treatment-monitoring system. Officials also concurred with the need for establishing Department-wide performance goals for specialty clinics to promote timely service delivery. Further steps are being taken to reduce no-show rates.

Emergency/Screening Clinic Process in VA Facilities

Veterans who want to receive medical care through VA must complete an Application for Medical Benefits form (VA Form 10-10). VA uses this form to determine whether a veteran is eligible for medical care. Usually, VA medical facilities combine this application process, which is an administrative function, with emergency/screening. A Medical Certificate (VA Form 10-10m) is started and the applicant is referred immediately to the examination unit. Facilities have a variety of names for the examination unit; for example: 10-10 area, walk-in clinic, emergency care unit, or emergency/screening clinic. VA facilities screen veterans who apply for care; that is, veterans who walk in unscheduled to request care from VA must go through a five-step process to obtain care: (1) check-in; (2) triage; (3) registration/eligibility; (4) physician evaluation; and (5) check-out/disposition. Some facilities may combine step one and step three or perform triage after an eligibility check. The following activities occur at each step. (The times are averages, rounded to the nearest 5 minutes, from the limited number of detailed time studies we received that examined intermediate steps in the process.)

- Check-in: A clerk at a reception desk records the veteran's name and the time of day. This step takes about 10 minutes to complete.
- Triage: A nurse assesses the veteran's condition and records all pertinent information on the medical record. The patient is placed in one of three categories according to the severity of his or her condition. Emergent and, usually, urgent patients are directed to the emergency room. Nonurgent patients wait for the registration clerk. Triage takes about 10 minutes to complete.
- Registration/eligibility: A clerk reviews the veteran's personal, demographic, and eligibility status to ensure that the veteran qualifies to receive the care requested. Registration generally takes about 15 minutes. First-time patients usually take longer to complete this step.
- Physician evaluation: A physician examines the veteran to determine the course of treatment. This evaluation may determine whether the veteran could require diagnostic tests. After all procedures are completed, the veteran may report back to the examining physician, who reviews the test results, provides appropriate treatment, and makes a final disposition. This step averages 20 minutes, but does not include time spent waiting or having the diagnostic testing.
- Check-out/disposition: Following the evaluation, the physician makes a disposition. There are three common dispositions for emergency/screening clinic patients: (1) completion of treatment and discharge of the patient, (2) admission to the hospital, and (3) scheduled follow-up appointments to general medicine or specialty clinics. The clerk

**Appendix I
Emergency/Screening Clinic Process in VA
Facilities**

records the veteran's disposition, enters the completion time in the computer, and schedules any future clinic appointments or tests ordered by the doctor. This step averages 25 minutes.

GAO Survey Instrument

This appendix presents our survey instruments and a summary of the responses. We abbreviated VA medical center and satellite outpatient clinic to VAMC and OPC, respectively. We combined the survey results from the VAMCs and OPCs because the two survey instruments varied only slightly in questions 23 and 26 and the suggested respondent in the introduction. Each question includes the actual number of respondents (N) that answered each question. We summarized the responses to questions using frequencies, means, and aggregates. On question 12, we presented a median because it best represented the data. For question 61, data on canceled appointments combine both patient and facility cancellations.

Appendix II
GAO Survey Instrument

U.S. GENERAL ACCOUNTING OFFICE

Survey of Veterans Affairs Medical Centers and Outpatient Clinics

Waiting Times for VA Ambulatory Care

At the request of the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, the U.S. General Accounting Office (GAO), an agency of the U.S. Congress, is conducting a survey of waiting times for ambulatory care at VA Medical Centers and Outpatient Clinics. The subcommittee is interested in the amount of time that veterans wait for appointments and the different processes used to schedule appointments.

This questionnaire is being sent to all VA Medical Centers nationwide. A similar questionnaire is being sent to all VA Outpatient Clinics. We suggest that the Associate Chief of Staff for Ambulatory Care complete the questionnaire. Because of the different types of information requested, it may also be necessary that they consult with other staff members.

Please return the completed questionnaire within three weeks of receipt to:

U.S. General Accounting Office
Attn: Dorothy Barrett
Suite 760
841 Chestnut Street
Philadelphia, PA 19107

A preaddressed business reply envelope is included for your convenience.

