

# Understanding Veteran Wait Times

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2014 was a pivotal moment for the U.S. Department of Veterans Affairs (VA). A nonstop drumbeat of media accounts reported an access crisis involving long waitlists for health care and, worse, suggested that some veterans were dying while waiting for care.

The extent of the VA's problems, like access issues in many other health care systems, was not immediately clear. However, the VA had difficult-to-understand wait-time measures, outdated scheduling software, and arbitrary and unrealistic scheduling metrics. The confluence of these problems led to allegations of secret waitlists and resulted in veterans losing trust in the VA.

In the wake of the crisis and in response to public outcry and new requirements from Congress, the VA began publicly posting wait-time data (1). Few if any other health systems had ever done this. The VA was breaking new ground. We consulted with the National Academy of Medicine and other industry and thought leaders (2). It became clear that no standards for wait times existed; the VA would have to create a new set of definitions and terminology.

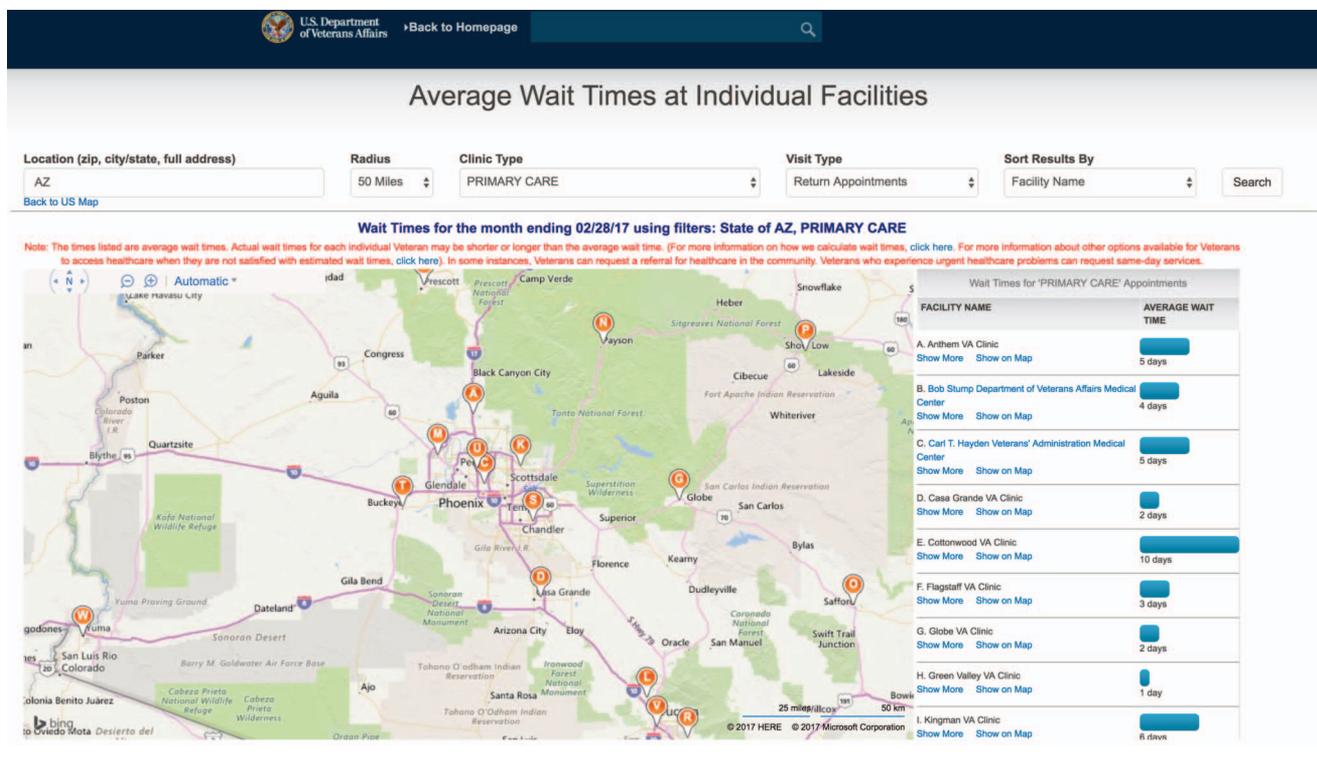
To be transparent and comprehensive, the VA produced reports with many wait-time metrics. These included when veterans requested an appointment

(create date), when they wanted the appointment (preferred date), and when clinicians felt the appointment was necessary (clinically indicated date). This resulted in 22 variations of pending and completed appointments. With almost 58 million appointments a year at more than 1000 locations and a large number of descriptive statistics for each appointment, the result was a data dump in Microsoft Excel spreadsheets (3). Although accurate, these metrics had little meaning to members of Congress who were holding the department accountable, to media reporting on the VA, or to taxpayers who fund the department. Most important, the metrics meant little to veterans who rely on VA care.

I recall sitting for a radio interview and trying to interpret our online wait-time data. It became apparent to me that we had created metrics so complex that, despite my best efforts, few listeners were likely to understand what I said. I realized then that we needed a better system. We needed reports on wait times that veterans could use to make informed decisions and administrators could use to improve our system.

In response to the 2014 access crisis, the VA initially focused only on those veterans waiting the longest for care and failed to differentiate veteran wait

Figure 1. Screenshot of wait-time map of days waiting for Phoenix, Arizona.



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times by clinical urgency. Once we shifted to reporting wait-time data as either “routine” or “urgent,” we began to see the true extent of our access problems. That led us to define solutions and target them to the most urgent locations where the largest number of veterans were at risk while waiting for care (4).

