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## PROCESS FOR ENSURING TIMELY ACCESS TO OUTPATIENT CLINICAL CARE

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive defines and clarifies policy and procedures for: managing patients in an outpatient setting; scheduling future appointments for patients; the provision of priority access to care for all veterans who are 50 percent service connected (SC) or greater; and the provision of priority access to care for veterans needing care for a SC disability regardless of the level of their service connection,

### 2. BACKGROUND

a. VHA has a commitment to provide priority care for non-emergent outpatient medical services for any condition of a SC veteran rated 50 percent or greater or for a veteran's SC disability. Poor access leaves VHA with the continued responsibility of providing timely holistic care for all eligible veterans receiving care. *NOTE: Medical care for emergent or urgent cases takes precedence over a priority of service connection.* VHA's goal is to have no waits, no delays and to create appointments that meet the patient's needs in order to provide quality care when veterans want and need it. In every instance, VHA must provide clinically-appropriate care to every enrolled veteran. Through the use of performance measures and monitors, VHA monitors wait times within primary care and certain outpatient specialty clinics; in addition it surveys its new and established patients to determine if they received an appointment when they wanted one. *NOTE: Acceptable levels of performance are established each year in VHA's performance plan.*

b. Public Law 104-262, the Veterans Health Care Eligibility Reform Act of 1996, mandated VHA establish and implement a national enrollment system to manage the delivery of health care services to veterans. Enactment of this legislation has generated a significant increase in VHA enrollees and patient users.

c. VHA currently is implementing the principles of Advanced Clinical Access (ACA) in all of its clinic settings as a method to assist with balancing supply and demand.

d. There is a need to standardize scheduling processes in meeting workload demands. This Directive is intended to standardize scheduling practices, thereby producing consistency in reporting the delays in providing health care to veterans.

f. **Definitions.** For purposes of this Directive, the following definitions are used:

(1) **New Enrollee.** A new enrollee is a previously un-enrolled veteran who applies for Department of Veterans Affairs (VA) health care benefits and enrollment by submitting VA Form 10-10EZ, Application for Health Benefits, and who is determined eligible, is then enrolled by VA, and who then seeks care from VA for the first time.

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(2) **Panel.** A panel is a discrete population of patients assigned within the VHA Primary Care Management Module software to a single Primary Care Provider (PCP) for their health care management.

(3) **Primary Care Provider (PCP).** A PCP is a single provider, supported by a team, who is assigned the responsibility for managing the health care of a discrete population (panel) of patients. Nurse Practitioners (NPs) and Physician Assistants (PAs) may serve as PCPs when their scope-of-practice, or locally-established privileges, encompass the skills and responsibilities required to provide primary care for these patients.

(4) **Urgent Care.** Urgent care is care for a condition for which there is a pressing need for treatment to prevent deterioration of the condition, or impairing possible recovery. For example, urgent care includes the follow-up appointment for a patient discharged from a VA hospital, if the discharging physician directs that the patient must return on a specified day for the appointment.

(5) **Emergent Care.** Emergent care is care for a condition for which immediate treatment is required to prevent the loss of life or limb, or is required to prevent the progression of a disease process that could lead to loss of life.

(6) **Dental Care Eligibility.** Dental care eligibility is specified by legislative authority and is defined in VHA Handbook 1130.1.

(7) **Open Primary Care (PC) Panel.** An Open PC Panel is a panel that has not reached its maximum capacity threshold as defined by facility or Veterans Integrated Service Network (VISN) policy.

(8) **Closed PC Panel.** A Closed PC Panel is a panel that has reached its maximum capacity threshold as defined by facility or VISN policy. For sites with a patient population reflecting the norms for disease severity and reliance on VHA, and who have current norms of 2.17 support staff per 1.0 full time equivalent (FTE) provider and 3.0 clinic rooms per 1.0 FTE provider, an expected panel would be 1,200 patients for a full-time, established primary care physician. After adjustment for the factors identified, expected panels for VHA primary care providers will largely fall in the range of 1,000 to 1,500. Non-physician provider (NP or PA) is expected to carry a panel 75 percent the size of a 1.0 FTE physician provider. However, ratios of support staff and space should be the same for a 1.0 FTE non-physician provider as for a 1.0 FTE physician provider.