Most questions can be answered by checking a box or filling in a number. If you have any questions, please call Dorothy Barrett or Bruce Eveland at (215) 574-4000.

Your participation in this survey is essential. We can provide the Congress with complete information on ambulatory care waiting times at VA Medical Centers and Outpatient Clinics only if you and the other VA hospital administrators respond fully.

Thank you for your cooperation.

Please enter the name, title and telephone number of the person who was primarily responsible for completing this questionnaire.

NAME: _____

TITLE: _____

TELEPHONE NUMBER: (_____) _____

**Appendix II
GAO Survey Instrument**

I. INTRODUCTION

The questionnaire consists of 7 sections:

- I. Introduction
- II. 10-10 Admission/Screening Area
- III. Specialty Clinics
- IV. Scheduling
- V. Primary Care
- VI. General Information
- VII. Data Section

Please make a copy of your completed questionnaire and all attachments before mailing it. This will facilitate any discussions we may have with you should we need to call after we receive your completed questionnaire to clarify your responses.

DEFINITION OF TERMS USED IN THIS QUESTIONNAIRE

10-10 Admission/ Screening Area:	An area that may consist of an "emergency room," "triage area," "walk-in clinic" or "emergency services area."
Administrative Workweek:	Monday through Friday, from about 8:00 - 9:00 A.M. to about 4:00 - 5:00 P.M.
Triage:	An initial examination of a patient to determine the priority of medical need and proper referral for evaluation of the presenting condition.
Emergent Care:	Care provided for a condition that threatens life, limb or sense organs.
Urgent Care:	Care provided for a condition that is time-related and must be treated within 12 hours, but does not threaten life or limb.
Nonurgent Care:	Care provided for a condition that is neither emergent nor urgent.
Telephone Triage:	A process where patients can call on a dedicated telephone line to discuss their medical condition with a health professional who determines whether or when they should visit the clinic.
Log-In Time:	The time a receptionist manually or electronically enters as the time of a patient's arrival.
Disposition Time:	The time your facility enters into the Disposition Total Log at the completion of a patient's visit to the 10-10 Admission/Screening Area.
Primary Care:	A method of health care to provide first-contact care, coordinate other relevant health services, and assume continuous responsibility for the patient.

**Appendix II
GAO Survey Instrument**

II. 10-10 ADMISSION/SCREENING AREA

1. On average, how many patients visit your 10-10 Admission/Screening Area during an administrative workday? (ENTER NUMBER.) (N=212)

Average number of patients: 59 (Mean)

2. The following is a list of events that might occur when a patient comes to the 10-10 Admission/Screening Area for care. For each, indicate whether or not you usually record the time at which these events occurred. If "YES," indicate whether these recorded times are entered into a computer system, whether they are reviewed in order to decrease or improve waiting times, and whether they are reported to Medical Center/Clinic management.

N=207-212
Except (8) N=21

(1-3, 7) N=176-197
(4-6) N=59-95
(8) N=21

	Do you usually record the time at which these events occurred?	
	NO (1)	YES --> (2)
1. Log-in with receptionist	9%	91%
2. Triage	16%	84%
3. 10-10 Registration	7%	93%
4. Start of evaluation by a physician	64%	36%
5. End of evaluation by a physician	72%	28%
6. Retrieval of a medical record	54%	46%
7. Sign-out with a clerk	17%	83%
8. Other (PLEASE SPECIFY.) _____	10%	90%

If "YES," are these times... (CHECK ALL THAT APPLY.)		
entered into a computer system? (1)	reviewed in order to decrease or improve waiting times? (2)	reported to VAMC/OPC management? (3)
62%	80%	66%
13%	64%	44%
87%	75%	70%
8%	61%	44%
24%	68%	56%
60%	79%	64%
88%	82%	74%
52%	71%	62%

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GAO Survey Instrument

3. During the second quarter of FY 1992, about what proportion of the disposition times recorded in your DISPOSITION TOTAL LOG accurately reflect the actual times that patients took to complete the 10-10 process? (CHECK ONE.) (N=212)

1. 51% All or almost all
2. 32% Most
3. 5% About half
4. 4% Some
5. 5% Few or none
6. 3% Don't know

