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VA Office of Inspector General Releases VISN 6 Access to Care Audit *Access to VA Health Care for New Patients is not Consistently Timely*

WASHINGTON – The VA Office of Inspector General (VA OIG) issued its report, *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6*, reporting that veterans experience a significant delay to access health care in Veterans Integrated Service Network (VISN) 6. Our audit found that 36 percent of appointments for new patients in VISN 6 had to wait longer than 30 days for an appointment during the first quarter of FY 2016. The average wait for new patients was 59 days. This was notably higher than the 10 percent of appointments that the Veterans Health Administration’s (VHA) electronic scheduling system showed were scheduled greater than 30 days. The OIG initiated this audit to review access to care and reliability of wait time data within an entire VISN. The Mid-Atlantic Health Care Network, VISN 6, covers VA medical facilities in Virginia and North Carolina. VISN 6 facilities include medical centers, outpatient clinics, community based outpatient clinics, and vet centers.

“Providing veterans more timely access to VA health care or fee-basis care from VA programs such as the Veterans Choice Program or Patient-Centered Community Care is an important goal,” said Michael J. Missal, Inspector General, U.S. Department of Veterans Affairs, Office of Inspector General. “This audit should help VISN 6 leadership, as well as other VISNs and facilities, provide more timely access to care for veterans.”

In addition to access to VA health care, the audit also examined access to care in the VA’s Veterans Choice Program (Choice). Under the Choice program, veterans who live more than 40 miles away from their VA medical center or have an appointment more than 30 days out may seek community health care that is reimbursed by VA. Our audit found that those veterans who received their care through the Choice program during the first quarter of 2016 had an average wait time of 84 days.

We also found that VISN 6 did not consistently manage the timeliness of specialty care consults in its facilities. The audit also identified weaknesses in the wait time data captured in the VHA’s electronic scheduling system.

OIG and the Government Accountability Office continue to report that access to VA health care is a recurring issue in the VHA. Since wait time issues surfaced in 2014 at the

Phoenix VA Health Care System OIG has continued to identify problems with VHA managing access to care.

The VA OIG conducts oversight of VA and its programs and operations, providing independent and objective reporting to the VA Secretary and the Congress for the purpose of preventing and detecting fraud and abuse, and bringing about positive change in the integrity, efficiency, and effectiveness of VA. To report potential criminal activity, fraud, waste, mismanagement, or other abuse, contact the VA OIG Hotline at vaoghline@va.gov or www.va.gov/oig/hotline/default.asp.

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