(9) **Service Connection.** Service connection or “service connected” means that with respect to a condition or disability, VA has determined that the condition or disability was incurred in, or aggravated by, military service.

(10) **Preferred Facility.** The preferred facility is the VA facility in which the veteran expresses preference for care and in which the major portion of the veteran’s PC is provided.

(11) **Preferred Location.** The preferred location is a campus, or Community-based Outpatient Clinic (CBOC) within a single facility, at which the patient has indicated they would prefer to receive either primary or specialty care.

(12) **Desired Appointment Date.** The desired appointment date is the earliest date on which the patient or clinician specifies the patient should be seen.

(13) **Electronic Wait List (EWL).** The EWL software module provides a standard mechanism for VHA to capture and track patients who are waiting for clinic appointments, primary care panel assignments, dental care, specialty care, or other clinical services or procedures.

(14) **Advanced Clinical Access (ACA).** ACA is a patient-centered, scientifically-based set of redesign principles and tools that enable staff to examine their health care processes and redesign them. The ACA principles are extraordinarily powerful and result not only in improved access, but also in improved patient, staff, and provider satisfaction, improved quality, improved efficiency, and decreased cost (see Att. A).

**3. POLICY:** It is VHA policy to enroll veterans promptly, to manage patient appointments in a timely and standardized manner, to provide priority access to outpatient medical care for veterans who are 50 percent SC or greater, and to provide priority access to care for veterans who require care for a SC disability regardless of the level of their SC rating.

#### 4. ACTION

a. **VISN Directors.** VISN Directors are responsible for:

(1) Ensuring the VISN-wide education of leadership, and clinical, administrative, and business services staff on the principles and strategies of ACA.

(2) Oversight of scheduling, processing and wait lists for eligible veterans to ensure compliance with the policy and procedures defined by this handbook.

(3) Assigning a VISN ACA leadership team (Quadrad).

(4) Assigning a VISN ACA Point of Contact (POC).

(5) Ensuring that there is an active VISN ACA Steering Committee which includes at least the VISN Quadrad, the VISN ACA POC, and a VISN Office ACA sponsor. **NOTE:** *A sponsor is an executive or senior management level official within the VISN assigned authority by the VISN Director for oversight of the ACA program within the VISN. The ACA POC is the VISN ACA project coordinator assigned by the Network Director and responsible for, among other things, liaison between the VISN, field facilities, and VHA Central Office.*

b. **VA Medical Center Director.** The VA Medical Center Director, or designee, is responsible for ensuring that:

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(1) Principles and strategies of the ACA initiative are implemented in all clinics (see Att. A).

**NOTE:** Additional information on ACA may be found at the following web address:

<http://aca.vssc.med.va.gov>

(2) All patients are scheduled for care correctly and on a timely basis.

(3) There is no “holding” of consult, procedure, dental, home and community based care, or diagnostic study requests. Services requested are scheduled or the patient is placed on EWL as soon as possible, but no later than 7 calendar days of the date the request is created.

(4) There are no manual wait lists, or unofficial EWLs.

(5) There is a process for monitoring and decreasing the missed opportunity rate including the number of no shows, and the number of patient and clinic cancellations (that are recorded after the time and date of the scheduled appointment).

(6) All patients are scheduled for care using the following business rules:

(a) Urgent or Emergent Care. Patients with emergent or urgent medical needs must be provided care, or be scheduled to receive care as soon as practicable, independent of service-connected status and whether care is purchased or provided directly by VA. This does not include patients who use the emergency room or urgent care settings simply for routine renewal of medication, or patients seeking VA prescriptions for medications that have been prescribed by outside providers. It is the responsibility of the medical center Director, or designee, to implement a system whereby patients with urgent needs can be identified, and whereby instructions are given to patients on how to access care for emergent conditions. **NOTE:** *A wait list for hospice or palliative care will not be maintained. VHA must offer to provide or purchase needed hospice or palliative care services without delay.*