4. In order to ASSESS WAITING TIMES or MANAGE WORKLOAD in the 10-10 Admission/ Screening Area, do you review your DHCP Disposition Total Log or DHCP Registration/Disposition Time Statistics? (CHECK ONE.) (N=212)

1. 12% YES, review the DHCP Disposition Total Log only
2. 8% YES, review the DHCP Registration/ Disposition Time Statistics only
3. 69% YES, review both the DHCP Disposition Total Log and the DHCP Registration/ Disposition Time Statistics
4. 11% NO, review neither the DHCP Disposition Total Log nor the DHCP Registration/Disposition Time Statistics

5. In the 10-10 Admission/Screening Area, is your workload higher at certain times of the day or days of the week? (CHECK ONE RESPONSE.) (N=211)

1. 3% YES, certain times of the day only
2. 5% YES, certain days of the week only
3. 90% YES, both certain times of the day and certain days of the week
4. 1% NO

**Appendix II
GAO Survey Instrument**

6. Listed below are several actions that might be taken in the 10-10 Admission/Screening Area. For each, indicate whether or not, when preparing the staff schedule for a future work period in the 10-10 Area, you routinely take this action in anticipation of peak workload periods. Also indicate whether or not you ever take the action during that work period when the number of patients seeking care exceeds the number that was anticipated by your staff schedule.

	N=202-207 Except (8) N=10		N=182-197 Except (8) N=9	
	When preparing the staff schedule, do you routinely take this action in anticipation of peak workload periods?		Do you ever take this action during that work period when the number of patients exceeds the number anticipated by your staff schedule?	
	YES	NO	YES	NO
1. Stagger the shifts of VA employees assigned to the 10-10 Area, so that the most staff is available during peak workload periods	71%	29%	59%	41%
2. Use contract <u>physicians</u> to work in the 10-10 Area during peak workload periods	10%	90%	9%	91%
3. Use contract staff <u>other than physicians</u> to work in the 10-10 Area during peak workload periods	2%	98%	0%	100%
4. Reassign VA <u>physicians</u> from other duties to serve in the 10-10 Area during peak workload periods	39%	61%	60%	40%
5. Reassign VA <u>physician extenders</u> from other duties to serve in the 10-10 Area during peak workload periods	26%	74%	35%	65%
6. Reassign VA <u>nurses</u> from other duties to serve in the 10-10 Area during peak workload periods	46%	54%	64%	36%
7. Reassign VA <u>clerks</u> from other duties to serve in the 10-10 Area during peak workload periods	60%	40%	80%	20%
8. Other (PLEASE SPECIFY.) _____	80%	20%	67%	33%

7. Listed below are methods by which a 10-10 Admission/Screening Area might monitor the number of patients arriving for care or adjust the staffing plan. For each, indicate whether or not you use that method. (CHECK ONE FOR EACH.) (N=209-211)

	YES	NO
1. Count the number of patients waiting in the 10-10 Area	66%	34%
2. Use a "status board" to track patients while they are in 10-10 processing	27%	73%
3. Use an alternative staffing plan that automatically goes into effect if a predetermined number of patients arrive for care	23%	77%

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GAO Survey Instrument**

17. On average, how many calls for triage does your telephone triage service receive in a day? (ENTER A NUMBER.) (N=23) (Mean)

 29 calls per day (Range 4 - 130)

18. As a result of telephone triage, to what extent are you able to distribute your workload across the administrative WORKWEEK more evenly? (CHECK ONE RESPONSE.) (N=24)

- 1. 4% To a very great extent
- 2. 33% To a great extent
- 3. 21% To a moderate extent
- 4. 25% To some extent
- 5. 8% To little or no extent
- 6. 8% Don't know

19. As a result of telephone triage, to what extent are you able to distribute your workload across the administrative WORKDAY more evenly? (CHECK ONE RESPONSE.) (N=24)

- 1. 8% To a very great extent
- 2. 17% To a great extent
- 3. 21% To a moderate extent
- 4. 33% To some extent
- 5. 12% To little or no extent
- 6. 8% Don't know

20. As a result of telephone triage, to what extent have patients' complaints about waiting times in the 10-10 Admission/Screening Area DECREASED? (CHECK ONE RESPONSE.) (N=23)

