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VETERANS AFFAIRS

Service Delays at VA Outpatient Facilities

Statement of
David P. Baine, Director,
Federal Health Care Delivery Issues,
Human Resources Division

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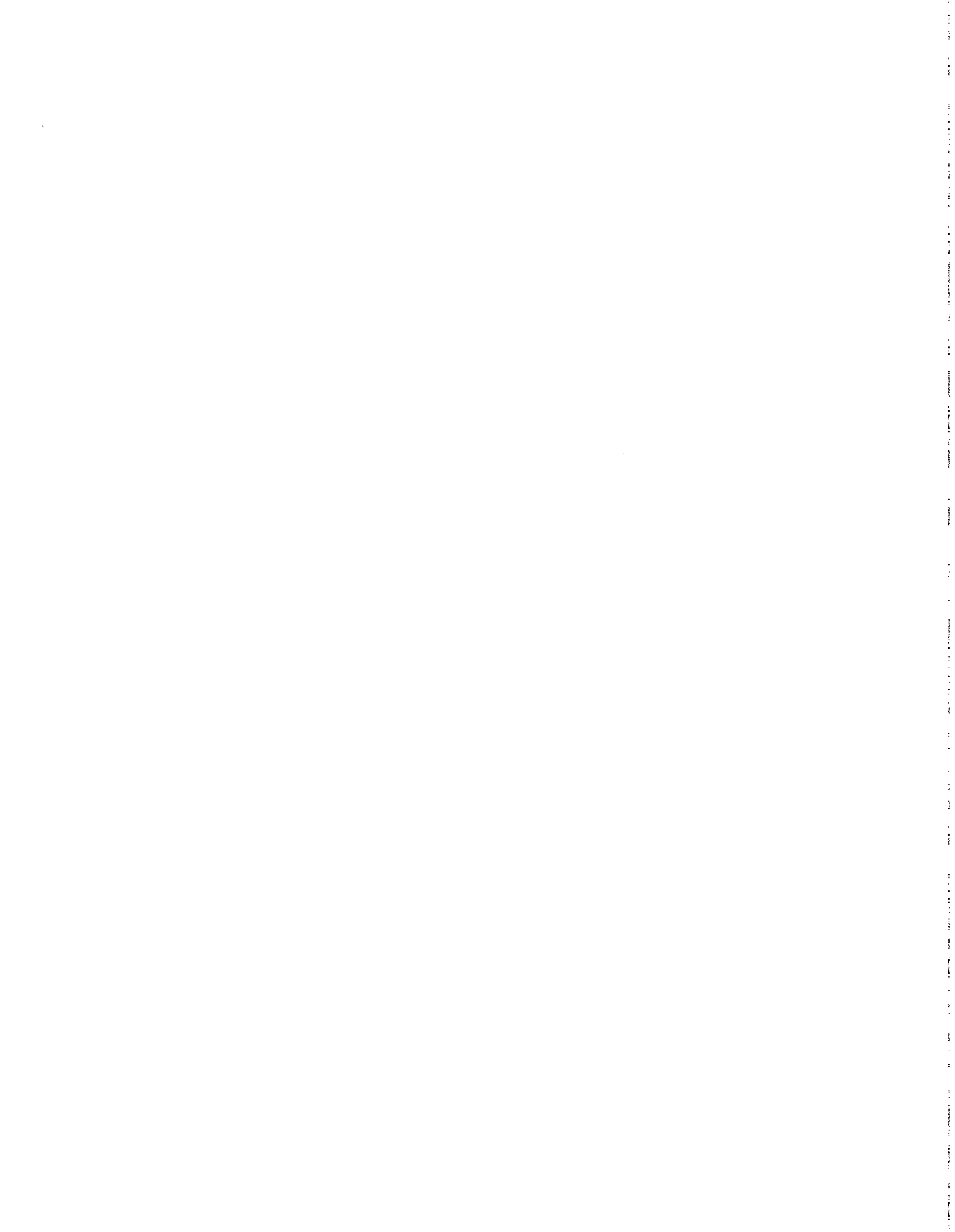
SUMMARY

In mid-October 1993, GAO reported that veterans experienced lengthy delays when they receive medical care in the more than 200 outpatient facilities operated by the Department of Veterans Affairs (VA). Veterans frequently waited 1 to 3 hours before having their nonurgent conditions examined by a physician in VA's emergency/screening clinics--the entry point for veterans initially seeking care. In addition, veterans waited an average of 8 to 9 weeks to obtain appointments in the specialty clinics that GAO surveyed, such as cardiology or orthopedic clinics which treat more complex medical conditions.