(b) Priority Scheduling for Outpatient Services (to include, but not limited to: PC, Medical, Surgical, Behavioral Health, Rehabilitative, and Dental services; Diagnostic Studies; Geriatric Evaluation and Management; Home-based Primary Care; Purchased Skilled Home Care; Adult Day Health Care; Non-Institutional Respite Care; and Homemaker and/or Home Health Aide Services.) Veterans who are SC 50 percent or greater or veterans who are rated less than 50 percent requiring care for a SC disability need to be scheduled within 0-30 days of the desired appointment date specified by the patient or clinician.

1. When it is unclear whether the care requested relates to the SC condition, the assumption is to be made that the patient is entitled to priority access. **NOTE:** *For cases that are unclear, the administrative staff is encouraged to consult with the PCP or member of the clinical team. In the event a veteran disagrees with an administrative decision, the decision may be referred for clinical review and determination.*

2. In the event the required care cannot be provided within the 30-day timeline, these SC veterans entitled to priority access need to be placed on the EWL. When placing the patient with

SC priority on the EWL, it must be documented in the comments section of the EWL that care could not be provided within 0-30 days. Maximum effort must be made to provide the necessary care within 0-30 days. The facility Director, or designee, is expected to carefully monitor the SC veterans entitled to priority access on the EWL, and make every effort to have them seen as soon as possible. Fee basis may be used if a medical determination has been made requiring emergent care that is not available at the VA facility or other VA facilities. **NOTE:** *Priority scheduling of any SC veteran should not impact the medical care of any other previously-scheduled veteran. Veterans with SC disabilities should not be prioritized over other veterans with more acute health care needs.*

3. In addition to ensuring that this priority for access to care is provided to veterans with a SC disability, maximum effort must be made to provide clinically-appropriate care to every enrolled veteran.

4. Service connection, in and of itself, will not be used to justify cancellation of a current appointment for another veteran as a mechanism for accommodating priority scheduling for the SC veteran.

5. Managing patient care is ensured through enrollment of each patient with a VHA PCP who assesses the patient's need for specialty care service. In responding to the request of a SC veteran eligible for priority access to specialty care services, it is at the discretion of the VHA clinician to determine whether direct scheduling to that specialty clinic is appropriate, or whether the patient's request needs to be assessed by a VHA PCP.

(c) Veterans Transfer of Care

1. When a veteran, who has been receiving ongoing care at a VA facility, permanently changes the place of residence, the veteran needs to be provided treatment based on an established provider-patient relationship. **NOTE:** *VHA has an obligation to ensure that it continues the care of these patients.*

2. Established patients wishing to transfer care to a more convenient location, but for whom VA care is currently accessible (e.g., transfer care from one campus or CBOC within a VA facility to a closer Campus or CBOC), may be subject to being placed on the EWL, and flagged as transfer patients until the service requested becomes available at their desired location. Until the EWL software has the capability to flag transfer patients, these patients need to be placed on the EWL in non-count clinics for the site they desire to receive the service requested.

(d) Balancing Supply and Demand for Outpatient Services through Continuous Forecasting and Contingency planning. Current and future demand for outpatient care in all modalities at all locations (at all campuses and CBOCs of the facility) need to be continuously monitored in order to :

1. Forecast instances in which demand can be expected to exceed capacity on either a permanent or temporary basis, and

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2. That the facility may be prepared in advance to immediately augment capacity at any location affected through appropriate actions to include, but not limited to, adding new PC panel(s) and/or specialty care staffing.

(e) Use of Wait Lists When Primary Care Panels are Full. If a patient would like to receive ongoing PC and the panels at the preferred location are full, the patient needs to be placed on the EWL for panel placement.

1. If there is availability on a PC panel at another proximate VA location, the patient should be offered this as an alternative care site on an interim basis. If the patient refuses to accept PC at the alternate location, the patient needs to be placed on EWL for the location where PC is desired, and a note must be entered in the comments section of the EWL that the patient refused PC at the alternate location.