- 1. 4% To a very great extent
- 2. 4% To a great extent
- 3. 17% To a moderate extent
- 4. 22% To some extent
- 5. 22% To little or no extent
- 6. 30% Don't know

21. Usually, about what percentage of all calls to telephone triage in a day result in each of the following: (ENTER PERCENTAGES; IF NONE, ENTER "0.") (N=21 for Percentage and 2 for Don't Know) (Mean)

	<u>Percentage</u>	<u>Don't Know</u>
1. Caller advised to seek medical treatment immediately	14%	9%
2. Caller advised to go to the VA 10-10 Area, but not immediately	21%	9%
3. Caller given an appointment in the VA 10-10 Area	9%	9%
4. Caller referred to a VA General Medicine or Primary Care clinic	26%	9%
5. Caller did not need medical care	21%	9%
6. Other (PLEASE SPECIFY) _____	9%	9%
	=100%	

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22. Listed below are several actions. For each, indicate whether or not you took that action at any time since the beginning of FY 1990 to improve the operation of the 10-10 Admission/Screening Area. (CHECK ONE FOR EACH.) (N=207-210; except (8) N=56)

	YES (1)	NO (2)
1. Increased the number of HOURS PER DAY the 10-10 Area is open	11%	89%
2. Increased the number of DAYS PER WEEK the 10-10 Area is open	2%	98%
3. Hired more PHYSICIANS in the 10-10 Area	46%	54%
4. Hired more SUPPORT STAFF in the 10-10 Area	49%	51%
5. Scheduled appointments for NONURGENT patients with primary care physicians or teams	56%	44%
6. Opened one or more General Medicine clinic sessions for NONURGENT patients	39%	61%
7. Dedicated a pharmacist solely to refill prescriptions	30%	70%
8. Other (PLEASE SPECIFY.)	46%	10%

III. SPECIALTY CLINICS

Definition:

SPECIALTY CLINICS: All clinic sessions for each physician in a specialty, excluding specialty procedure clinics, nursing clinics, education clinics or subspecialty clinics that may be counted under that stop code.

23. Indicate whether or not reports about the number of available appointments are sent to each of the following VA managers. (CHECK ONE RESPONSE FOR EACH.) (N=167-176; except (1) N=29, (5) N=68)

	YES (1)	NO (2)
1. Clinic Director (OPC ONLY)	72%	28%
2. Medical Center Service Chiefs	81%	19%
3. Medical Center Director	65%	35%
4. VA Regional Director	16%	84%
5. Other (PLEASE SPECIFY.) _____	94%	6%

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24. In your opinion, to what extent does the amount of time patients wait for appointments in specialty clinics contribute to their using the 10-10 Admission/Screening Area rather than waiting for an appointment in a specialty clinic? (CHECK ONE.) (N=181)

- 1. 15% To little or no extent
- 2. 34% To some extent
- 3. 25% To a moderate extent
- 4. 17% To a great extent
- 5. 9% To a very great extent
- 6. 0% Don't know

25. In your opinion, to what extent does the amount of time patients wait for appointments in specialty clinics contribute to physicians hospitalizing patients rather than waiting for an appointment? (CHECK ONE.) (N=181)

- 1. 56% To little or no extent
- 2. 32% To some extent
- 3. 6% To a moderate extent
- 4. 3% To a great extent
- 5. 2% To a very great extent
- 6. 2% Don't know

26. Listed below are several actions that a VA Medical Center/Clinic might take to improve the operation of specialty clinics. For each, indicate whether or not you took that action at any time since the beginning of FY 1990. (CHECK ONE FOR EACH.) (N=178-181; except (10) N=151, (12) N=21)

	YES (1)	NO (2)
1. Increased the number of hours per day that one or more clinics are open	56%	44%
2. Increased the number of days per week that one or more clinics are open	70%	30%
3. Increased the number of hours one or more Chiefs of Services spend in clinics	28%	72%
4. Hired more physicians	52%	48%
5. Hired more support staff	50%	50%
6. Added a separate clinic for special procedures	64%	36%
7. Added a separate clinic for specific disease processes (e.g., epilepsy, glaucoma)	61%	39%
8. Added separate clinic sessions for NEW and ROUTINE patients	52%	48%
9. Expanded the facility space available to one or more clinics	56%	44%
10. Converted facility space from inpatient space to clinic space (VAMC ONLY)	32%	68%
11. Arranged for a specialist within a clinic to review paperwork from referring physicians and approve new patients before scheduling them in clinics	57%	43%
12. Other (PLEASE SPECIFY.)	86%	14%

