Department of Veterans Affairs
Access Audit
System-Wide Review of Access

Results of Access Audit Conducted May 12, 2014, through June 3, 2014

OVERVIEW

These Access Audit findings address the Secretary of The Department of Veterans Affairs directive that the Veterans Health Administration conduct a system-wide audit of scheduling and access management practices. This audit assesses the integrity of these practices and recommends next steps to improve service to Veterans.

Access Audit Results

At the direction of the Secretary of the Department of Veterans Affairs (VA), the Veterans Health Administration (VHA) conducted an Access Audit to determine if allegations about inappropriate scheduling practices are isolated instances of improper practices or if broader, more systemic problems exist. The audit was designed to:

1. Gauge front-line staff understanding of proper scheduling processes;
2. Assess the frequency and pervasiveness of both desired and undesirable practices employed to record Veteran preferences for appointment dates, manage waiting lists, and process requests for specialty consultation; and
3. Identify factors that interfere with schedulers' ability to facilitate timely care for Veterans.

The Access Audit was by necessity a rapidly deployed, system-wide assessment of scheduling practices across VA, and was not intended as a formal investigation of individual staff or managers. Site survey teams were not able to interview all employees, and time did not allow assessment of intent or potential culpability. All of the information collected from audit site visits has been shared with VA's Office of Inspector General (OIG).

Audit Scope

The audit was conducted in two phases. Phase One covered VA medical centers (VAMC) and large Community-Based Outpatient Clinics (CBOC) serving at least 10,000 Veterans. Phase Two covered additional VA facilities, including Hawaii VA and Phoenix VA Health Care Systems. Combined, the two phases covered 731 total facilities, including 140 parent facilities and all VAMCs. During the course of the audit, over 3,772 staff were interviewed.

Audit Findings

The Phase One findings were a strong basis to commence immediate action, even while Phase Two data were being collected. Ultimately, VA chose to limit Phase Two data collection after initial assessments restated high consistency with the findings of Phase One.

The Access Audit was subject to certain limitations (emphasized in later sections of this report) that were unavoidable given the scope and accelerated timeframe. Notwithstanding these limitations, findings include:

1. Efforts to meet needs of Veterans (and clinicians) led to an overly complicated scheduling process that resulted in high potential to create confusion among scheduling clerks and front-line supervisors.
2. Meeting a 14-day wait-time performance target for new appointments was simply not attainable given the ongoing challenge of finding sufficient provider slots to

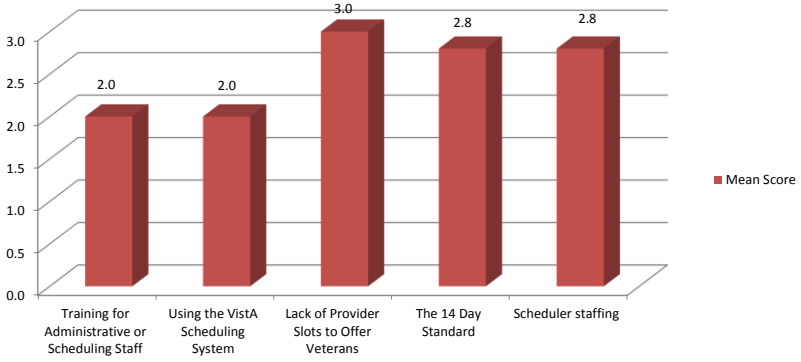
accommodate a growing demand for services. Imposing this expectation on the field before ascertaining the resources required and its ensuing broad promulgation represent an organizational leadership failure.

3. The concept of "desired date" is a scheduling practice unique to VA, and difficult to reconcile against more accepted practices such as negotiating a specific appointment date based on provider availability, or using a "return to clinic" interval requested by providers.
4. Overall, 13 percent of scheduling staff interviewed indicated they received instruction (from supervisors or others) to enter in the "desired date" field a date different from the date the Veteran had requested. At least one instance of such practices was identified in 76 percent of VA facilities. In certain instances this may be appropriate (e.g., a provider-directed date can, under VA policy, override a date specified by a patient), but the survey did not distinguish this, nor did it determine whether this was done through lack of understanding or malintent unless it was clearly apparent.
5. Eight percent of scheduling staff indicated they used alternatives to the Electronic Wait List (EWL) or Veterans Health Information Systems and Technology Architecture (VistA) package. At least one of such instance was identified in 70 percent of facilities. As with desired date practices, we did not probe the extent to which some of these alternatives might have been justified under VA policy. The questionnaire employed did not isolate appropriate uses of external lists.
6. Findings indicate that in some cases, pressures were placed on schedulers to utilize inappropriate practices in order to make waiting times (based on desired date, and the waiting lists), appear more favorable. Such practices are sufficiently pervasive to require VA re-examine its *entire* performance management system and, in particular, whether current measures and targets for access are realistic or sufficient.
7. Staffing challenges were identified in small CBOCs, especially where there were small counts of providers or administrative support.

Obstacles to Timely Access

Critical insights came from asking front-line staff members to rate the degree to which certain factors interfered with timely access to care. The *highest* scored single barrier or challenge was lack of provider slots, closely followed by the peculiarities of the fourteen day goal[1]. Limited clerical staffing was also deemed a significant obstacle.

Obstacles that have been posited as significant inhibitors to scheduling timely appointments, such as inadequate training of schedulers, or the inflexibility of the legacy VistA scheduling software system, were cited much



Average (Mean) Scores of Barriers and Challenges to Providing Timely Access to Care (Higher number means greater challenge to staff members)

[1] For example, a Veteran might have month, but that could have been vie

less often during this audit.

We also highlight that there were many potential opportunities identified that could improve the consistency of desirable practices among schedulers, such as calling Veterans about upcoming appointments, addressing other obstacles, making performance improvement activities more routine, and ensuring that clinic operations data are regularly reviewed at team and management meetings.

Further Actions

VA will establish follow-up accountability actions based on the results of the audit. Senior leaders will be held accountable to implement policy, process, and performance management recommendations stemming from this audit and other reviews. Where audited sites identify concerns within the parent facility or its affiliated clinics, the VA will trigger administrative procedures to ascertain the appropriate follow-on actions for specific individuals.

Based on the findings of the audit, VA will critically review its performance management, education, and communication systems to determine how performance goals were conveyed across the chain of command such that some front-line, middle, and senior managers felt compelled to manipulate VA's scheduling processes. This behavior runs counter to VA's core values; the overarching environment and culture which allowed this state of practice to take root must be confronted head-on if VA is to evolve to be more capable of adjusting systems, leadership, and resources to meet the needs of Veterans and families. It must also be confronted in order to regain the trust of the Veterans that VA serves.

I. ACCESS AUDIT RESULTS

The following section provides details about the conduct of and results from the VA nationwide audit of scheduling and access management practices.

1. Research Question(s)

The essential discovery questions built into the audit are listed below:

- Do front-line staff receive appropriate training, supervision, and feedback to correctly perform their scheduling and access management practices?
- Do front-line staff members exhibit the proper understanding of scheduling and access management policies and practices?
- Do front-line staff members receive instruction to modify dates when a Veteran wants to be seen, and if so, how and why do they receive that instruction?
- What are the main barriers and challenges staff members face in offering Veterans timely access to care? Do they feel personally capable of delivering high-quality service?

2. Data Collection Method(s)

The audit management team assessed various techniques to support the collection of data. It was determined that, given the sensitivity of information to be collected, that face-to-face interviews would need to be collected by independent site audit teams using confidential, in-person administered questionnaires.

2.1 Site Audit Teams

Phase One site audit teams were comprised of four senior field and headquarters staff members. These staff members were typically General Schedule (GS)-14, GS-15, Senior Executive Service (SES), and SES Equivalent. Phase Two site audit teams were comprised of two field and headquarters staff members. These staff members were typically at the GS-14 and above level.

Staff members selected were senior leaders in the organization familiar with conducting audits and site visits, e.g., administrative investigations where sworn testimonies are collected; consultative site visits based on defined technical criteria. Further, these staff members would carry authority and stature sufficient to ensure access to key staff members in the field and independence in performing their functions. A final rationale behind the selection of these leaders was to create a shared awareness and learning of scheduling and access management practices across the system.

To ensure independence, no member of any site audit team either worked in the facility being audited, the Veterans Integrated Service Network (VISN) overseeing that facility, or any other facility in same VISN as the facility being audited.

Over 205 staff supported Phase One, including staff that assisted in data management and analysis. Over 264 staff supported Phase Two, including staff that assisted in data management and analysis.

2.2 Dates of Site Audits

Audits commenced May 12, 2014, and concluded June 3, 2014.

2.3 Sites Visited

Site audit teams visited 731 total facilities, including 140 parent facilities and all VAMCs The list of sites visited is contained in Appendix B.

Each site audit was initiated with a joint in-briefing to local union leadership and facility management. During that in-briefing, the list of requested interviewees was identified.

2.4 Questionnaires

Site audit teams were responsible for collecting data from front-line staff through the use of detailed questionnaires. Additionally, site teams generated nightly reports summarizing their site audits and identifying any issues of concern. An example of the questionnaire is contained in Appendix E.

2.5 Sampling Method

The audit management team created a listing of all 30,000 VA employees with access to the VistA scheduling package who had actually performed scheduling functions. This included mainly front-line scheduling staff (typically a position called a medical scheduling assistant) and clinic managers (typically a nurse clinic manager) who were all eligible to be interviewed by the site audit teams. From the list of eligible schedulers at the site they were visiting, the audit teams selected their respondents on the day of their site audit, not announcing their selections until the in-briefing.

In order to complete all data collection as quickly as possible, no more than 1 business day was feasible at each site. A total of 10 respondents were selected per facility comprised of 9 front-line schedulers and one clinic manager. Overall, each site audit team was expected to interview:

- The Chief of Health Administration Service, Medical Administration Service, or Chief Business Officer
- Nine interviews with schedulers, including:
    - Between three and four with primary care schedulers;
    - Between two and three with mental health schedulers;
    - Between two and three with specialty care schedulers; and
    - One clinic manager.

2.6 Interviews Completed

In total, 3,772 interviews were conducted with VAMC and CBOC staff members. Interviews were conducted in private and no names of interviewees were recorded with questionnaire data. Each interview was allotted a full-hour but lasted approximately 45 minutes.

Staff members interviewed by the site audit teams were informed that if they wanted union representation, this was both permitted and encouraged. Further, if potential interviewees were uncomfortable with being interviewed, they were informed they would not be required to complete the interview.