The VA now reports veteran experience data for both routine and urgent care (5). For established patients, we will use a single measure of wait time: the patient-indicated date, which reflects the outcome of a discussion that veterans have with their clinicians. We believe this best reflects the current standard for how appointments are scheduled in the community.

For new patients, the VA will report the wait time from when the veteran requests an appointment (Figure 1). We will report on what veterans say about their experience in obtaining access to care using the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey (as recently recommended and endorsed by the Institute for Healthcare Improvement [6]) for both urgent and routine care. We will also report on locations that provide same-day services, telehealth services, and other urgent care options (Figure 2) (6).

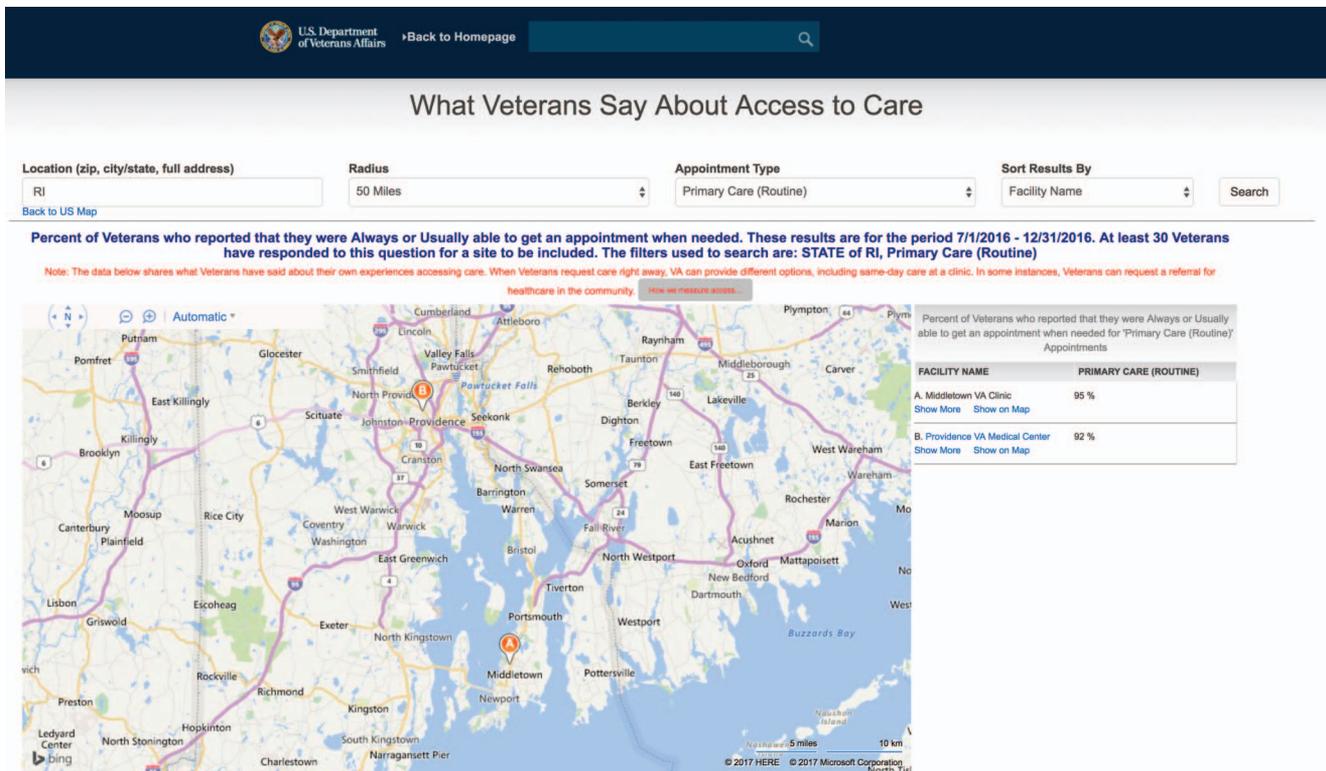
The VA is transitioning measures from a system that has focused almost exclusively on data comparing its performance with other VA hospitals to comparisons between the VA and private sector health care. This approach to measurement reflects closer integration

between the VA and community providers along with our desire to give veterans greater choice for their care. Although several independent assessments have found that the VA provides care that is as good as or superior to that provided by the private sector, we recognize that metrics that describe overall performance can obscure weak performers (7, 8). We also understand that veterans seek comparisons in their community and not at the national level.

This change is difficult for the VA because we have been limited in our ability to find comparable measures in the private sector. For decades, the VA has led in reporting on comprehensive performance metrics in behavioral health, ambulatory care, and management that are not readily found elsewhere in the industry. The VA’s current measurement tool is called Strategic Analytics for Improvement and Learning. As the largest integrated health care system in the nation, we invite others to adopt these metrics, as well as our new wait-time measures, so that our comparisons with the private sector will be more robust (9). As we continually improve our approach to reporting on performance, guided by veteran feedback, we hope other health care organizations will take a similar approach—allowing veterans to truly seek the care that best fits their needs and delivers optimal outcomes.

The VA of the future will be based on how veterans want to receive care. In his 2007 book, *Best Care Anywhere*, Phillip Longman described the VA health care

Figure 2. Screenshot of CAHPS scores from map for Providence, Rhode Island.



CAHPS = Consumer Assessment of Healthcare Providers and Systems.

system as a model system of care (10). A decade later, we are defining our network to include the VA system and our federal, academic, and community partners. We seek to expand the Longman notion and believe we are on the cusp of being able to deliver veterans the “best care everywhere.”

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