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27. Listed below are five specialty clinics; also arrayed are four resources. For each specialty clinic, indicate whether or not you have enough of each resource to provide appointments to patients within seven calendar days of their visit to the 10-10 Admission/Screening Area. (CHECK ONE RESPONSE FOR EACH ITEM.) (N=126-158)

		Definitely Yes (1)	Probably Yes (2)	Probably No (3)	Definitely No (4)
Cardiology	Physicians	12%	10%	19%	60%
	Non-physician medical staff	15%	25%	23%	37%
	Clinic space	25%	24%	16%	34%
	Medical supplies and equipment	42%	39%	6%	14%
Gastroenterology	Physicians	8%	16%	27%	49%
	Non-physician medical staff	13%	28%	25%	35%
	Clinic space	21%	31%	19%	29%
	Medical supplies and equipment	36%	42%	9%	13%
Neurology	Physicians	12%	14%	22%	51%
	Non-physician medical staff	18%	25%	23%	33%
	Clinic space	25%	27%	18%	29%
	Medical supplies and equipment	45%	34%	7%	15%
Ophthalmology	Physicians	10%	15%	22%	54%
	Non-physician medical staff	18%	23%	24%	36%
	Clinic space	31%	26%	15%	29%
	Medical supplies and equipment	38%	36%	10%	16%
Orthopedics	Physicians	7%	13%	22%	58%
	Non-physician medical staff	16%	21%	24%	39%
	Clinic space	28%	25%	14%	33%
	Medical supplies and equipment	36%	41%	8%	15%

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IV. SCHEDULING

28. Listed below are three methods for initially scheduling an appointment in a specialty clinic. For each, enter about what percentage of patient appointments, if any, were scheduled by that method during FY 1991. (ENTER PERCENTAGES; IF NONE, ENTER "0.") (N=180) (Mean)

- | | |
|--|----------------------|
| 1. Arrange a convenient appointment with the patient before s/he leaves the Clinic | _____ 68 % |
| 2. Arrange a convenient appointment with the patient by telephone | _____ 6 % |
| 3. Mail patient the day and time of the next available appointment without consulting him or her | _____ 25 % |
| 4. Other (PLEASE SPECIFY.) _____ | _____ 1 %
= 100 % |

29. When scheduling an appointment, do you usually provide the patient with a telephone number for canceling or rescheduling appointments? (N=181)

1. 99% YES
2. 1% NO

30. About what proportion of your scheduled patients, if any, do you remind of their appointments by MAIL? (CHECK ONE.) (N=181)

1. 29% All
2. 28% Almost all
3. 6% Most
4. 3% About half
5. 12% Some
6. 10% Few
7. 12% None

31. About what proportion of your scheduled patients, if any, do you remind of their appointments by TELEPHONE? (CHECK ONE.) (N=180)

1. 1% All
2. 3% Almost all
3. 1% Most
4. 0% About half
5. 23% Some
6. 42% Few
7. 30% None

32. Do you usually schedule nonurgent patients for specialty clinic appointments on a "first come first serve" basis, or do you further prioritize nonurgent patients based on their service connected or non-service connected classification, or do you use some other method to prioritize nonurgent patients for specialty clinic appointments? (CHECK ONE RESPONSE.) (N=177)

1. 63% solely on a "first come first serve" basis
2. 26% further prioritized based on the service connected or non-service connected classification
3. 11% other (PLEASE SPECIFY.) _____

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33. Listed below are several actions that a VA Medical Center/Clinic might take if a patient does not keep a scheduled appointment, i.e., is a "no show." For each, indicate whether or not you usually take that action when a patient does not keep a scheduled appointment. (CHECK ONE RESPONSE FOR EACH.) (N=179-181; except (5) N=41)

	YES (1)	NO (2)
1. Send patient a letter acknowledging that s/he did not keep an appointment	71%	29%
2. Automatically reschedule the appointment	60%	40%
3. Initiate a record review for possible discharge of the patient from a clinic	75%	25%
4. Discharge patient from the clinic	41%	59%
5. Other (PLEASE SPECIFY.)	93%	7%