Inefficient operating practices are major contributors to veterans' service delays. For example, VA's emergency/screening clinics generally require veterans with nonurgent conditions to walk in to obtain care rather than call in advance to schedule visits to general medicine clinics. Because these veterans are treated on a first-come, first-served basis, they tend to arrive in the early morning hours and overwhelm clinic staff. Such uncontrolled workloads result in needless waits, dissatisfied veterans, and stressful working conditions for VA staff.

In his recent proposal to reform the nation's health care system, President Clinton proposed that VA compete with other providers to serve the health care needs of veterans. To be a viable competing provider, VA needs to quickly restructure its outpatient care delivery system to provide more timely ambulatory services. In doing this, VA should focus on developing systemwide patient-oriented processes, such as the establishment of telephone assistance networks and appointment scheduling systems for veterans who have nonurgent conditions.

The Secretary of Veterans Affairs generally agreed with GAO's findings and conclusions. The Secretary recognizes that the efficiency of VA's outpatient facilities can be improved and has expressed a commitment to implement the corrective actions that GAO recommended.



Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the timeliness of care veterans receive in the more than 200 outpatient facilities operated by the Department of Veterans Affairs (VA).

During your July 1993 hearing, we reported widespread inconsistencies in access to VA outpatient care.[1] Veterans with similar medical conditions and economic status were receiving care at some centers but not at others, due primarily to differing interpretations of statutory eligibility rules. At that hearing, veterans' service organizations expressed concern that veterans who gain access to VA care frequently face lengthy waits before receiving needed services.

As you know, this was not the first time that concerns have been voiced about the timeliness of VA's outpatient care. For example, during a 1991 hearing before the House Committee on Veterans' Affairs, witnesses testified that VA's system was not well suited to meet veterans' needs. In response to concerns voiced at the 1991 hearing, you asked us to examine VA's ambulatory care system to determine how long veterans wait for care, identify factors causing service delays, and recommend ways to shorten veterans' waiting times. To do this, we focused on VA's emergency/screening clinics, which are the entry points for veterans seeking care, and specialty clinics, such as those for cardiology or orthopedics, which provide care for more complex medical conditions.

As we reported to you in mid-October,[2] veterans too often encounter lengthy waits for care in VA clinics. Veterans being served in the more than 200 emergency/screening clinics we surveyed frequently waited 1 to 3 hours or longer before physicians examined them for nonurgent conditions. In addition, veterans waited 8 to 9 weeks, on average, for appointments to the more than 700 specialty clinics we surveyed.

Inefficient operating practices are the major contributors to veterans' service delays. These practices result in many veterans with nonurgent conditions arriving unscheduled at emergency/screening clinics and receiving care on a first-come, first-served basis. This, in turn, often results in uneven workloads for staff at the clinics and overcrowding during peak hours. Also, VA operating policies allow many veterans to receive general medical care in specialty clinics after their medical conditions have been stabilized, thereby resulting in overcrowding

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[1]Veterans Affairs: Accessibility of Outpatient Care at VA Medical Centers (GAO/T-HRD-93-29, July 21, 1993).

[2]VA Health Care: Restructuring the Ambulatory Care System Would Improve Service to Veterans (GAO/HRD-94-4, Oct. 15, 1993).

of these clinics as other veterans needing specialty care are referred to the same clinics.

I would like to describe, in a little more detail, some of the major causes of service delays in emergency/screening and specialty clinics as well as approaches that facilities should consider to improve service delivery.

EMERGENCY/SCREENING CLINICS

VA's emergency/screening clinics follow standard procedures when providing ambulatory care to veterans. In general, veterans visit the clinics in person whenever they have new conditions they believe require treatment. Upon arrival, veterans must first check-in with a clerk and then go through "triage," where health professionals determine the severity of their conditions. Once this is completed, clerks process their applications for care and check eligibility. Veterans then wait for evaluations by physicians, generally being seen in the order in which they arrived, unless their conditions are considered to be emergencies.

During our visits to seven emergency/screening clinics, we saw first-hand many overcrowded conditions where veterans were patiently waiting for care. In addition, we gained a greater appreciation for veterans' concerns about the timeliness of VA's ambulatory care by reading hundreds of veterans' letters describing service delays that they had experienced. Through reviews of medical records, we learned that veterans frequently visited emergency/screening clinics to have routine medical questions answered about previously diagnosed conditions or about prescribed medications.

Too often, we found veterans waiting needlessly for general medical assistance that could have been provided much more efficiently by telephone or through a scheduled visit. For example, we identified many instances where veterans were required to travel to VA clinics, go through time-consuming clinic processing requirements, and wait to see doctors, merely to have their prescriptions refilled. It is no wonder that one veteran in a letter noted: "These days when I get ready to go to the VA I pack a lunch and take a book . . .."