2.7 Site Reports Submitted

During the site audits conducted, 596 site audit summary reports were submitted by the site audit teams. These summary reports rolled-up to 140 parent VAMCs ("facilities").

3. Audit Limitations

VA undertook an ambitious effort to schedule, prepare, coordinate, train and deploy over 400 staff across the Nation over 5 days. This accelerated effort led, unavoidably, to a number of limitations, which serve to caution against over-interpretation of these findings, including:

- Design of the survey which was intended to provide a very low threshold (i.e., high sensitivity) for eliciting potentially improper scheduling practices.
    - VA intentionally designed the survey to be sensitive to non-conforming scheduling policies. As such, the results will group misunderstanding of proper scheduling methodology together with intentional instruction to report alternate waiting times. The sensitivity in the instrument enables VA to identify a broader set of sites with potentially problematic practices.
- The Audit Survey tool itself did not undergo pre-testing to ensure all respondents would understand the intent of each item.
    - Certain items on the questionnaire may have been misunderstood.
- Individual questions were not worded to ascertain the reason that policy may have been violated.
    - Therefore, findings from this audit cannot be extended to identify deliberate deception, fraud, or malfeasance.
- The scope of the audit precluded independent verification of any narrative statements, though all data collected throughout the Access Audit have been shared with VA's OIG.
    - Furthermore, the audit did identify sites necessitating more intensive management investigations. VHA will ensure that accountability for inappropriate practices is pursued through further investigations to substantiate initial findings. In pursuing accountability, VHA will follow

statutory and regulatory due process requirements accorded to all Federal government employees.

- Site audit teams had limited time (90 minutes of pre-survey coaching plus additional document review) for training.
    - While site teams were generally knowledgeable about audits, investigations, and consultative visits, not all were experts in all the complexities associated with scheduling and access management.
- Sampling of staff was based on availability.
    - Staff selected for interviews may not have been available to complete the requested interview. In these cases, the site audit team selected another candidate.
- Treatment of respondents prior to interview
    - In certain instances staff selected for interviews had experienced recent training (e.g., within days of the requested interview). This treatment may have altered results, affecting baseline assessments of understanding of scheduling policies and practices.
- Limited validation of responses
    - Survey science includes methodology for internal validation to ensure consistency of responses. This is limited in the audit and where included does not support a high correlation (see 5.1 of this audit results for details).

4. Site Visit Reports Overall Impressions

4.1 Site Visit Reports – Overall Impressions

By May 17, 2014, 596 close-out reports had been submitted by site audit teams. Of these, 229 (38.4 percent) indicated "Concerns (they) wished to report to the National Stand Down Team." Out of the 229 site reports indicating some degree of concern, 112 (or roughly 19 percent of all reports) were flagged because of concerns that indicated undesired scheduling practices or because detailed responses by interviewed staff indicated they had received instruction to modify scheduling dates (or similar concerns). This listing of sites requiring further review is based on a review of responses by front-line staff contained in site audit reports. VA is providing the list of sites requiring further review to OIG for further investigation; however, the listing of these sites should be understood as a preliminary step, and further review will be necessary to determine the extent of issues related to scheduling and access management practices. CBOC sites of concern in Phase Two of the audit tended to correlate with parent facilities.

Negative practices identified in site reports included:

- Staff being instructed by supervisors to alter desired date;

- Staff keeping manual logs of appointment requests outside of electronic systems (VistA or the EWL);
- Staff lacking familiarity with scheduling policies;
- Other practices inconsistent with policy:
    - Non-count clinics ;
    - Cancelling consults;
    - Cancelling appointments; and
- Employees indicating reluctance to participate in the survey due to fear they would be subject to disciplinary action due to deviation from national policy.

4.2 Staff Questionnaire Responses from Site Audits

What follows are summaries, both quantitative and qualitative, for each question in the survey. The questions are grouped by theme and are not necessarily presented in the order in which they were administered during the survey visit.

Because the number of respondents at an individual site is low, we are unable to make statistically valid distinctions in performance at site level, and present national summary data in order to answer the question "are problems isolated or pervasive".

For "Yes"/"No" questions, we present the following information:

- Total responses received;
- Percent of respondents indicating "Yes";
- Percent of facilities in which AT LEAST 1 RESPONDENT indicated a "Yes";
- Percent of facilities in which AT LEAST ONE QUARTER of RESPONDENTS indicated a "Yes";
- Percent of facilities in which AT LEAST THREE QUARTERS of RESPONDENTS indicated a "Yes";
- This approach was adopted in order to convey the *frequency and pervasiveness,* of various scheduling practices, both desirable and undesirable, across VA's health care system. For instance, it is possible that an undesirable practice such as using alternatives to VistA or the EWL is endorsed by a small proportion of schedulers (low prevalence) but is found at least once in a high percentage of VA facilities (pervasive across the system). The consistency of either desirable or undesirable practices within a given facility can be inferred by comparing values for "AT LEAST 1", "AT LEAST ONE QUARTER", and "AT LEAST THREE QUARTERS of RESPONDENTS;
- For questions where responses were scored on a 5-point Likert scale, we provide a Mean Score (overall) as an estimate of prevalence. Pervasiveness is indicated by noting the Percent of facilities where the MEAN among respondents is HIGH (score of 3 or better among all those responding from a single site) or LOW (mean less than 3 among all respondents at a site); and
- Questions relating to undesirable practices are highlighted in yellow in the tables below.

5. Scheduling Practices

For purposes of establishing the percentage of responses, further analysis is aggregated at the parent facility level. The sites and locations visited roll-up to 140 parent facilities (e.g., one hospital has numerous outpatient clinics).

5.1 Staff Understanding about Scheduling Policy

The figure provides a summary of responses about staff members understanding of scheduling practices.

*** indicates mandatory questions**	**Responses**	**% "Yes"**	**No.(%) Facilities Where >= one Response "Yes"**	**No.(%) Facilities Where >25% Responses "Yes"**	**No.(%) Facilities Where >75% of Responses "Yes"**
Q6. * Based on the response above, does the clerk report the **correct** procedure for determining desired date?	3,208	78	140 (100%)	138 (99%)	92 (66%)
Q8. * Based on the above, does the clerk report the **correct** procedure for determining the desired date?	3,208	75	140 (100%)	139 (99%)	84 (60%)
Q10. * Based on the response above, does the scheduler report **correct** use of the Electronic Wait List (EWL)?	3,208	49	140 (100%)	115 (82%)	16 (11%)
Q11. * Do you track appointment requests in **places other than the VistA scheduling system or EWL**?	3,208	8	108 (77%)	5 (4%)	0(0%)
Q39. * Do you track appointment requests in **places other than the VISTA scheduling system or EWL**?	3,208	7	98 (70 %)	4 (3 %)	0 (0 %)
Q41. * Are you **aware of the (New Enrollee Appointment**	3,208	31	140 (100 %)	78 (96 %)	1 (1 %)

* indicates mandatory questions	Responses	% "Yes"	No.(%) Facilities Where >= one Response "Yes"	No.(%) Facilities Where >25% Responses "Yes"	No.(%) Facilities Where >75% of Responses "Yes"
Request) list?					
Q45. * Are you aware of any **consults that are used specifically to request that appointments** be scheduled?[2]	3,208	57	139 (99%)	126 (90%)	34 (24%)

Scheduling staff were twice asked the question "do you track appointment requests in places other than the VistA scheduling system or EWL", spaced by several minutes, in order to allow an internal check of survey reliability. Although the summary values for each question are very similar, the calculated agreement in this instance is only 0.53 using the Kappa score (a statistical measure of inter-rater agreement), which is quite low as compared to modern survey standards, but understandable in light of the rapid deployment of this national initiative (see "Limitations" above).

While any individual item on the survey might be suboptimal, several related survey items and their accompanying verbal comments allows a more confident estimate of the prevalence of problematic scheduling practices. For instance, a question asked of clinic managers provided responses that closely paralleled the responses of scheduling staff:

	Responses	Within 1 day	Within 3 days	Within 7 days	More than 7 days	Don't know
Q46. If you are aware of any consults that are used specifically to request that appointments be scheduled, how often are they processed? (PERCENT)	3,208	57	139 (99%)	126 (90%)	34 (24%)	3,208

[2] CPRS contains the ability to generate a consult request for appointments. Staff should be aware of these requests in order to accurately gauge Veterans' access needs.

5.2 Facility Instruction to Record Dates Other than Dates Veteran Wants to be Seen

Thirteen percent of schedulers indicated they received instruction to enter a desired date other than the date a Veteran asked to be seen. In 76 percent of VA parent facilities, at least one respondent indicated that she or he received instruction to modify the date when a Veteran wanted to be seen. However, it must be noted that this includes instances where one respondent in one CBOC associated with the parent facility indicated she/he received instruction to modify dates. The practice was not seen consistently among scheduling staff within a given facility - only 15 percent of facilities, for instance, had over 25 percent of respondents indicating "yes", and in no facility did over three-quarters of respondents indicate such a practice. The reasons for entering a Desired Date different from the one voiced by the Veteran varied greatly.

*** indicates mandatory questions**	**Responses**	**% "Yes"**	**No.(%) Facilities Where >= one Response "Yes"**	**No.(%) Facilities Where >25% Responses "Yes"**	**No.(%) Facilities Where >75% of Responses "Yes"**
Q12. Do you feel you **receive instruction** from the facility to **enter a desired date other than the date a Veteran asks to be seen**?	3,036	13	107 (76%)	20 (14%)	0 (0%)

5.3 Qualitative Probe Questions

Initial qualitative analysis yielded several themes. The audits included 3,722 participant interviews, of which 2,218 were non-clinicians. Initial qualitative analysis yielded themes similar to those in Phase I.

<u>Extent of scheduling practices that were not concordant with policy</u>

A minority of respondents (188 or 8% from 119 clinics, 29%) reported that they had previously selected desired date from among available dates, rather than determining desired date based upon the Veteran's preferred date or the date requested by the provider. A majority of respondents (1,575 or 71% from 346 clinic sites, 85%) reported that they had previously presented the Veteran with available dates from which to select a desired date.

Many respondents reported that this scheduling policy (i.e., selecting the desired date irrespective of available dates) was not well-understood previously, and that they began

recording desired date correctly after receiving recent additional training. Some respondents specifically cited a web-based training session in VA's online Talent Management System (TMS) as helping to provide the clarification that was needed to do this correctly.

Reports of potentially fraudulent practices

Respondents at 90 clinic sites provided responses indicating they had altered desired dates that had been entered. In virtually all cases, they indicated they were instructed by supervisors, but many believed the policy of altering dates was coming from facility leadership. In at least 2 clinics, respondents believed someone else (not a scheduler) was routinely accessing records and changing desired dates in order to improve performance measures.