34. For each specialty clinic listed below, indicate whether or not you usually adjust the clinic's schedule to compensate for "no shows" by OVERBOOKING, that is, by making appointments in addition to those the normal schedule would allow. Also indicate if you usually adjust by SETTING SHORTER APPOINTMENT LENGTHS in the clinic profile than would normally be scheduled for seeing a patient. (CHECK ONE RESPONSE.) (N=122-157)

	Do you overbook?		Do you set shorter appointment lengths?	
	Yes (1)	No (2)	Yes (1)	No (2)
Cardiology	70%	30%	10%	90%
Gastroenterology	72%	28%	9%	91%
Neurology	70%	30%	7%	93%
Ophthalmology	73%	27%	9%	91%
Orthopedics	71%	29%	6%	94%

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35. If you use any other techniques to adjust your clinics' schedules to compensate for "no shows," please describe those techniques in the space below. (N=48)

48 Comments

Definition:

CLINIC PROFILES: Schedules for each clinic that set the days and times of the clinic, the length of new and routine appointments, the number of overbooks permitted, and other pertinent information, such as the number of physicians and residents, etc.

36. For each specialty clinic listed below, indicate whether or not during FY 1991, you reviewed the clinic's profile according to a fixed, routine schedule. If "YES," also indicate whether you conducted the scheduled reviews at least once a quarter, at least once in six months, or at least once a year.

	(N=124-157)		(N=78-97)		
	During FY 1991, did you review each clinic's profile according to a fixed, routine schedule?		Did you conduct the scheduled reviews... (CHECK ONE RESPONSE.)		
	NO (1)	YES --> (2)	at least once a quarter? (1)	at least once in 6 months? (2)	at least once a year? (3)
Cardiology	42%	58%	20%	29%	50%
Gastroenterology	37%	63%	15%	30%	53%
Neurology	37%	63%	21%	30%	48%
Ophthalmology	38%	62%	21%	30%	48%
Orthopedics	34%	66%	16%	31%	52%

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39. For each of the specialty clinics listed below, indicate about what proportion of appointment slots during each clinic session are set aside solely for new patients. (CHECK ONE RESPONSE.) (N=125-157)

	About what proportion of slots are set aside for new patients? (CHECK ONE RESPONSE.)						
	0%	1 - 20%	21 - 40%	41 - 60%	61 - 80%	81 - 99%	100%
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Cardiology	40%	40%	13%	3%	0%	1%	2%
Gastroenterology	39%	30%	18%	9%	2%	1%	1%
Neurology	33%	34%	16%	11%	3%	1%	2%
Ophthalmology	47%	34%	11%	6%	1%	1%	1%
Orthopedics	51%	29%	11%	7%	1%	0%	1%

40. For each of the specialty clinics listed below, about what proportion of new patients, if any, are you able to give an appointment when needed only by overbooking? (CHECK ONE RESPONSE.) (N=126-155)

	About what proportion of new patients, if any, are you able to give an appointment when needed only by overbooking? (CHECK ONE RESPONSE.)						
	None	Few	Some	About Half	Most	Almost All	All
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Cardiology	13%	26%	24%	4%	8%	15%	10%
Gastroenterology	10%	24%	30%	8%	10%	10%	9%
Neurology	15%	30%	24%	4%	13%	8%	6%
Ophthalmology	12%	24%	29%	8%	8%	10%	8%
Orthopedics	10%	20%	32%	8%	10%	11%	9%