2. If the patient accepts an appointment at the alternative site, the patient should still be placed on the EWL to receive PC at the preferred location, designated as a transfer patient in the EWL software, and informed when a panel slot becomes available at their desired location.

*NOTE: Until the software has the capability to flag transfer patients, these patients need to be placed on the EWL in non-count clinics for the site they desire to receive PC.*

(f) Use of Wait Lists When Wait Times Exceed 120 Days (or Exceed 30 Days for Patients Entitled to Priority Access) for Specialty Care Services at a CBOC or at a Campus of an Integrated Health Care System (HCS).

1. If a patient would like to receive specialty care from an established specialty clinic at a CBOC, or at one specific campus of an integrated HCS, but cannot be scheduled to be seen within 0-120days (or 0-30 days for patients entitled to priority access) at that location, but could be scheduled within these time frames at another location within the facility, the patient is to be offered an appointment at that other location on, at least, an interim basis.

2. If the patient refuses to accept specialty care at the alternate location, the patient needs to be placed on EWL for the location and specialty desired and a note entered into the comments section of the EWL that the patient refused specialty care at the alternate location.

3. If the patient accepts an appointment at the alternative site, the patient is still to be placed on the EWL to receive specialty care at the preferred location, designated as a transfer patient in the EWL software (is not to be included in the EWL count), and informed when a timely appointment becomes available at their desired location.

4. The patient is to be removed from EWL if their specialty care need is completed at the alternate location.

*NOTE: Until the software has the capability to flag transfer patients, these patients are to be placed on the EWL in non-count clinics for the site they desire to receive this specialty care.*

(g) Requests from Veterans to be Enrolled or Registered at a Facility at Which the Veteran has not Previously Been Seen

1. When a veteran requests care from a facility at which the veteran has not previously been seen, the local facility is responsible for determining whether the veteran needs to be enrolled, or is already enrolled with VHA and can simply be registered at the local facility in order to be provided the services requested.

2. All requests to be enrolled at a VHA facility are to be processed as soon as administratively feasible, and as soon as possible, but no later than 7 calendar days of the receipt of a signed application from a veteran. Upon acceptance of the veteran's enrollment, the Health Eligibility Center (HEC) mails the new enrollee a general welcome letter that provides information about the veterans' priority group and instructions on how to contact their local VA health care facility if they desire an appointment. *NOTE: Veterans are never to be discouraged from applying due to capacity constraints.*

(h) Timely Scheduling of Veterans for Clinical Care and Use of Wait Lists When Appropriate. All appointment requests must be acted on by the facility as soon as possible, but no later than 7 calendar days of the request. This includes: requests from patients newly enrolled, or registered, at the facility; requests from established patients; consult requests to a specialist; dental and procedure requests; and requests for diagnostic studies generated by a VHA physician. The requirement to act on a request as soon as possible, but no later than 7 calendar days of the request may be fulfilled by any of the following:

1. Completing the consult, procedure, or study;
2. Discontinuing the consult procedure or study;
3. Canceling the consult, procedure or study; or
4. Scheduling the consult, procedure or study.

(i) By the end of the 7 calendar day, the patient must be immediately placed on the EWL if:

1. The request has not been fulfilled, or
2. An appointment is not scheduled for the service to be provided within 0-30 days of the desired appointment date (for patients entitled to priority access as described in the preceding), or
3. An appointment is not scheduled for the service to be provided within 0-120 days of the desired appointment date for all others.

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(j) Patients Needing PC Panel Placement. The use of PC panels is a fundamental principle in managing PC capacity, in achieving advanced clinical access, and in ensuring continuity of care. Panels establish a relationship between the patient and a single PCP who oversees all aspects of care, which results in the improvement of care delivered. *NOTE: It is expected that, if a PC panel is sized properly, the patients on the panel should be able to receive an appointment when they want one.*

(k) Patients Seeking Ongoing PC from VA. Patients seeking ongoing PC must be placed on an Open PC Panel at their preferred facility. Sites have devised a variety of methods for determining if a patient will be seeking on-going primary care from VA. The important point is that panels should only be filled with patients who demonstrate a desire for continuing PC. Panels need to be regularly managed to remove inactive patients so that other patients can be placed on the panel.