In 24 sites, respondents reported that they felt threatened or coerced to enter specific desired dates. Respondents at 14 sites reported having been sanctioned or punished over scheduling practices. Respondents at 2 sites reported having been sanctioned ("written up") for either not complying with supervisors' orders to inappropriately enter or alter recorded desired dates, or for expressing concerns over what they were being asked to do

- A number of respondents presented detailed descriptions of instructions from supervisors to change or alter data in order to affect reported wait times. The descriptions reflect a perception of the practice as both widespread and overt.

- Although uncommon, several respondents expressed concerns with or related reports of punitive actions related to a demand to manage reported wait times.
- Work demands and difficulty "keeping up" were described as exacerbating factors in problematic scheduling and wait list management.

Factors Contributing to Inappropriate Scheduling Related Activities

When explaining the context of inappropriate scheduling activities respondents described a numbers driven system with unrealistic performance measures as having created a highly stressful work environment that limits the focus on serving the Veteran.

6. Findings : Barriers and Challenges to Providing Veterans Improved Access to Care

6.1 Main Challenges

This section provides summary results regarding primary challenges and obstacles staff face in offering Veterans timely access to care. When front-line staff members were requested to score from a range of 1 (never a barrier or challenge) to 5 (always a barrier or challenge) the degree to which various aspects posed barriers and/or challenges to providing Veterans with timely access to care, the highest scored barrier or challenge was the lack of provider slots to offer Veterans, closely followed by limited clerical staffing and the fourteen day standard. These previous barriers and challenges far outscored training and the legacy scheduling software system.

Challenges and Obstacles to Providing Timely Access to Care (Score 1 = never, 2 = rarely, 3 = sometimes, 4 = often, and 5 = always)	Responses	Mean Score	No. Facilities with mean rating 3 or greater	No. Facilities with mean rating less than 3
Q14. Rate how often "*Training for Administrative or Scheduling Staff like Me"* presents challenges	2,719	2.0	1	137
Q15. Rate how often using the VISTA Scheduling System presents challenges	2,834	2.0	5	134
Q16. Rate how often Lack of Provider Slots to Offer Veterans presents challenges	2,867	3.0	72	67
Q17. Rate how often the 14 Day Standard presents challenges	2,856	2.8	45	94
Q20. Rate how often other obstacles present challenges	1,416	3.5	122	18
Q26. How often is scheduler staffing an issue?	2,876	2.8	44	96

The most common “other obstacles” identified by schedulers in responses are listed below:

- Staffing problems were frequently cited as an “other” obstacle to scheduling Veterans and were reported at many sites. Respondents commonly reported difficulties and distress related to being understaffed, both in terms of scheduling staff and providers.
- Respondents attributed staffing problems to turnover, difficulty hiring and, in some cases, salary.
- The challenges of hiring were described as most problematic for providers.
- Although far less frequently reported than HR issues, low morale was described as both a result of, and cause of low staffing.
- Scheduling software and, to a lesser degree, telephone equipment were frequently described as antiquated and problematic.
- Some respondents identified training issues, both the lack of customer service training and the time training pulls staff away from customer service tasks, as a problem for scheduling.

- Scheduling policies were described as sometimes unclear and frequently problematic. The most prevalent issues cited in this area were handling walk-ins and phone calls.

A less commonly reported obstacle was changes in care delivery model, specifically Patient Aligned Care Teams (PACT). However, other respondent perceived PACT as a potential solution to access problems.

Another less common concern was that the lack of facilities as an obstacle for patient access, both at the individual clinic and system level.

Additional data regarding customer service, training, supervisory oversight, and scheduling improvement activities are provided in Appendix D. It is noteworthy that VA is engaging in the opportunities (highlighted in yellow in Appendix D) to increase the consistency of desirable practices within VA facilities such as:

- Calling Veterans who have missed prior appointments ("missed opportunities") to remind them of upcoming appointments
- Involving schedulers regularly in performance improvement activities
- Reviewing clinic operations data regularly in team meetings

II. STRUCTURE AND PROCESS CHANGES FOR MANAGING ACCESS TIMELINESS TO BE IMPLEMENTED IMMEDIATELY

The following section provides systematic and broad reaching actions that VA has already initiated.

1. Overview

VA and VHA will perform thorough analyses, assess root causes and develop a long term plan to ensure that VHA's system of care employs valid assessments of demand, capacity and productivity. Notwithstanding this need for deliberative development of longer-range efforts, VHA can and must address evident and solvable problems immediately. Paramount in this immediate set of actions is to identify where Veterans are waiting for care and ensure that the have access to quality, timely care.

VHA will make rapid and definitive changes to ensure integrity in managing Veterans' access to care so the agency can maintain its focus on providing Veterans timely access. Additionally, VHA will provide hands-on attention to all staff engaged in providing Veterans health care and managing access.

The actions in the sections to follow will be coordinated through a near term plan that commenced May 23, 2014.

- Accelerate Care for Veterans Currently Waiting for Care Assess Care Delivery Capacity vs. Health Care Demand to Ensure Resource Levels
- Remove 14-Day Performance Goal from Performance Contracts
- Revise and/or Rescind Scheduling Directive
- Suspend VHA Executive Performance Awards for FY14
- Face-to-Face Engagement with Medical Support Assistants, Clinic Managers and Other Critical Front-line Staff
- Communicate VA Values' Applicability to Day-to-Day Performance
- Review and Modify Performance Plans for Wait Time Accountabilities
- Modify Management Dashboards Designed for Organizational and Operational Levels
- Enhance Patient Satisfaction Monitoring to Assess Satisfaction with Access and Experience
- Implement Medical Center Access Audits, Ongoing Monitoring, Elevation Triggers, and Clear Line Accountability Including Specific Requirements for Regular Inspection and Reporting
- Enhance VHA National Program with Focus on Access to Care
- Implement VHA-Wide Site Inspection Process
- Cross-Organization Surveying of Scheduling and Access Best Practices
- Review Medical Support Assistant Classification to Ensure Correct Grading
- Revise, Enhance and Deploy Scheduling Training
- Assess Position Management Practices and Staffing Required to Fully Support VA Medical Centers
- Establish Wait-Time Based Guidance for Non-VA Care Referral
- Assess Implementation of System-Wide Contracts for Primary Care

2. Accelerating Care and Ongoing Capacity Assessments

In the immediate term, VHA will accelerate care for Veterans experiencing delays in receiving their care. Additionally, VHA will develop and deploy quantitative mechanisms to assess demand, capacity and delays. VHA will supplement the considerable range of productivity measures that have already been deployed and will use these measures to assess the adequacy of resources for the provision of timely access to care for Veterans.

Accelerate Care for Veterans Currently Waiting for Care

Commencing May 23, 2014, VHA deployed the expanded Accelerating Access to Care Initiative. This initiative has identified roughly 100,000 Veterans who are currently experiencing long wait times for receipt of their VA health care. VHA has provided training to VHA, VISN and facility staff to implement this plan. On the first day of the Accelerating Care initiative, VHA provided training to over 900 VHA field staff. Specifically, for Primary Care, Mental Health, and Specialty Care, VHA is assessing each of its clinics using productivity data to determine if greater productivity can be gained (e.g. for clinics with lower productivity). Additionally, each VHA medical center has assessed if it can provide expanded clinic hours to increase clinic capacity. Lastly, each VHA medical center is assessing if care is available through non-VA care or through the national, Patient Centered Care in the Community (PC3) contract.

These immediate tactics to accelerate care rely heavily on financial and other resources (e.g. overtime, etc.). Each VHA medical has assessed mechanisms to increase productivity, capacity or care in the community, and then each medical center is contacting Veterans directly to accelerate their care. As additional resources are required to accelerate access, these requests are being provided to VHA corporate office to identify available resources.

VHA will track progress through online corrective plans from each facility that address productivity enhancements, capacity increases, non-VA care acquisitions, Veteran contacts, and, ultimately, reduction in the number of Veterans waiting 30 days or more for health care services.

Appendix A: Analytic Methods

A.1 Coding of Quantitative, Ordinal and Categorical Variables
Numerical and categorical responses (i.e., Yes/No/Do not Know, Rating Scale 1-5, Time Scale [e.g. Daily/Monthly/Quarterly/etc.] to questionnaire items were provided by 2,290 individuals who were interviewed by the site visit teams. These items included Q6, Q8, Q10, Q11, Q12, Q14, Q15, Q16, Q17, Q18, Q20, Q21, Q22, Q24, Q25, Q26, Q29, Q30, Q31, Q32, Q35, Q37, Q39, Q41, Q42, Q45, Q46, Q51, Q53, Q55, Q56, Q57, and Q58. Items that provided numerical responses included Q44, Q48, and Q52. Responses to these items were summarized at the level of National VA, VISN and parent facility.

Several steps were taken to prepare the data and conduct analysis:

- A copy of the excel data set was created with question number defined as column names to replace the question text column headers. Data from the excel file were then entered into SAS.
- A facility crosswalk was created to address the multiple VISN assignments issue stated below and to determine the parent facility station number for analysis purposes.

A reference table with distinct combinations of responses to Q1, Q2A and Q2B was created. Station numbers were manually assigned based on responses to Q2A and Q2B. The table was merged with another table containing information from VHA Site Tracking (VAST) system to obtain VISN, parent facility name, number, city and state. Issues that were addressed:

- Responses from the same location of site visit (survey question 2a) with 2 different VISN responses (survey question 1).
- Survey responses to question 2b :
  - The station numbers entered did not always match the facility/clinic name
  - Station numbers entered may have had transposed characters
  - Missing station numbers
  - Spelling variation in facility/clinic names

The facility crosswalk was systematically and manually validated.

Numeric responses of 999, 9999, and >= 99999 to questions 44, 48, and 52 were assumed to imply “Do Not Know”. “Do not know” responses were counted but were excluded from the calculation of the summary statistics for each question.

All free-text responses were grouped to a response category=”OTHER” for questions with defined categorical responses and “Other (Fill-in)” response option. This applied to questions 20, 22, 30, 37, and 57.

A.2 Qualitative Responses

Several items permitted verbal explanation to accompany a categorical (i.e., yes/no) response. An initial qualitative analysis comments was performed to provide a fuller understanding of the scope and nature of problematic activities pertaining to patient scheduling and electronic waitlists and to complement the quantitative analysis of categorical response items. We analyzed the unstructured interviews to assess the extent to which scheduling procedures may not have followed national policy. Narrative data recorded by site visit teams from interviews with 1,962, non-clinician respondents (clinicians didn't provide narrative responses) representing 260 clinic sites were coded.