**Appendix II
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V. PRIMARY CARE

41. Under your General Medicine Clinic Stop, do any of the clinics operate as a Primary Care Clinic? (CHECK ONE RESPONSE.) (N=214)
1. 61% YES, all General Medicine clinics
 2. 19% YES, some General Medicine clinics
 3. 20% NO, none of the General Medicine clinics
--> If "NO," skip to question 49.
42. When was a General Medicine Primary Care Clinic first established in your VA Medical Center/Clinic? (CHECK ONE.) (N=170)
1. 4% in FY 1992
 2. 6% in FY 1991
 3. 14% sometime between FY 1988 and FY 1990
 4. 77% sometime before FY 1988
43. To what extent, if at all, were you able to treat more patients at the General Medicine Clinic Stop as a result of using PRIMARY CARE physicians or teams? (CHECK ONE RESPONSE.) (N=159)
1. 18% To a very great extent
 2. 19% To a great extent
 3. 14% To a moderate extent
 4. 24% To some extent
 5. 25% To little or no extent
44. Approximately what percentage of your total outpatients are currently assigned to a PRIMARY CARE physician or a PRIMARY CARE team? (ENTER PERCENTAGE.) (N=170) (Mean)
- 61 %
45. Listed below are several changes that might result from operating one or more clinics as primary care clinics. For each, indicate whether or not, that change occurred after your clinic began operating as a primary care clinic. (CHECK ONE FOR EACH.) (N=146-154; except (6) N=13)

	YES (1)	NO (2)
1. Continuity of care improved	95%	5%
2. The total number of patients in the 10-10 Area decreased	35%	65%
3. Patients assigned to primary care went to the 10-10 Area less frequently	70%	30%
4. The length of time that patients wait in the 10-10 Area decreased	41%	59%
5. The length of time that patients wait for an appointment in a specialty clinic decreased	27%	73%
6. Other (PLEASE SPECIFY.) _____	54%	46%

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46. Since the beginning of FY 1991, have any patients under the care of physician specialists been reassigned to PRIMARY CARE physicians or PRIMARY CARE teams? (N=141)

1. 87% YES
2. 13% NO

47. In any of your clinics, do you ever suggest to physician specialists that they may want to review patients to decide if they can be reassigned to primary care? (N=139)

1. 73% YES
2. 27% NO

48. In any of your clinics, do you have a formal policy that physician specialists should evaluate every patient to decide if s/he can be reassigned to primary care? (N=138)

1. 19% YES
2. 81% NO

VI. GENERAL INFORMATION

49. Has your VA Medical Center/Clinic ever studied any waiting times for ambulatory care? (N=214)

1. 76% YES
2. 24% NO

50. Has your VA Medical Center/Clinic ever studied the impact that the amount of time patients wait for ambulatory care has on their health? (N=214)

1. 9% YES
2. 91% NO

51. If the answer to question 49 or question 50 is "YES," please enclose a copy of the information or study with this questionnaire and send it to:

US General Accounting Office
ATTN: Dorothy Barrett
Suite 760
841 Chestnut Street
Philadelphia, PA 19107

52. At any time since the beginning of FY 1990, have you made any changes, other than those previously mentioned, in the operation of your 10-10 Admission/Screening Area or ambulatory clinics to shorten waiting times for care? (N=209)

1. 56% YES
2. 44% NO ---> If "NO," skip to question 54.

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53. In the space below briefly describe any changes since the beginning of FY 1990, other than those previously mentioned, in the operation of your 10-10 Admission/Screening Area or ambulatory clinics to shorten waiting times for care. If you need additional space, please use a separate sheet of paper and attach it to this questionnaire. (N=108)

108 Comments

54. Since FY 1990, has your VA Medical Center/Clinic conducted any type of Total Quality Improvement project on ambulatory care? (N=212)

1. 62% YES
2. 38% NO ---> If "NO," skip to question 56.

55. Briefly list the Total Quality Improvement projects your VA Medical Center/Clinic has conducted for ambulatory care since FY 1990. (N=128)

128 Comments

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VII. DATA SECTION

Definition:

EVALUATION: *Post-triage assessment usually, but not always, performed by a physician.*

56. During a typical administrative workday in the 10-10 Admission/Screening Area, in total, about how many staff hours are spent by 10-10 Area staff on:

- (A) TRIAGE by all physicians, physician extenders, and nursing staff;
 - (B) POST-TRIAGE EVALUATION by all attending physicians, house staff, and physician extenders;
 - (C) REGISTRATION by all MAS clerks; and
 - (D) OTHER ACTIVITIES PERFORMED IN THE 10-10 AREA by nursing staff not doing triage.
- (ENTER A NUMBER FOR EACH.)
(N=208) (Mean)

- 1. Triage: 18 staff hours
- 2. Post-triage Evaluation: 28 staff hours
- 3. Registration: 24 staff hours
- 4. Other activities: 12 staff hours