(l) Patients Seeking Primary Care at More than one Facility. A patient already assigned to a PC panel at another VA facility should only be assigned to a PC panel by the local facility if the veteran is requesting to change their preferred facility for PC, and thereby transferring their PC. *NOTE: A veteran may request and qualify for an exception to having a single PC panel assignment.*

(m) Primary and Specialty Care Appointments Scheduled. Appointments are not to be scheduled more than 120 days beyond the desired appointment date. *NOTE: Appointments scheduled more than 120 days beyond the desired appointment date are subject to high cancellation rates resulting in the inefficient use of clinic resources.*

(n) Use of Wait Lists when Appointments Cannot be Scheduled within 120 days of the Desired Appointment Date (30 days for SC Patients Entitled to Priority Access)

1. As soon as possible but no later than 7 calendar days of the request (see preceding subpar. 4b(6)(g)), patients seeking an appointment for outpatient care that cannot be scheduled within 0-120 days of the desired appointment date as specified by the patient or clinician (or 0-30 days of desired appointment date as specified by the patient or clinician for SC patients entitled to priority access) must be placed on VA's EWL.

2. If the patient requests, or the provider feels it is clinically indicated (even when the wait time from the desired appointment date exceeds the preceding timelines), the patient may be given the soonest possible scheduled appointment (while also being placed on the EWL). However, every effort must continue to be made to reschedule that appointment to shorten the wait for that veteran to be seen.

a. This applies to appointments for all outpatient services including for primary care; medical, surgical, behavioral health, rehabilitative, and dental services; diagnostic studies; geriatric evaluation and management; HBPC; purchased skilled home care; adult day health care; non-institutional respite care; and homemaker and home health aide services; and elective procedures.

b. Sites need to establish a system of managing the patients on the EWL by reviewing them regularly and contacting patients prior to their desired appointment date to set up the appointment, if it is available.

3. When a patient is placed on the EWL and waiting beyond 120 days of the desired appointment date (beyond 30 days of the desired appointment date if entitled to priority access), even though the veteran may have requested and been given an appointment scheduled longer than these timelines, the veteran needs to be notified (either directly, in person, or by phone) by the facility, of being placed on the EWL.

a. This 120 day scheduling-cut off (30 days for SC patients entitled to priority access) establishes a boundary limit for scheduling, unless otherwise indicated, and does not preclude sites from placing patients on the EWL before this 120 day time period (30 days for SC patients entitled to priority access) for better management of clinic scheduling.

b. When patients, who are already on a PC panel, must wait more than 120 days beyond the desired appointment date (30 days for SC patients entitled to priority access) for a PC appointment, a problem may exist in the management of the panel. **NOTE:** *Facility administration needs to assess the management of the panel to determine the source of the problem. Panels that are sized properly and managed using ACA techniques need to be able to provide paneled patients appointments when they are needed.*

(o) Patients are Removed from the EWL as Appropriate. If, as determined locally, the condition of any patient on the EWL becomes urgent or emergent, this patient must take precedence over all other patients; must be provided appropriate care and follow-up; and must be removed from the EWL.

1. Any veteran, who is SC 50 percent or greater, or less than 50 percent SC and requiring care for a SC disability, must be given priority when removing patients from the EWL.

2. When removing patients from the EWL, veterans, who have been receiving ongoing care at another VA facility and who have permanently changed their place of residence, need to be treated as if they have an established patient-provider relationship at the new facility.

3. All other patients need to be removed from the EWL on a first-on, first-off basis.

4. Patients need to be removed from a facility's EWL when any of the following conditions occur:

a. The patient is no longer seeking care from that VA facility (e.g., the patient has died, or moved, or declined care at that site).

b. The patient has been seen for the requested care, or has been given a scheduled appointment that is within 0-120 days of the desired appointment date (within 0-30 days of the desired appointment date if entitled to priority access) in the requested clinic.