Analysis

A team of 14 coders reviewed narrative survey fields and coded for 7 scheduling practices:

i. Using the date patient wants to be seen as the desired date
ii. Using the date the provider orders as the desired date
iii. Routinely entering only an available date as desired date (no input from Vet)
iv. Routinely entering only an available date as desired date in negotiation with the Veteran
v. Changing the desired date after it has been entered (i.e., altering data for a non-clinical reason)
vi. Threats or coercion to follow scheduling practice
vii. Punishment or retribution for scheduling practice or voicing concerns

For respondents that were coded positive for v, vi or vii, an observation we independently coded by one of two coders, who then reviewed findings and agreed on the final set of coded data.

For findings on obstacles to appropriate scheduling, one coder reviewed narrative data from a site visit item on obstacles to appropriate scheduling, and compiled a list of the most common major obstacles.

Limitations

These were site visit data, not a respondent survey. The site visit teams for the Phase Two visits had less training and guidance due to logistical constraints and so potentially may exhibit more variability in data collection. The data were filtered through the members of the site audit teams and were generally not verbatim quotations. Thus, many responses likely lack much of the context provided by the respondents during the visit. Because respondents were generally not expressly asked about the specific behaviors enumerated in this report (e.g., whether they felt coerced or threatened), the absence of the behavior being reported cannot be considered to be equivalent to the respondent reporting the behavior was absent.

Moreover, respondents may have self-censored, or may have responded to questions in order to be helpful even when they had incomplete information (helpful respondent bias). For reports of potentially fraudulent practices, which have the most significant

implications for the personnel involved, in most cases the reports are from a single individual at the clinic setting.

Because of the limited time available, an initial analysis was performed only on question #12 (“Do you feel you receive instruction from the facility to enter a desired date other than the date a Veteran asks to be seen?”) for which there were 2,086 categorical responses, for which additional explanation was provided by 270 respondents (12.9%) (coded as Question #13). Data preparation occurred in several steps:

- A copy of the excel data set was created for qualitative data analysis to ensure integrity of the original data. Purposive sampling was used to identify respondents who described problematic activities pertaining to patient scheduling and electronic waitlists (EWL) using “Yes” to question 12; A separate excel spreadsheet was created that contained all of the survey data fields for the identified subset (Q12-Yes). Dichotomous and numerical fields were retained but hidden for ease of coding.

- This excel data set was analyzed using an inductive content analysis approach to identify emergent categories. Coding was done within Excel by adding columns for each identified category and pasting relevant quotes within the corresponding category. Operational definitions were developed and included as a footer in the spreadsheet. The initial set of codes included 10 (Details re. Q 12, Scheduling practice descriptions, Training, Instructed, Perceived Deviation from protocol, Concern re. lying, Acknowledged lying, Reading between the lines, Saving emails, Expectations and Staff Empowered).

Appendix B: Sites Visited by Day of Access Audit

B.1 Phase I Sites Visited

Trip #	May 12	May 13	May 14	May 15	May 16
1	Manchester, NH	White River Junction, VT	Togus (Augusta), ME	Bedford, MA	Boston (Jamaica), MA
2	Boston (West Roxbury), MA	Boston (Brockton), MA	West Haven, CT	Providence, RI	Central Western Mass, MA
3	Syracuse, NY	Bath, NY	Canandaigua, NY	Rochester, NY	Buffalo, NY
4	Albany, NY	HV HCS Montrose, NY	HV HCS Castle Point, NY	NYH HCS Bronx, NY	NYH HCS St Albans, NY
5	NYH HCS Brooklyn, NY	NYH HCS, Manhattan	Northport, NY	NJHCS East Orange, NJ	Brick, NJ
6	Erie, PA	Butler, PA	Pittsburgh (HD), PA	Pittsburgh (Uptn), PA	Altoona, PA
7	NJHCS Lyons, NJ	Wilkes-Barre, PA	Allentown, PA	Lebanon, PA	Horsham, PA
8	Clarksburg, WV	Martinsburg, WV	Washington, DC	Richmond, VA	Salem, VA
9	Philadelphia, PA	Wilmington, DE	Baltimore, MD	Perry Point, MD	Loch Raven, MD
10	Asheville, NC	Mountain Home, TN	Middle Tenn (York), TN	Middle Tenn (Main), TN	Memphis, TN
11	Raleigh, NC	Durham, NC	Winston-Salem, NC	Salisbury, NC	Charlotte, NC
12	Fayetteville, NC	Myrtle Beach, SC	Goose Creek, SC	Charleston, SC	Savannah, GA
13	Greenville, SC	Columbia, SC	Augusta, GA	Dublin, GA	Atlanta, GA
14	Birmingham, AL	Tuskegee, AL	Montgomery, AL	Pensacola, FL	Mobile, AL
15	Tallahassee, FL	Lake City, FL	Gainesville, FL	Jacksonville, FL	Ocala, FL
16	Daytona Beach, FL	The Villages, FL	Lake Baldwin, FL	Tuscaloosa, AL	None
17	Tampa, FL	New Port Richey, FL	Bay Pines, FL	Bradenton, FL	Sarasota, FL
18	Lee County Health Care Ctr, FL	Sunrise, FL	Miami, FL	West Palm Beach, FL	Viera OPC, FL
19	Cleveland, OH	Parma, OH	Lorain, OH	Canton, OH	Youngstown, OH
20	Dayton, OH	None	Cincinnati, OH	Chillicothe, OH	Columbus, OH

Trip #	May 12	May 13	May 14	May 15	May 16
21	Ft Wayne, IN	Marion, IN	Indianapolis, IN	Danville, IL	Peoria, IL
22	Saginaw, MI	Battle Creek, MI	Ann Arbor, MI	Toledo, OH	Detroit, MI
23	Iron Mountain, MI	Appleton, WI	Tomah, WI	Madison, WI	Milwaukee, WI
24	Chicago, IL	Crown Point, IN	Hines, IL	Lovell FHCC, IL	None
25	Saint Louis, MO	Evansville, IL	Marion, IL	Popular Bluff, MO	Mount Vernon, MO
26	Kansas City, KS	Leavenworth, KS	Topeka, KS	Columbia, MO	Wichita, KS
27	Jackson, MS	New Orleans, LA	Alexandria, LA	Baton Rouge, LA	None
28	Shreveport, LA	Little Rock, AR	None	Beaumont, TX	Houston, TX
29	Oklahoma City, OK	Tulsa, OK	Muskogee, OK	Ft Smith, OK	Fayetteville, AR
30	Dallas, TX	Bonham, TX	Ft Worth, TX	Waco, TX	None
31	Harlingen, TX	McAllen, TX	Corpus Christie, TX	None	None
32	San Antonio, TX	Temple, TX	Austin, TX	None	None
33	San Diego, CA	Mission Valley, CA	Prescott, AZ	Mesa, AZ	Phoenix, AZ
34	Amarillo, TX	Big Spring, TX	None	None	None
35	Tucson, AZ	El Paso, TX	Albuquerque, NM	None	None
36	Portland (East), OR	Portland (Main), OR	Vancouver, WA	Seattle, WA	Tacoma, WA
37	Portland (West), OR	Eugene, OR	Roseburg, OR	White City, OR	Spokane, WA
38	Cheyenne, WY	Denver, CO	Colorado Springs, CO	None	None
39	Walla Walla, WA	Boise, ID	None	None	None
40	Grand Junction, CO	Salt Lake City, UT	None	None	None
41	San Francisco, CA	Palo Alto, CA	Livermore, CA	San Jose, CA	Fresno, CA
42	Redding, CA	Reno, NV	Sacramento, CA	Martinez, CA	None
43	Oceanside, CA	Loma Linda, CA	Long Beach, CA	West Los Angeles, CA	Sepulveda, CA
44	Las Vegas (Main), NV	Las Vegas (NW), NV	Las Vegas (NE), NV	Las Vegas (SW), NV	Las Vegas (SE), NV
45	Ft Meade, SD	Hot Springs, SD	None	None	None
46	Ft Harrison, MT	Billings, MT	Sheridan, MT	None	None

Trip #	May 12	May 13	May 14	May 15	May 16
47	Grand Island, NE	Lincoln, NE	Omaha, NE	Des Moines, IA	Iowa City, IA
48	Fargo, ND	Sioux Falls, ND	St. Cloud, MN	Minneapolis, MN	None
49	Louisville, KY	Lexington, KY	Knoxville, TN OPC	Chattanooga, TN OPC	None
50	Hampton, VA	Huntington, VA	Beckley, WV	Coatesville, PA	None
51	None	None	None	Anchorage, AK	None
52	None	None	None	None	San Juan, PR

B.2 Phase Two Sites Visited (Label of Y indicates the site visit was completed).

Trip #	Day 1		Day 2		Day 3		Day 4		Day 5			
1	Williston, ND		Minot, ND		Dickinson, ND	Y	Bismarck, ND	Y				
2	Grafton, ND	Y	Grand Forks, ND	Y	Jamestown, ND	Y						
3	Bemidji, ND	Y	Hibbing, MN	Y	Ely, MN	Y	Superior, WI	Y				
4	Fergus Falls, MD	Y	Alexandria, MN		Montevideo, MN		Brainerd, MN	Y				
5	Faith, SD	Y	Pierre, SD	Y	Isabel, SD	Y						
6	Aberdeen, SD	Y	McLaughlin, SD		Eagle Butte, SD	Y	Watertown, SD	Y				
7	Mission, SD	Y	Winner, SD	Y	Wagner, SD	Y	O'Neill, NE	Y				
8	Newcastle, WY		Pine Ridge, SD		Gordon, NE		Rapid City, SD	Y				
9	Hayward, WI	Y	Rice Lake, WI	Y	Maplewood, WI	Y	Chippewa Valley, WI	Y	Ramsey, MN	Y		
10	Mankato, MN		St. James MN		Spirit Lake, IA		Rochester, MN	Y	Albert Lea, MN	Y		
11	Sioux City, IA	Y	Norfolk, NE	Y	Carroll, IA	Y	Fort Dodge, IA	Y				
12	Mason City, IA	Y	Decorah, IA	Y	Waterloo, IA		Marshalltown, IA		Knoxville, IA			
13	Dubuque, IA		Cedar Rapids, IA	Y	Coralville, IA	Y	Bettendorf, IA					
14	Sterling, IL		Galesburg, IA		Ottumwa, IA		Quincy, IL					
15	North Platte, NE	Y	Holdrege, NE	Y	Bellevue, NE		Shenandoah, IA	Y				
16	Mount Vernon, WA	Y	Bremerton, WA	Y	Bellevue, WA	Y	Lake City, WA	Y	Port Angeles, WA	Y		
17	Chehalis, WA	Y	Warrenton, OR	Y	Federal Way, WA	Y	West Linn, OR	Y				
18	The Dales, OR	Y	Yakima, WA	Y	Richland, WA	Y	Wenatchee, WA	Y	Boardman, OR	Y		
19	Newport, OR	Y	Salem, OR	Y	Bend, OR	Y	Burns, OR					
20	**No longer a trip**											
21	Kalispell, MT	Y	Libby, MT	Y	Coeur d'Alene, ID		Lewiston, ID					
22	Enterprise, OR		LaGrande, OR	Y	Caldwell, ID	Y	Mountain Home, ID	Y	Twin Falls, ID			