These types of service delays occur because VA's ambulatory care system is not set up to handle most veterans' conditions efficiently. VA officials estimated that nearly three-fourths of the veterans who came to emergency/screening clinics had nonurgent conditions, meaning that they were neither life- nor limb-threatening and were not time sensitive. VA's ambulatory care system forces these veterans to walk in to VA's emergency/screening clinics regardless of their medical needs.

Our survey showed that only 18 percent of all visits to emergency/screening clinics were scheduled. Because nonurgent veterans are treated on a first-come, first-served basis, they tend to arrive in the early morning hours and overwhelm clinic staff. Officials believe that such uneven workloads contribute to long waits, dissatisfied veterans, and stressful working conditions for VA staff.

VA facilities have independently taken a variety of steps to reduce veterans' waiting times. A few facilities developed alternative delivery options, such as telephone assistance networks, that attempt to resolve veterans' problems by phone or through scheduled clinic visits. One facility reduced the volume of veterans walking in to the emergency/screening clinic by 18 percent after adopting a telephone assistance network. About 60 percent of nonurgent veterans at this facility waited less than 30 minutes for physician evaluations compared with 17 percent systemwide.

Another facility restructured its ambulatory care program using primary care providers as the cornerstone. Veterans are assigned to primary care providers who assure continuity of care from the time a veteran first applies for care. This facility decreased the number of veterans in the emergency/screening clinic and assigned nonurgent walk-ins to primary care providers at scheduled times.

SPECIALTY CLINICS

Veterans are usually referred to specialty clinics by emergency/screening clinic physicians or by their attending physicians at the time of their discharge from a VA inpatient stay. 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 a specialist to review test results, make a diagnosis, and start necessary treatment. The specialist then continues to monitor the veteran's condition.

We reviewed several specialty clinic schedules and observed operations during our site visits. Too often we found that veterans had to wait several months to see specialists. VA staff 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.

These long delays frequently occur at specialty clinics because too many veterans continue to 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. For example, at one facility we visited, a veteran was initially diagnosed in the cardiology

clinic as having mild congestive heart failure. This patient continued to be given appointments every 6 months to the cardiology clinic for routine monitoring of his condition. This routine monitoring could have been done by a primary care physician, thereby freeing specialists to treat veterans needing evaluations of new conditions.

Facilities have independently taken a variety of steps to reduce appointment delays. For example, some facilities have reviewed the medical requirements of veterans being treated in specialty clinics. These clinics then transferred veterans needing only routine follow-up care for stable conditions to general medicine clinics. One cardiology clinic transferred 20 percent of its patients to its primary care clinic using this technique. This reduced waits for appointments from 1 year to 4 months.

Some facilities used primary care providers to coordinate specialty referrals. For example, two facilities we visited coordinated specialty referrals by allowing only primary care providers to make referrals unless emergencies arose. Using this gatekeeper approach, one facility decreased waits in specialty clinics to about 30 days.

NEEDED: RENEWED EMPHASIS ON PATIENT SERVICE

Mr. Chairman, in his recent proposal to reform the nation's health care system, President Clinton proposed that VA compete with other providers to serve the health needs of our nation's veterans. VA's ability to serve its patients in a timely way will be a key factor that veterans will consider when choosing a health care plan in a reformed health care system. VA has not, heretofore, placed sufficient emphasis on the need for timely ambulatory services to veterans as evidenced by the fact that it does not keep systemwide data on waiting times for care. Neither has it established Department-wide performance goals against which individual facilities' waiting times can be monitored and corrective action taken.

We believe that VA needs to restructure its ambulatory care delivery system to provide timely, patient-oriented services that meet veterans' varying health care needs. To do this, we recommended in our October 1993 report that VA focus on basic process changes, such as establishing telephone assistance networks and appointment scheduling systems to expedite veterans' access to care for nonurgent conditions. Moreover, VA needs to (1) identify the best practices in use at its different centers and develop a strategy for replicating them systemwide and (2) establish Department-wide performance goals to reinforce a renewed emphasis on reducing the time veterans have to wait for outpatient care.

From a veteran's perspective, having a single primary care provider who is familiar with his or her condition, who will be accessible for nonurgent problems, and who can coordinate any needed specialty care seems desirable. Such an approach will counteract complaints about fragmented and episodic care and can reduce waiting times in emergency/screening and specialty clinics. Again, a few facilities have experimented with this approach and the preliminary results seem encouraging.

The Secretary of Veterans Affairs commented, in an October 5, 1993, letter, that he generally agreed with the findings and conclusions in our October 1993 report. He stated that VA is developing a strategic planning goal to implement a managed care approach that focuses on primary care. Through this effort, VA expects to enhance services to veterans as well as address our recommendations.