57. Estimate the percentage of your 10-10 Admission/Screening Area EMERGENT care patients, URGENT care patients, and NONURGENT care patients during FY 1991 who waited the following lengths of time from the time they were triaged until evaluation. (ENTER PERCENTAGES; IF NONE, ENTER "0.") (N=203-208) (Mean)

	EMERGENT care patients (1)		URGENT care patients (2)		NONURGENT care patients (3)	
a. No wait	87	%	23	%	2	%
b. Less than 30 minutes	12	%	44	%	15	%
c. At least 30 minutes, but less than 1 hour	1	%	20	%	29	%
d. At least 1 hour, but less than 3 hours	0	%	11	%	43	%
e. At least 3 hours, but less than 6 hours	0	%	2	%	11	%
f. 6 or more hours	0	%	0	%	1	%
Total patients for FY 1991	= 100%		= 100%		= 100%	

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58. Are the estimates you entered in question 57 based mainly on official records of waiting times, observations made by someone working in the 10-10 Admission/ Screening Area, a study done on waiting times or something else? (N=204) (CHECK ONE RESPONSE.)

1. 22% Official records of waiting times, such as the DHCP Registration/Disposition Time Statistics
2. 57% Observations by someone working in the 10-10 Admission/Screening Area
3. 12% A study done on waiting times
4. 9% Other (PLEASE SPECIFY.) _____

59. If you have already compiled your 10-10 Admission/Screening Area REGISTRATION/ DISPOSITION TIME STATISTICS for the second quarter of FY 1992, enter the total number of patients in your VA Medical Center/Clinic, and the average waiting time for all dispositions. If you have not already compiled these statistics, check the "Not Available" box. (ENTER NUMBERS.) (N=143)

Total number of patients: 474,921 (Total)

Average time: 2 hours 8 minutes (Mean)

[72] Not available

60. For each specialty clinic listed below, enter the average number of days, without overbooking, that NEW patients and ROUTINE patients currently wait from the time an appointment is requested until the next available appointment. If you cannot report separate information for NEW and ROUTINE patients, then enter the average number of days, without overbooking, that ALL patients currently wait for the next available appointment. If you do not have a specialty clinic, please check the "N/A" column. (ENTER NUMBERS FOR EACH SPECIALTY CLINIC.) (N= (2,3) 59-75; (4) 64-97) (Mean)

	N/A Do not have this specialty (1)	Average number of days that NEW patients currently wait (2)	Average number of days that ROUTINE patients currently wait (3)		Average number of days that ALL patients currently wait (4)
Cardiology	66	<u>56</u> days	<u>66</u> days	or	<u>66</u> days
Gastroenterology	90	<u>57</u> days	<u>63</u> days	or	<u>69</u> days
Neurology	66	<u>57</u> days	<u>68</u> days	or	<u>57</u> days
Ophthalmology	59	<u>62</u> days	<u>58</u> days	or	<u>62</u> days
Orthopedics	73	<u>67</u> days	<u>53</u> days	or	<u>63</u> days

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61. For each of the specialties listed below, enter the workload record for the second Quarter of FY 1992 for this VA Medical Center/Clinic. Please follow the "Clinic Workload Report" as detailed in the MAS v.5.1 USER MANUAL, Volume II or a similar method for detailing clinic workload. Include the number of: scheduled appointments, unscheduled appointments, inpatient appointments, over-booked appointments, no-shows, canceled appointments and total number of patients seen. (ENTER A NUMBER IN EACH BLANK.) (N=127-158) (Total)

	Sched Appts	Unsch Appts	Inpat Appts	Over-Books	No-Shows	Cancel Appts	Total Patients Seen
303 Cardiology	78,912	4,655	5,565	14,390	10,831	24,031*	105,532
307 Gastro- enterology	45,203	1,987	2,813	11,875	11,633	18,914*	62,549
315 Neurology	60,034	2,159	1,746	11,372	14,962	26,564*	74,875
407 Ophthal- mology	112,601	5,154	5,788	41,456	23,699	47,835*	162,931
409 Ortho- pedics	78,081	3,426	2,504	29,279	22,782	35,003*	113,166

* Includes cancellations by both patient and facility

62. If you have any other comments about waiting times for ambulatory care at VA Medical Centers/Clinics, please use the space below or attach additional sheets. (N=49)

General Comments - 23%

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