Trip #	Day 1		Day 2		Day 3		Day 4		Day 5			
23	North Bend, OR		Brookings, OR	Y	Grants Pass, OR							
24	Yreka, CA		Eureka, CA		Klamath Falls, OR							
25	Ukiah, CA	Y	Clearlake, CA	Y	Chico, CA	Y	Yuba City, CA	Y	McClellan Park, CA	Y		
26	Susanville, CA	Y	Auburn, CA	Y	Fallon, NV	Y	Gardnerville, NV	Y				
27	Santa Rosa, CA		Fairfield/Travis, CA		Mare Island, CA							
28	Winnemucca, NV											
29	Oakland, CA	Y	SF Downtown, CA		San Bruno, CA		Fremont, CA	Y	Monterey, CA/Capitola, CA			
30	Stockton, CA				Modesto, CA	Y	Sonora, CA	Y				
31	Oakhurst, CA	Y	Atwater/Merced, CA	Y	Tulare, CA	Y						
32	Santa Maria, CA	Y	Santa Barbara, CA	Y	Oxnard, CA	Y	San Luis Obispo, CA	Y	Bakersfield, CA	Y		
33	Antelope Valley, CA	Y	Victorville, CA	Y	Rancho Cucamonga, CA	y						
34	East Los Angeles, CA		Gardena, CA									
35	Whittier/Santa Fe Springs, CA	Y	Cabrillo, CA	Y	Anaheim, CA	Y	Corona, CA	Y				
36	Santa Ana, CA	Y	Laguna Hills, CA	Y	Murrieta, CA	Y	Palm Desert, CA	Y	Yuma, AZ	Y		
37	Escondido, CA	Y	Chula Vista, CA	Y	Imperial Valley, CA	Y	Oceanside, CA	Y	Mission Valley, CA			
38	Cutbank, MT	Y	Great Falls, MT	Y	Glasgow, MT							
39	Salmon, ID		Missoula, MT	Y	Anaconda, MT	Y	Bozeman, MT	Y				
40	Lewiston, MT		Glendive, MT		Miles City, MT							
41	Powell, WY	Y	Gillette, WY	Y	Casper, WY	Y	Riverton, WY	Y				
42	Pocatello, ID	Y	Roosevelt, UT		Rock Springs, WY							

Trip #	Day 1		Day 2		Day 3		Day 4		Day 5			
43	Ogden, UT	Y	W Salt Lake Valley, UT	Y	Orem, UT							
44	Fort Collins, CO				Greeley, CO		Golden, CO	Y	Aurora, CO	Y		
45	Sidney, NE	Y										
46	Montrose, CO		Durango, CO	Y	Farmington, NM	Y						
47	Lamar, CO	Y	La Junta, CO	Y	Pueblo, CO	Y	Alamosa, CO	Y	Raton, NM	Y		
48	Kingman, AZ	Y	Lake Havasu, AZ	Y	Flagstaff, AZ	Y						
49	Show Low, AZ	Y	Globe, AZ		Safford, AZ							
50	Cottonwood, AZ		Payson, AZ	Y	Phoenix (Thunderbird), AZ	Y	Surprise, AZ		SE Gilbert, AZ/Anthem, AZ			
51	Casa Grande, AZ	Y	Green Valley, AZ	Y	Sierra Vista, AZ		Tucson, AZ (NW)		Tucson, AZ (SE)			
52	Childress, TX	Y	Lubbock, TX	Y	Stamford, TX		Abilene, TX					
53	San Angelo, TX	Y	Big Spring, TX	Y	Odessa, TX	Y	Fort Stockton, TX					
54	Gallup, NM	Y	Espanola, NM	Y	Las Vegas, NM	Y	Santa Fe, NM	Y	Dalhart, TX	Y		
55	Clovis, TX		Hobbs, TX		Artesia, TX		Alamogordo, TX	Y	Las Cruces, TX	Y	Eastside El Paso, TX	
56	Rio Rancho, NM		Truth or Consequence, NM	Y	Silver City, NM							
57					Del Rio, TX	Y	Laredo, TX	Y				
58	Polk Street Annex Clinic	Y	Sherman, TX	Y	Bridgeport, TX	Y	Denton, TX	Y	Greenville, TX	Y	Bonham, TX	Y
59	Brownwood, TX	Y	Granbury, TX	Y	Tyler, TX	Y	Palestine, TX	Y	Sherman, TX	Y		
60	New Braufels, TX		Cedar Park, TX	Y	College Station, TX	Y	La Grange, TX	Y				
61	Beeville, TX	Y	Seguin, TX		South Bexar County, San Antonio, TX	Y	Pecan Valley, San Antonio, TX	Y	Victoria, TX	Y		
62	LaSalle, IL	Y	Joliet, IL	Y	Manteno, IL	Y						

Trip #	Day 1		Day 2		Day 3		Day 4		Day 5			
					(Kankakee)							
63	Oak Lawn, IL	Y	Chicago Heights, IL	Y	Auburn Gresham, IL	Y	Lakeside, IL		Evanston, IL			
64	Freeport, IL	Y	Rockford, IL	Y	Aurora, IL		McHenry, IL		Elgin, IL			
65	Janesville, WI	Y	Union Grove, WI	Y	Kenosha, WI	Y						
66	Baraboo, WI		LaCrosse, WI		Beaver Dam, WI	Y	Cleveland, WI		LaCrosse #2, WI			
67	Loyal, WI/Clark County, WI		Wisconsin Rapids, WI		Green Bay, WI							
68	Rhinelander, WI	Y	Wausau, WI	Y	Menominee, WI	Y						
69	Ironwood, MI	Y	Hancock, MI	Y	Marquette, MI	Y	Sault St. Marie, MI	Y	Manistique, MI			
70	Bangor, ME/Lincoln, ME	Y	Caribou, ME	Y			Calais, ME	Y				
71	Tilton, NH	Y	Conway, NH	Y	Rumford, ME		Lewiston, ME		Bingham, ME			
72	Portland, ME	Y	Saco, ME	Y	Somersworth, NH	Y	Portsmouth, NH		Haverhill, MA			
73	Littleton, NH	Y	Burlington, VT	Y	Rutland, VT	Y	Bennington, VT					
74	Brattleboro, VT		Keene, NH		Fitchburg, MA	Y	Greenfield, MA	Y	Pittsfield, MA	Y		
75	Lowell, MA	Y	Gloucester, MA	Y	Lynn, MA	Y	Causeway St, Boston, MA	Y	Quincy, MA	Y		
76	Middletown, RI	Y	New Bedford, MA	Y	Oak Bluff, MA		Hyannis, MA	Y	Plymouth, MA			
77	New London, CT	Y	Willimantic, CT	Y	Winsted, CT	Y	Waterbury, CT	Y	Danbury, CT	Y		
78	Plattsburgh, NY		Malone, NY	Y	Massena, NY	Y	Saranac Lake, NY		Westport, NY			
79	Troy, NY	Y	Clifton Park, NY	Y	Glen Falls, NY	Y	Fonda, NY	Y	Schenectady, NY	Y		
80	Rome, NY	Y	Watertown, NY	Y	Oswego, NY	Y	Auburn, NY	Y	Freeville, NY	Y		
81	Bainbridge, NY		Binghamton, NY		Elmira, NY		Mansfield, PA		Coudersport, PA			
82	Niagara Falls, NY		Lockport, NY	Y	Lackawanna, NY	Y	Springville, NY	Y	Dunkirk, NY	Y		
83	Wellsville, NY	Y	Olean, NY	Y	Jamestown, NY	Y	McKean, PA		Warren, PA	Y		

Trip #	Day 1		Day 2		Day 3		Day 4		Day 5			
84	Catskill, NY	Y	Kingston, NY	Y	Sayre, PA	Y	Williamsport, PA	Y	Columbia County, PA			
85	Tobyhanna, PA	Y	Pottsville, PA	Y	Reading, PA		Frackville, PA	Y	Northampton County, PA	Y		
86	Camp Hill, PA	Y	York, PA	Y	Lancaster, PA		Spring City, PA		Springfield, PA			
87			Fort Dix, NJ	Y	Camden, NJ	Y	Atlantic County, NJ		Gloucester, NJ	Y		
88	Cumberland County, NJ	Y	Kent County, DE		Cape May County, DE	Y	Sussex County, DE		Cambridge, MD	Y		
89	Ft. Howard, MD	Y	Ft. Meade, MD	Y	Greenbelt, MD	Y	Glen Bernie, MD	Y				
90	Ft. Belvoir, VA	Y	Southeast, DC	Y	S. PG County, MD	Y	Charlotte Hall, MD	Y	Pocomoke City, MD	Y		
91	Fort Detrick, MD	Y	Hagerstown, MD	Y	Cumberland, MD	Y	Petersburg, WV	Y	Stephens City, VA	Y		
92	Ashtabula, OH	Y	Crawford, PA	Y	Venango, PA	Y	Clarion County, PA		Dubois, PA			
93	Mercer County, PA	Y	Lawrence County, PA	Y	Beaver County, PA	Y	Cranberry Township, PA	Y	Armstrong County, PA			
94	State College, PA	Y	Westmoreland, PA		Washington County, PA		Fayette County, PA		Belmont County, OH/Johnstown, PA	Y		
95	Monongalia County, WV	Y	Wood County, WV	Y	Braxton County, WV		Tucker County, WV		Franklin, WV	Y		
96	Morristown, NJ		Piscataway, NJ	Y	Hamilton, NJ	Y	Tinton Falls, NJ	y	Elizabeth, NJ	Y		
97	Paterson, NJ		Port Jarvis, NJ	Y	Goshen, NJ	Y	Monticello, NJ	Y				
98	White Plains, NY		New City, NY	Y	Carmel, NY	Y	Poughkeepsie, NY	Y	Pine Plains, NY	y		
99	Newark, NJ		Hackensack, NJ	Y	Yonkers, NY		Harlem, NY		Jersey City, NJ			
100	Staten Island, NY		Chapel Street (NYC), NY		Valley Stream, NY	Y	Sunnyside(NYC), NY		Stamford, CT	Y		
101	East Meadows, NY	Y	Bay Shore, NY		Patchogue, NY		Riverhead, NY	Y				

