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VA HEALTH CARE

Management and Oversight of Consult Process Need Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care

GAO Highlights

Highlights of GAO-14-808, a report to the Chairman, Subcommittee on Oversight & Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

There have been numerous reports of VAMCs failing to provide timely care to veterans, including specialty care. In some cases, delays have reportedly resulted in harm to patients. In 2012, VHA found that its consult data were not adequate to determine the extent to which veterans received timely outpatient specialty care. In May 2013, VHA launched an initiative to standardize aspects of the consult process at its 151 VAMCs and improve its ability to oversee consults.

GAO was asked to evaluate VHA's management of the consult process. This report evaluates (1) the extent to which VHA's consult process has ensured veterans' timely access to outpatient specialty care, and (2) how VHA oversees the consult process to ensure veterans are receiving outpatient specialty care in accordance with its timeliness guidelines. GAO reviewed documents and interviewed officials from VHA and from five VAMCs that varied based on size and location. GAO also reviewed a non-generalizeable sample of 150 consults requested across the five VAMCs.

What GAO Recommends

GAO recommends that VHA take actions to improve its oversight of consults, including (1) routinely assess VAMCs' local consult processes, (2) require VAMCs to document rationales for closing unresolved consults, (3) develop a formal process for VAMCs to share consult management best practices, and (4) develop a policy for managing patient no-shows and cancelled appointments. VA concurred with all of GAO's recommendations and identified actions it is taking to implement them.

View GAO-14-808. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

Based on its review of a non-generalizable sample of 150 consults requested from April 2013 through September 2013, GAO found that the Department of Veterans Affairs' (VA) Veterans Health Administration's (VHA) management of the consult process has not ensured that veterans always receive outpatient specialty care in a timely manner, if at all. Specifically, GAO found that for 122 of the 150 consults reviewed—requests for evaluation or management of a patient for a specific clinical concern—specialty care providers did not provide veterans with the requested care in accordance with VHA's 90-day timeliness guideline. For example, for 4 of the 10 physical therapy consults GAO reviewed for one VA medical center (VAMC), between 108 and 152 days elapsed with no apparent actions taken to schedule an appointment for the veteran. VAMC officials cited increased demand for services, and patient no-shows and cancelled appointments among the factors that lead to delays and hinder their ability to meet VHA's timeliness guideline. Further, for all but 1 of the 28 consults for which VAMCs provided care within 90 days, an extended amount of time elapsed before specialty care providers properly documented in the consult system that the care was provided. As a result, the consults remained open in the system, making them appear as though the requested care was not provided within 90 days.

VHA's limited oversight of consults impedes its ability to ensure VAMCs provide timely access to specialty care. VHA officials reported overseeing the consult process primarily by reviewing data on the timeliness of consults; however, GAO found limitations in VHA's oversight, including oversight of its initiative designed to standardize aspects of the consult process. Specifically:

- VHA does not routinely assess how VAMCs are managing their local consult processes, and thus is limited in its ability to identify systemic underlying causes of delays.
- As part of its consult initiative, VHA required VAMCs to review a backlog of thousands of unresolved consults—those open more than 90 days—and if warranted to close them. However, VHA did not require VAMCs to document their rationales for closing them. As a result, questions remain about whether VAMCs appropriately closed these consults and if VHA's consult data accurately reflect whether veterans received the care needed in a timely manner, if at all.
- VHA does not have a formal process by which VAMCs can share best practices for managing consults. As a result, VAMCs may not be benefitting from the challenges and solutions other VAMCs have discovered regarding managing the consult process.
- VHA lacks a detailed system-wide policy for how VAMCs should manage patient no-shows and cancelled appointments for outpatient specialty care, making it difficult to compare timeliness in providing this care system-wide.

Consequently, concerns remain about the reliability of VHA's consult data, as well as VHA's oversight of the consult process.