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c. The facility has not been able to contact the patient to schedule an appointment. Attempts to contact the patient must include at least three phone calls at least 7 calendar days apart and a letter to the patient. This effort must be documented.

(p) Veterans Are Notified of Their Placement on the EWL. If the appointment cannot be scheduled, and the veteran is placed on the EWL, it must be documented that the veteran has been notified in person, or by phone, of the following:

1. VA is not able to provide care within the time period desired by the patient,
2. The approximate expected waiting time,
3. Instruction on what to do in case of an emergency, and
4. The patient will be contacted when appointment slots become available.

(q) Ensuring Appropriate Mechanisms are in Place. Appropriate mechanisms must be in place to monitor the:

1. Time in queue for patients awaiting their first appointment in PC.
2. Time in queue for patients awaiting their first specialty care appointment.
3. PC panel size and capacity.
4. Number of patients on EWL for PC.
5. Number of patients on EWL for specialty care by specialty.

## 5. REFERENCES

- a. Public Law 104-262.
- b. Title 38 United States Code (U.S.C.) Sections 1710 and 1705.
- c. Title 38 Code of Federal Regulations, Sections 17.36, 17.37, 17.38 and 17.49.
- f. VHA Handbook 1130.1, Dental Program Procedures for VHA Medical Facilities.

**6. FOLLOW-UP RESPONSIBILITY:** The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the contents of this Directive. Questions may be directed to 202-273-5852.

**7. RECISSIONS:** VHA Directive 2003-062, VHA Directive 2002-059, and VHA Directive 2003-068, are rescinded. This VHA Directive expires May 31, 2011.

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Under Secretary for Health

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ATTACHMENT A

PRINCIPLES AND STRATEGIES FOR ACCESS IMPROVEMENT

1. IMPROVING ACCESS FOR AN APPOINTMENT

a. **Know, Understand, and Measure Supply and Demand**

- (1) Establish equitable workload
- (2) Measure demand for appointments
- (3) Measure supply of appointments

b. **Work Down the Backlog**

- (1) Measure backlog
- (2) Estimate bad backlog
- (3) Create a written backlog reduction plan

c. **Decrease Appointment Types and Times**

- (1) Reduce Appointment types
- (2) Reduce Appointment lengths

d. **Develop Contingency Plans**

- (1) Establish plans for short and long term loss of supply
- (2) Establish plans for variation of demand
- (3) Plan for unusual but predictable events

e. **Reduce Demand for Visits**

- (1) Increase continuity
- (2) Consider lengthening re-visit intervals
- (3) Max pack patient complaints
- (4) Decrease no-shows

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- (5) Create alternatives to face-to-face visits
- (6) Consider group visits
- (7) Manage prescheduled appointments
- (8) Promote self-care

**f. Increase Supply and Optimize the Care Team**

- (1) Perform provider task analysis
- (2) Redesign provider tasks
- (3) Maximize team roles to meet patient needs
- (4) Use standard protocols to optimize use of other providers
- (5) Separate responsibilities for phone triage, patient flow, and paper flow

**2. IMPROVING ACCESS AT AN APPOINTMENT**

**a. Balance Supply and Demand for Non-appointment Work**

- (1) Flow-chart patient journey
- (2) Identify patient waiting steps
- (3) Measure constraint supply and demand
- (4) Take steps to reduce constraint

**b. Synchronize Patient, Provider, Information, Equipment, and Room**

- (1) Establish and measure synchronization time
- (2) Identify barriers to synchronization
- (3) Improve slowest step

**c. Predict and Anticipate Needs**

- (1) Review communication efficiency
- (2) Implement communication tools

**ATTACHMENT A**

**d. Optimize Rooms, Equipment, and Staff**

- (1) Standardize rooms
- (2) Review and/or correct equipment needs and/or functions