Trip #	Day 1		Day 2		Day 3		Day 4		Day 5			
102	Lynchburg, VA	Y	Charlottesville, VA	Y	Staunton, VA	Y	Harrisonburg, VA	Y	Fredericksburg, VA	Y		
103	Greenbrier, WV	Y	Tazewell, VA	Y	Wytheville, VA	Y	Danville, VA		Emporia, VA			
104	Virginia Beach, VA	Y	Elizabeth City, NC (Albemarle)	Y	Goldsboro, NC	Y	Wilmington, NC	Y	Greenville, NC			
105			Hamlet, NC	Y	Robeson, NC	Y	Jacksonville, NC	Y	Morehead City, NC			
106	Hickory, NC	Y	Rutherfordton, NC	Y	Franklin, NC	Y	Blairsville, GA	Y	Oakwood, GA	Y		
107	Rock Hill, SC/Sumter, SC	Y	Spartanburg, SC	Y	Anderson, SC	Y	Florence, SC	Y	Aiken, SC	Y		
108	Orangeburg, SC/Trident, SC	Y	Beaufort, SC	Y	Brunswick, GA		Valdosta, GA		Hinesville, GA	Y	Waycross, GA	
109	Columbus, GA	Y	Perry, GA	Y	Albany, GA		Dothan, GA		Baldwin County, FL			
110	Macon, GA	Y	Newnan, GA		Ft. McPhearson, GA	Y	Stockbridge, GA		Carrollton, GA			
111	Lawrenceville, GA	Y	Smyrna, GA	Y	Rome, GA	Y			Athens, GA			
112	Jasper, AL	Y	Gadsden, AL	Y	Decatur, AL	Y	Shoals Area, AL	Y	Huntsville, AL	Y		
113	Columbus, MS	Y	Smithville, MS	Y	Kosciusko, MS		Meridian, MS		Hattiesburg, MS			
114	Natchez, MS	Y	Macomb, MS		Bogalusa, LA		Slidell, LA		Hammond, LA	Y		
115	St. John, LA	Y	Houma, LA	Y	Franklin, LA	Y	Lafayette, LA		Baton Rouge, LA	Y		
116	Jennings, LA	Y	Lake Charles, LA	Y	Ft Polk, LA	Y	Natchitoches, LA	Y	Monroe, LA			
117	Longview, TX		Texarkana, TX		El Dorado, AR		Greenville, MS	Y	Pine Bluff, AR	Y		
118	Richmond, TX		Texas City, TX	Y	Galveston, TX	Y	Lake Jackson, TX	Y				
119	Katy, TX	Y	Tomball, TX	Y	Conroe, TX	Y	Charles Wilson, TX	Y				
120	Hot Springs, AR	Y	Mena, AR	Y	Hartshorne, OK		Ada, OK					
121	Altus, OK	Y	Lawton, OK	Y	Wichita Falls, TK		Ardmore, OK					
122	Stillwater, OK	Y	Enid, OK	Y	Blackwell, OK	Y	Vinita, OK		Jay, OK			

Trip #	Day 1		Day 2		Day 3		Day 4		Day 5			
123	Harrison, AR	Y	Branson, MO	Y	Mountain Home, AR	Y	Mt. Vernon, MO	Y				
124	Conway, AR	Y	Russellville, AR	Y	Ozark, AR	Y	Searcy, AR	Y				
125	Liberal, KS		Dodge City, KS		Hays, KS		Salina, KS		Hutchinson, KS			
126	Emporia, KS		Chanute, KS		Parsons, KS		Ft Scott, KS		Nevada, KS			
127	Junction City, KS	Y	Ft Riley, KS		Seneca, KS		St. Joseph, KS					
128	Cameron, KS	Y	Kirksville. MO	Y	Excelsior Springs, MO	Y						
129	Wyandotte, KS	Y	Lawrence, KS	Y	Garnett, KS		Paola, KS		Belton, KS	Y		
130	Warrensburg, MO	Y	Sedalia, MO	Y	Jefferson City, MO	Y	Mexicon, MO	Y				
131	Lake of Ozarks, MO	Y	Marshfield, MO	Y	Ft Leonard Wood, MO	Y	St. James, MO	Y	Salem, MO			
132	Bellville, MO		St Louis CBOC, MO	Y	St Charles, MO	Y	Washington, MO	Y	Farmington, MO			
133	Mayfield, KY	Y	Sikeston, MO	Y	Paragould, AR		Pocahontas, AR	Y	West Plains, AR			
134	Paducah, KY	Y	Cape Girardeau, MO	Y	Carbondale, IL	Y	Mount Vernon, IL	Y	Harrisburg, IL	Y		
135	Hanson, KY	Y	Owensboro, KY	Y	Evansville, IL	Y	Vincennes, IL	Y	Effingham, IL	Y		
136	Martinsville, IN	Y	Bloomington, IN	Y	Terra Haute, IN	Y	Lafayette, IN	Y				
137	Springfield, IL	Y	Decatur, IL	Y	Mattoon, IL	Y						
138	Muncie, In	Y	Peru, IN	Y	Goshen, IN	Y	South Bend, IN	Y				
139	Benton Harbor, MI	Y	Muskegon, MI	Y	Cadillac, MI	Y	Claire, MI	Y	Lansing, MI	Y		
140	Gaylord, MI		Cheboygan, MI		Traverse City, MI		Alpena, MI		Oscoda, MI/Grand Rapids, MI			
141	Pontiac, MI	Y	Yale, MI	Y	Bad Axe, MI	Y	Grayling, MI	Y	Flint, MI	Y		
142	Jackson, MI		Lima, OH		Springfield, OH	Y	Richmond, IN	Y				
143	Middletown, OH	Y	Hamilton, OH	Y	Dearborn, IN	Y	Bellevue, KY	Y	Florence, KY	Y	Lawrenceburg, IN	Y

Trip #	Day 1		Day 2		Day 3		Day 4		Day 5			
144	Clermont County, OH	Y	Georgetown, OH	Y	Portsmouth, OH		Athens, OH		Lancaster, OH			
145	Grove City, OH	Y	Newark, OH	Y			Marietta, OH	Y				
146	Marion, OH	Y	Mansfield, OH	Y	Sandusky, OH	Y	McCaferty, OH	Y				
147	Zanesville, OH	Y	Cambridge, OH	Y	New Philadelphia, OH	Y	East Liverpool, OH	Y				
148	Ravenna, OH		Warren, OH	Y	Painesville, OH		Akron CBOC, OH					
149	St Augustine, FL	Y	Palatka, FL	Y	Orange City, FL	Y	St. Mary's, FL					
150	Kissimmee, FL	Y	Leesburgh, FL	Y			Clermont, FL	Y	Lecanto, FL	Y		
151	Lakeland, FL	Y	Zephyrhills, FL	Y	Brookville, FL	Y	Palm Harbor, FL	Y	St. Petersburg, FL			
152	Sebring, FL		Okeechobee, FL		Port Charlotte, FL		Naples, FL	Y				
153	Hollywood, FL	Y	Homestead, FL	Y	Key Largo, FL	Y	Key West, FL					
154	Miami (CBOC), FL		Pembroke Pines, FL	Y	Deerfield Beach, FL	Y	Boca Raton, FL	Y	Del Ray Beach, FL	Y		
155	Ft. Pierce, FL		Vero Beach, FL		Stuart, FL	Y	Port St. Lucie	Y				
156	Helena, AR	Y	Memphis South, TN	Y	Byhalia, MS	Y	Jonesboro, AR	Y	Covington, TN	Y		
157	Jackson, TN/Savannah, TN	Y	Dyersburg, TN	Y	Dover, KY		Clarkesville, TN		Hopkinsville, KY			
158	Maury County, KY	Y	Tullahoma, TN	Y	McMinnville, TN	Y	Coopersville, TN	Y				
159	Morristown, TN		Roane County, TN	Y	Sevierville , TN		Rogersville, TN					
160	Bowling Green, KY	Y			Grayson County, KY	Y	Ft Knox, KY	Y	Newberg, KY	Y		
161	Shivery, KY		DuPont, KY	Y	New Albany, IN	Y	Scott County, KY	Y	Carroll County, KY	Y		
162	Charleston, WV	Y	Prestonsburg,	Y			Norton, VA		Bristol, VA			

Trip #	Day 1		Day 2		Day 3		Day 4		Day 5			
			KY									
163	Gallipolis, OH	Y	Lenore, WV	Y								
164	Biloxi VAMC		Panama City, FL	Y	Eglin ARB	Y	Marianna, FL	Y				
165												
166	Springfield, MA		Worcester, MA	Y	Farmington, MA	Y						
167	Selma	Y	Monroeville, AL	Y	Ft. Rucker	Y	Guntersville	Y				
168	Colville, WA	Y	Republic, WA	Y	Ponderay, ID	Y	Tonasket, WA	Y				
169	St. George, UT	Y	Pahrump, CA	Y								
170	NE 410, San Antonio, TX		NW 410, San Antonio, TX/SW Military Clinic, San Antonio, TX		North Central, San Antonio, TX	Y	Valcones Heights, San Antonio, TX		Shavano Park, San Antonio, TX	Y		
171	Oxford, AL	Y	Childersburg, AL	Y	Bessemer, AL	Y						
172	Hazard, KY	Y	Berea, KY	Y	Somerset, KY	Y	Morehead, KY	Y				
173	Scotts Bluff, NE	Y										
172 - San Juan	Arecibo, SJ	Y	Ponce, SJ	Y	Mayaguez, SJ	Y	Guayama, SJ	Y	Ceiba, SJ	Y		
173 - Haw	VA Pacific Islands, Honolulu, HI	Y	Hilo, HI	Y	Kona, HI	Y	Ewa Beach, HI (Leeward CBOC)	Y	Maui, HI	Y		
	Kauai, HI (173)	Y	Kahului (173)	Y	Batavia, NY	Y	Kerrville, TX		Newington, CT	Y		
Total By Day		124		131		114		94		54		
Complete Total		517										
Total to Visit		746										

Appendix C: Phase One Sites Determined to Require a Further Review

C.1 Phase One Sites Requiring Further Review

The table below provides a list of sites determined to require a further review based on assessment of site team reports. **Overall, 81 (37%) of the sites from the 216 sites visited in the Phase One Access Audit require further review.** This initial assessment of sites requiring further review is based on a review of qualitative responses by front-line staff to questions contained in site audit reports. The listing of these sites should be understood **as a preliminary step, and further actions will be taken after the determination of the extent of issues** related to scheduling and access management practices.