In our view, VA is moving in the right direction. However, identifying the causes of service delays and reaching conceptual agreement on potential solutions may be the easier part of VA's task. Implementing the needed changes in a system as large as VA's will be a formidable challenge. This is because such implementation will entail shifting medical centers' ambulatory care emphasis from a specialty orientation to one focused on primary care and a corresponding reallocation of resources to make that shift happen.

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In summary, Mr. Chairman, VA has a responsibility now and in the future to provide the veterans of this country with timely health care. Clearly, it has some catching up to do. We think that our recommendations offer sound first steps towards meeting this responsibility. More importantly, overhauling the ambulatory care system--and doing it quickly--is essential if VA is to be a viable competitor under the President's health care reform proposal.

This concludes my prepared statement. We will be glad to answer any questions you and Members of the Subcommittee have.

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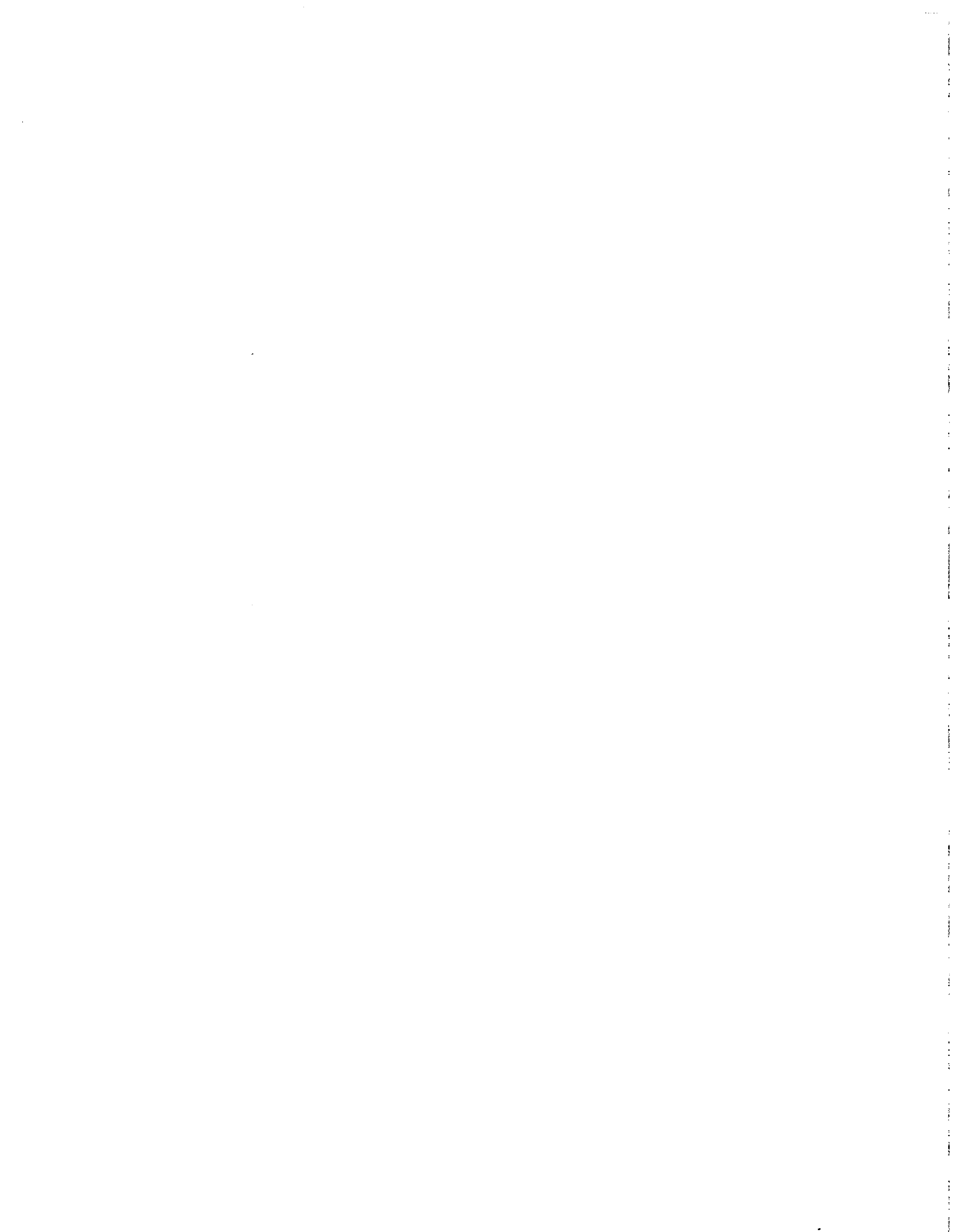

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