**e. Manage Constraints**

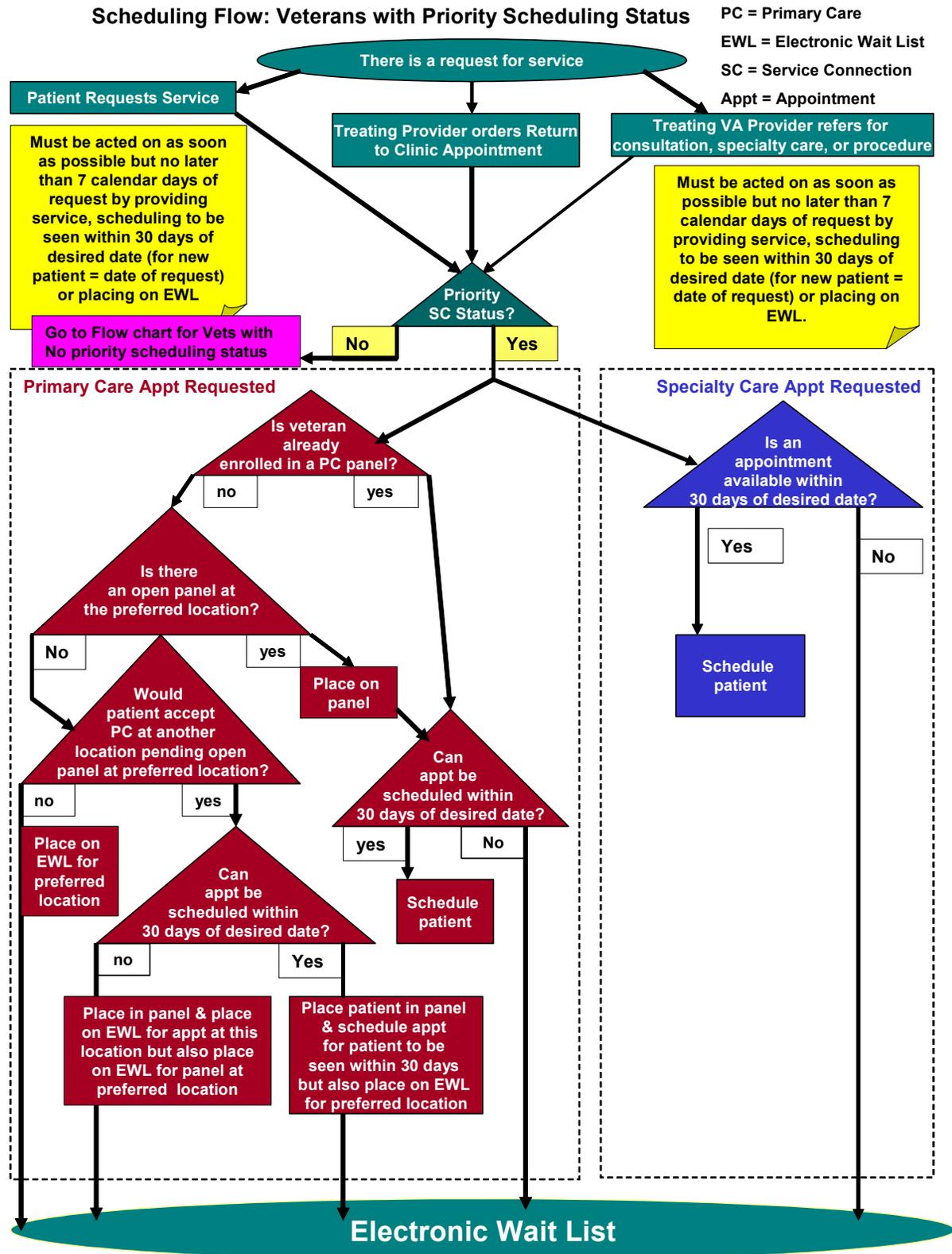
- (1) Constantly know constraints
- (2) Constantly manage constraints

**3. IMPROVING ACCESS BETWEEN APPOINTMENTS**

**a. Create Service Agreements Between Primary Care and Specialty Clinics**

**b. Ensure Effectiveness of Service Agreements Through Ongoing Monitoring**

ATTACHMENT B



ATTACHMENT C