	VISN	Facility Name	Requires Further Review
1	1	VA Central Western Mass, MA	Yes
2	1	Boston (Brockton), MA	Yes
3	3	New Jersey Health Care System (HCS) Lyons Campus, NJ	Yes
4	3	Castle Point Campus Hudson Valley VA HCS, NY	Yes
5	4	Clarksburg VA Medical Center (VAMC), WV	Yes
6	4	Philadelphia VAMC, PA	Yes
7	4	Pittsburgh University Drive, PA	Yes
8	4	Wilmington VAMC, DE	Yes
9	4	Altoona, PA	Yes
10	4	Erie, PA	Yes
11	4	Lebanon VAMC, PA	Yes
12	4	Horsham/Willow Grove Community Based Outpatient Clinic (Philadelphia), PA	Yes
13	5	Martinsburg VAMC, WV	Yes
14	5	Washington, DC	Yes
15	6	Raleigh CBOC, NC	Yes
16	6	Richmond VAMC, VA	Yes
17	6	Charlotte, NC	Yes
18	7	Charleston, SC	Yes
19	7	Myrtle Beach SC	Yes
20	7	Savannah, GA	Yes
21	7	Dublin, GA	Yes
22	7	Montgomery, AL	Yes
23	7	Tuskegee, AL	Yes
24	7	Augusta, GA	Yes

	VISN	Facility Name	Requires Further Review
25	7	Columbia, SC	Yes
26	7	Atlanta, GA	Yes
27	8	Gainesville, FL	Yes
28	8	Sarasota CBOC, FL	Yes
29	8	San Juan, PR	Yes
30	8	Bay Pines, FL	Yes
31	8	Lake City, FL	Yes
32	9	Nashville Main Campus, TN	Yes
33	9	Memphis, TN	Yes
34	9	Chattanooga CBOC, TN	Yes
35	10	Cleveland, OH	Yes
36	10	Cincinnati, OH	Yes
37	11	Ann Arbor HCS, MI	Yes
38	11	Indianapolis, IN	Yes
39	11	Danville, IL	Yes
40	11	Peoria, IL	Yes
41	12	Hines VAMC, IL	Yes
42	12	Adam Benjamin Jr. Clinic (Crown Point)	Yes
43	12	Madison VAMC, WI	Yes
44	15	Wichita, KS	Yes
45	15	Leavenworth, KS	Yes
46	15	Marion, IL	Yes
47	16	New Orleans, LA	Yes
48	16	Shreveport, LA	Yes
49	16	Alexandria, LA	Yes
50	16	Mobile, AL	Yes
51	16	Houston, TX	Yes
52	16	Baton Rouge, LA	Yes
53	16	Pensacola, FL	Yes
54	17	South Texas Veterans HCS (San Antonio), TX	Yes
55	17	Central Texas HCS (Temple), TX	Yes
56	17	Dallas, TX	Yes
57	17	Fort Worth, TX	Yes
58	17	Corpus Christi Outpatient Clinic and PACT Annex, TX	Yes
59	17	Harlingen (Texas Coastal Bend HCS), TX	Yes
60	17	McAllen (Texas Coastal Bend HCS), TX	Yes
61	17	Central Texas Health Care System – Austin, TX	Yes
62	18	Big Springs (West TX VA Medical Center), TX	Yes

	VISN	Facility Name	Requires Further Review
63	18	New Mexico VA Health Care System (Albuquerque), NM	Yes
64	18	Prescott, AZ	Yes
65	19	Fort Harrison, MT	Yes
66	19	Billings (CBOC), MT	Yes
67	19	Grand Junction, CO	Yes
68	19	Cheyenne, WY	Yes
69	19	Colorado Springs CBOC, CO	Yes
70	20	Spokane, WA	Yes
71	20	VA Puget Sound HCS (Seattle Division), WA	Yes
72	20	VA Puget Sound HCS (American Lake Division), WA	Yes
73	20	Walla Walla VAMC, WA	Yes
74	20	Portland VAMC (Vancouver Campus), WA	Yes
75	20	Portland VAMC (Oregon Campus), OR	Yes
76	20	Roseburg, OR	Yes
77	21	Livermore VAMC, CA	Yes
78	22	Sepulveda (Los Angeles), CA	Yes
79	22	Las Vegas (Main), NV	Yes
80	22	Las Vegas Southwest (CBOC), NV	Yes
81	23	Minneapolis HCS, MN	Yes

C.1 Phase Two Sites Requiring Further Review

The table below provides a list of sites determined to require a further review based on assessment of site team reports. **Overall, 30 sites in the Phase Two Access Audit require further review.** This initial assessment of sites requiring further review is based on a review of qualitative responses by front-line staff to questions and comments contained in site audit reports. The listing of these sites should be understood **as a preliminary step, and further actions will be taken after the determination of the extent of issues** related to scheduling and access manage

	VISN	Facility Name	Requires Further Review
1	4	Westover, WV	Yes
2	4	Wood County, WV	Yes
3	6	Virginia Beach, VA	Yes
4	6	Elizabeth City, NC	Yes
5	6	Wilmington, NC	Yes
6	6	Jacksonville, NC CBOC	Yes
7	7	Smyrna/Austell, GA	Yes
8	8	San Juan Primary Care, PR	Yes
19	9	McMinnville, TN	Yes
10	9	DuPont, KY	Yes
11	9	Ft. Knox, KY	Yes
12	10	Richmond, IN CBOC	Yes
13	11	Muskegon, MI CBOC	Yes
14	11	Lansing, MI CBOC	Yes
15	12	Joliet, IL CBOC	Yes
16	12	Kenosha, WI Clinic	Yes
17	12	Janesville, WI Clinic	Yes
18	15	West Plains, MO	Yes
19	16	Gulf Coast HCS, MS	Yes
20	16	Hot Springs, AR	Yes
21	16	Eglin, FL CBOC	Yes
22	19	Great Falls CBOC, MT	Yes
23	20	South Sound CBOC (Chihalis, WA)	Yes
24	20	Wenatchee, WA CBOC	Yes
25	21	Yuba City	Yes
26	22	Escondido, CA CBOC	Yes
27	22	Imperial Valley, CA	Yes
28	23	Rapid City, SD CBOC	Yes
29	23	Prairie Health: Faith, Isabel and, Eagle Butte CBOCs, SD	Yes
30	23	Rochester, MN	Yes

Appendix D: Further Data Tables

This section contains certain additional tabular reports from the Access Audit questionnaires. It is noteworthy that there are many opportunities (highlighted in yellow) to increase the consistency of desirable practices within VA facilities

D.1 Customer Service Emphasis

	Responses	% "Yes"	% Facilities with at least 1 Response "Yes"	% Facilities with >25% Responses "Yes"	% Facilities with >75% Responses "Yes"
Q35. Are patients on the missed opportunity list **called to remind them** of upcoming appointments?	2,893	57	140 (100 %)	127 (91 %)	35 (25 %)

Self Rating of Customer Service (1=poor, 2=fair, 3=good, 4=very good, 5=excellent)	Responses	Mean Score	% Facilities with mean rating 3 or greater	% Facilities with mean rating less than 3
Q24. Please rate yourself on customer service	2,925	4.6	140	0
Q25. Please rate your facility on customer service	2,909	4.1	139	1

Respondents indicated that other specific barriers existed to offering Veterans timely access to care.

* indicates mandatory questions	Responses	% "Yes"	% Facilities with at least 1 Response "Yes"	% Facilities with >25% Responses "Yes"	% Facilities with >75% Responses "Yes"
Q18. Are there **other obstacles** to being able to provide Veterans timely access to care?	2,921	51	140 (100%)	129 (92%)	20(14%)

D.2 Supervision for Frontline Staff

* indicates mandatory questions	Responses	% "Yes"	% Facilities with at least 1 Response "Yes"	% Facilities with >25% Responses "Yes"	% Facilities with >75% Responses "Yes"
Q29. Does your supervisor periodically check your work?	3,006	79	140 (100 %)	140 (100 %)	91 (65 %)
Q31. Do you receive any feedback?	2,354	94	140 (100 %)	140 (100 %)	136 (97 %)

	Responses	Daily	Weekly	Monthly	Every 6 mo	Annually	Don't know	other
Q30. How often does your supervisor check your work? (PERCENT)	1539	30%	26%	15%	4%	1%	16%	7%

D.3 Training for Frontline Staff

A large proportion of staff appear to have received training on the scheduling policy, but 50% of schedulers could not recall when their last training had occurred, and, for 14% of schedulers, the training appears to have occurred in anticipation of the audit.

* indicates mandatory questions	Responses	% "Yes"	% Facilities with at least 1 Response "Yes"	% Facilities with >25% Responses "Yes"	% Facilities with >75% Responses "Yes"
Q21. Have you **received training** on the scheduling policy at your facility?	3,052	96	140 (100 %)	140 (100 %)	138 (99 %)

	Responses	Within last week	Within last month	Within last 6 mo	Within last year	More than a year ago	OTHER
Q22. If yes, when was the last training completed? (PERCENT)	1927	14%	0%	0%	23%	14%	50%

D.4 Improvement of Scheduling Practices

* indicates mandatory questions	Responses	% "Yes"	% Facilities with at least 1 Response "Yes"	% Facilities with >25% Responses "Yes"	% Facilities with >75% Responses "Yes"
Q32. Has anything been done at your facility to improve the scheduling process including entry of desired date?	2,950	59	140 (100 %)	137 (98 %)	18 (13 %)

D.5 Regular review by Clinic Managers of Clinic Operations and Access Data.

* indicates mandatory questions	Responses	% "Yes"	% Facilities with at least 1 Response "Yes"	% Facilities with >25% Responses "Yes"	% Facilities with >75% Responses "Yes"
Q56. * Do you **review clinic operations data** (i.e. the Access Index or the like information) at regular team meetings?	259	71%	87%	86%	58%

	Responses	Daily	Weekly	Monthly	Every 6 mo	Annually	Other
Q57. If you review clinic operations data, how often is it reviewed? (PERCENT)	183	13%	35%	36%	5%	0%	12%

Appendix E: Questionnaire

Access and Scheduling Audit 2014

Scheduling Background

The purpose of the visit is to assess the integrity of the scheduling process as it relates to three main issues: 1) Is the desired date entered correctly? 2) Are the pathways to request appointments timely and reliable? and 3) Do clinicians use clinic operations data to manage their access?

Desired Date

VHA scheduling procedure has two steps: first, determine desired date and secondly, make the appointment.

According to VHA Outpatient Scheduling Policies and Procedures 2010-027, desired appointment date is the date the patient or provider wants the patient to be seen. There are two different situations staff must be aware of in determining desired date: 1) Return visit requests by a provider (sometimes called internal demand) and 2) Patient appointment requests (sometimes called external demand). The correct staff procedure to determine desired date is different for each situation. For internal demand, without regard to schedule capacity, the scheduler simply enters the return to clinic request from the provider order date as the desired date. (If for some reason the patient wants to change it, the patient desired date is entered.) In the external demand situation, the scheduler asks (without regard to the scheduler), "when would you like to be seen"? The patient response is entered as the desired date.

The most common error in determining desired date is to look for a future open appointment and offer that time to the patient asking if that time is "ok". If the patient says yes, they put in this date as the desired date. This is not the desired date; it is the next available appointment date.

**Indicates questions are required.*

Is this survey a part of Phase 2 of the Access Stand Down (phase that began on May 19 to include smaller CBOCs)?

YES
NO

1. * VISN:
   [*1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 20, 21, 22, 23*]

2. Location:
   a. *Please select the location of the site visit (if your specific location is not found, please enter the location under the Specify Your Own Value option at the bottom of the list):
      List provided

   b. *Enter facility/clinic name and number:
      [ ]

c. *Please enter the name of the site team member completing the survey (if your name is not found, please enter your name under the Specify Your Own Value option at the bottom of the list):

Lead in questions:

3. Information about the individual being interviewed.

   a. What is your job title?
   [ ]

   b. *Is the interviewee a clinician?
   Yes (proceed to #55)
   No (proceed to #4)

4. *Please explain your understanding of the scheduling process.
   [ ]

5. *For established patients completing a visit with their provider today, how do you determine the desired date when scheduling their future appointments?
   [ ]

6. *Based on the response above, does the clerk report the correct procedure for determining desired date?
   Yes
   No
   Do not know

7. *For patients who call-in or walk-in, how do you determine the desired date for their appointment request?
   [ ]

8. *Based on the above, does the clerk report the correct procedure for determining the desired date?
   Yes
   No
   Do not know

9. *Please describe which appointments would be placed on the electronic waiting list (EWL) and which appointments would be scheduled?
   [ ]

10. *Based on the response above, does the scheduler report correct use of the EWL?
    Yes
    No
    Do not know
11. *Do you track appointment requests in places other than the VISTA scheduling system or EWL?
    Yes
    No
    Do not know

12. Do you feel you receive instruction from the facility to enter a desired date other than the date a Veteran asks to be seen?
    Yes (proceed to question #13)
    No (proceed to question #14)

13. If you do receive instruction from the facility to enter a desired date other than the date a Veteran asks to be seen, please describe how you receive it?
    [ ]

14. On a scale ranging from 1 to 5 (where 1 = never, 2 = rarely, 3 = sometimes, 4 = often, and 5 = always) please rate how often **Training for Administrative or Scheduling Staff like Me** presents challenges to being able to provide Veterans timely access to care:
    (5, 4, 3, 2, 1)

15. On a scale ranging from 1 to 5 (where 1 = never, 2 = rarely, 3 = sometimes, 4 = often, and 5 = always) please rate how often **Using the VistA Scheduling System** presents challenges to being able to provide Veterans timely access to care:
    (5, 4, 3, 2, 1)

16. On a scale ranging from 1 to 5 (where 1 = never, 2 = rarely, 3 = sometimes, 4 = often, and 5 = always) please rate how often **Lack of Provider Slots to Offer Veterans** presents challenges to being able to provide Veterans timely access to care:
    (5, 4, 3, 2, 1)

17. On a scale ranging from 1 to 5 (where 1 = never, 2 = rarely, 3 = sometimes, 4 = often, and 5 = always) please rate how often **The 14 Day Standard** presents challenges to being able to provide Veterans timely access to care:
    (5, 4, 3, 2, 1)

18. Are there **other obstacles** to being able to provide Veterans timely access to care?
    Yes (proceed to question #19 and #20)
    No (proceed to question #21)

19. If there are **other obstacles** to being able to provide Veterans timely access to care, please describe them:
    [ ]
20. On a scale ranging from 1 to 5 (where 1 = never, 2 = rarely, 3 = sometimes, 4 = often, and 5 = always) please rate how often **these other obstacles** present challenges to being able to provide Veterans timely access to care:
    (5, 4, 3, 2, 1, other (fill-in))

21. Have you received training on the scheduling policy at your facility?
    Yes (proceed to question #22)
    No (proceed to question #23)

22. If yes, when was the last training completed?
    Within the last week
    Within the last month
    Within the last 6 months
    Within the last year
    More than a year ago
    Other (fill-in)

23. How does the facility assure excellent scheduling customer service?
    [ ]

24. Please rate yourself from 1 to 5 on customer service (where 5 = excellent, 4 = very good, 3 = good, 2 = fair, 1 = poor):
    (5, 4, 3, 2, 1)

25. Please rate your facility from 1 to 5 on customer service (where 5 = excellent, 4 = very good, 3 = good, 2 = fair, 1 = poor):
    (5, 4, 3, 2, 1)

26. How often is scheduler staffing an issue (where 1 = never, 2 = rarely, 3 = sometimes, 4 = often, and 5 = always)?
    (5, 4, 3, 2, 1, Do not know)

27. Please describe the impacts (if any) of your scheduler vacancy and turnover rates.
[ ]

28. How does the facility audit the scheduling process including entry of desired date?
[ ]

29. Does your supervisor periodically check your work:
Yes (proceed to question #30 and #31)
No (proceed to question #32)
Do not know (proceed to question #32)

30. How often does your supervisor check your work?
Daily
Weekly
Monthly
Every 6 months
Annually
I do not know
Other (fill in)

31. Do you receive any feedback?
Yes
No
Do not know

32. Has anything been done at your facility to improve the scheduling process including entry of desired date?
Yes (proceed to question #33)
No (proceed to question #34)
Do not know (proceed to question #34)

33. Please describe what has been done at your facility to improve the scheduling process including entry of desired date?
[ ]

34. What is the facility policy and practice regarding patients who no-show?
[ ]

35. Are patients on the missed opportunity list called to remind them of upcoming appointments?
Yes
No
Do not know

36. Please describe the facility's efforts to decrease cancellation due to absent providers.
[ ]

37. How much notice do providers give you before taking planned leave?
Never
<7 days
1-2 weeks
2-4 weeks
1-2 months
2-4 months
4-6 months
> 6 months
Other (fill-in)

38. What suggestions do you have for changes and improvement?
[ ]

Appointment Request Pathways

Background: Facilities have at a number of pathways that lead to either an entry on the EWL or an appointment being scheduled. These pathways include: New Enrollees (through the NEAR list), Consults or Orders (typically from the ED), phone calls and in-person requests or other places. The goal of the site visit is to identify each pathway and then review their timeliness and reliability. We suggest using the "tracer" methodology, identify each pathway and follow it from the initial request, through the information system, to the point where it gets either scheduled or on the EWL.
(Click to continue survey)

39. *Do you track appointment requests in places other than the VISTA scheduling system or EWL?
Yes (proceed to question #40)

No (proceed to question #41)
Do not know (proceed to question #41)

40. *If you do track appointment requests in places other than the VISTA scheduling system or EWL, please describe the process:
[ ]

New Enrollee Appointment Requests (NEAR)

41. *Are you aware of the (NEAR) list?
Yes (proceed to question #42)
No (proceed to question #45)
Do not know (proceed to question #45)

42. *If you aware of the (NEAR) list, how often is it processed?
Within 1 day
Within 3 days
Within 7 days
Greater than 7 days
Do not know

43. *If you aware of the (NEAR) list, who processes it?
[ ]

44. *If you aware of the (NEAR) list, how many patients are currently on the NEAR list?
(Number)

Consult or Order Appointment Requests

45. *Are you aware of any consults that are used specifically to request that appointments be scheduled?
Yes (proceed to #46)
No *(proceed to #49)*
Do not know *(proceed to #49)*

46. If you are aware of any consults that are used specifically to request that appointments be scheduled, how often are they processed?
Within 1 day

Within 3 days
Within 7 days
Greater than 7 days
Do not know

47. If you are aware of any consults that are used specifically to request that appointments be scheduled, who processes them?
[ ]

48. If you are aware of any consults that are used specifically to request that appointments be scheduled, how many patients go through this process?
(*Number*)

Phone calls, in-person appointment requests, and any other pathways

49. Please describe how a patient calling or walking in can make an appointment request.
[ ]

50. Who is responsible for scheduling walk in and call in appointment requests?
[ ]

51. *In general what is the response time to address these requests?
Immediately
Within a day
Within 3 days
Longer than a week
Do not know

52. *What is the average daily number of walk in and call in appointment requests?
(*Number*)

53. *Do staff record appointment requests from phone calls or in-person interactions outside of the VISTA scheduling system?
Yes
No
Do not know

54. What suggestions do you have for changes and improvement?
[ ]

(END OF SURVEY FOR NON-CLINICIANS)

Clinician Management of Access

Background: "Scheduling" fails when clinic management and scheduling functions are disconnected from the clinician leadership and engagement in managing clinic access. The knowledge about "how" to manage clinic operations has grown and is contained in the "Advanced Clinic Access" educational tools. With that in mind, it is suggested site visitors limit their questions to assess the clinician level of engagement and understanding in managing access.

(Click to continue survey)

55. *Do you track appointment requests in places other than the VISTA scheduling system or EWL?
    Yes
    No
    Do not know

56. *Do you review clinic operations data (i.e. the Access Index or the like information) at regular team meetings?
    Yes (proceed to question #57)
    No (proceed to question #58)
    Do not know (proceed to question #58)

57. If you review clinic operations data (i.e. the Access Index or the like information) at regular team meetings, how often is it reviewed?
    Daily
    Weekly
    Monthly
    Quarterly
    Annually
    Other(fill-in)

58. *Do you feel you understand scheduling processes and procedures in your clinic (where 5 = excellent, 4 = very good, 3 = good, 2 = fair, 1 = poor)?
    (5, 4, 3, 2, 1)

59. What suggestions do you have for changes and improvement?
    [ ]