Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

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VHA DIRECTIVE 2010-027

June 9, 2010

VHA OUTPATIENT SCHEDULING PROCESSES AND PROCEDURES

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy for implementing processes and procedures for the scheduling of outpatient clinic appointments and for ensuring the competency of staff directly or indirectly involved in any, or all, components of the scheduling process.

2. BACKGROUND

a. It is VHA's commitment to provide clinically appropriate quality care for eligible Veterans when they want and need it. This requires the ability to create appointments that meet the patient's needs with no undue waits or delays. Wait times for patients to be seen through scheduled appointments in primary care and specialty care clinics are monitored. In addition, patients (both new and established) are surveyed to determine if they received an appointment when they wanted one.

b. VHA is mandated to provide priority care for non-emergent outpatient medical services for any condition of a service-connected (SC) Veteran rated 50 percent or greater or for a Veteran's SC disability. Priority scheduling of any SC Veteran must not impact the medical care of any other previously scheduled Veteran. Veterans with SC disabilities are not to be prioritized over other Veterans with more acute health care needs. Emergent or urgent care is provided on an expedient basis. Emergent and urgent care needs take precedence over a priority of service connection.

c. The assurance of timely access to care requires consistent and efficient use of Veterans Health Information Systems and Technology Architecture (VistA) in the scheduling of outpatient clinic appointments.

d. Tracking and assessing the utilization and resource needs for specialty care also require use of the Computerized Patient Record System (CPRS) electronic consult request package.

e. **Definitions**

(1) **Desired Date**. The desired appointment date is the date on which the patient or provider wants the patient to be seen. Schedulers are responsible for recording the desired date correctly.

(2) **Emergent and Urgent Care**

(a) Urgent Care is care for an acute medical or psychiatric illness or for minor injuries for which there is a pressing need for treatment to manage pain or to prevent deterioration of a condition where delay might impair recovery. For example, urgent care includes the follow-up appointment for a patient discharged from a Department of Veterans Affairs (VA) medical facility if the discharging physician directs the patient to return on a specified day for the appointment.

(b) Emergency care is the resuscitative or stabilizing treatment needed for any acute medical or psychiatric illness or condition that poses a threat of serious jeopardy to life, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

(3) **Provider.** A provider is an individual licensed to deliver health care and services to patients.

(4) **Service-Connected (SC).** Service connection or "service-connected" means that VA has determined that a condition or disability was incurred in, or has been aggravated by, military service.

(5) **Non-Service Connected (NSC).** NSC refers to a condition or disability VA has not determined was incurred in, or has been aggravated by, military service.

(6) **New Enrollee.** A new enrollee is a previously non-enrolled Veteran who applies for VA health care benefits and enrollment by submitting VA Form 10-10EZ, Application for Health Benefits, is determined to be eligible, and is enrolled.

(7) **New Enrollee Appointment Request (NEAR) Call List.** The NEAR Call List is a tool to be used by enrollment staff to communicate to Primary Care Management Module (PCMM) Coordinators or schedulers, at the Veteran's designated preferred location, that a newly enrolled Veteran has requested an appointment during the enrollment process.

(8) **Appointment Type.** Using VistA, an outpatient appointment requires the selection of at least one appointment type, which combined with the "Purpose of Visit" code creates one of 40 unique appointment types. Appointment types can be critical when scheduling different types of appointments. Examples of appointment types include: regular, employee, collateral of Veteran, sharing agreement, etc. For a complete list of appointment types, see the Patient Appointment Information Transmission (PAIT) Release Notes and Installation Guide Patch SD*5.3*333 at http://www.va.gov/vdl/documents/Clinical/Patient_Appointment_Info_Transmission/sd_53_p333_rn.doc .

(9) **Newly registered Patient to the Facility.** A newly registered patient to the facility is a Veteran who is enrolled with VHA, but who has not been registered at a specific facility.

(10) **New Patient as Defined for VHA Wait Time Measurement Purposes.** For VHA Wait Time Measurement purposes, a "new patient" is any patient not seen by a qualifying provider type within a defined stop code or stop code group at that facility, within the past 24 months. ***NOTE:*** *See data definitions at http://vssc.med.va.gov/WaitTime/New_Patient_Monitor.asp# . This is an internal VA Web site not available to the public. In order to access this site, VA staff may need to go first to http://vssc.med.va.gov and accept the VHA Support Service Center Data Use Agreement.*

(11) **Electronic Wait List (EWL).** The EWL is the official VHA wait list. The EWL is used to list patients waiting to be scheduled, or waiting for a panel assignment. In general, the EWL is used to keep track of patients with whom the clinic does not have an established relationship (e.g., the patient has not been seen before in the clinic).

(12) **Service Agreement.** A service agreement is a written agreement defining the work flow rules between any two or more services that send work to one another. Ideally, this document is developed based on discussion and consensus between the two or more involved services. The document is signed by service chiefs from involved services. If the agreement is between services at separate facilities, as with inter-facility consult service agreements, it needs to be signed by the Chiefs of Staff of each involved facility.

(13) **Encounter.** An encounter is a professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

(a) Contact can include face-to-face interactions or those accomplished using telecommunications technology.

(b) Encounters are neither occasions of service nor activities incidental to an encounter for a provider visit. For example, the following activities are considered part of the encounter itself and do not constitute encounters on their own: taking vital signs, documenting chief complaint, giving injections, pulse oximetry, etc.

(c) Use of e-mail is limited and does not constitute an encounter. E-mail communications are not secure and e-mails must not contain patient specific information. ***NOTE:*** *Secure messaging communication is available through the My Health**e**Vet (MHV) personal health record (PHR). These communications may meet the definition of an encounter, based on type of message and content.*

(d) A telephone contact between a practitioner and a patient is only considered an encounter if the telephone contact is documented and that documentation includes the appropriate elements of a face-to-face encounter, namely, history and clinical decision-making. Telephone encounters must be associated with a clinic that is assigned one of the Decision Support System (DSS) Identifier telephone codes and are designated as count clinics.

(14) **Occasion of Service.** Formerly known as ancillary service, an "occasion of service" is a specified identifiable instance of an act of technical and administrative service involved in the care of a patient or consumer, which is not an encounter and does not require independent clinical judgment in the overall diagnosing, evaluating, and treating the patient's condition(s).

(a) Occasions of service are the result of an encounter. Clinical laboratory tests, radiological studies, physical medicine interventions, medication administration, and vital sign monitoring are all examples of occasions of service.

(b) Some occasions of service, such as clinical laboratory and radiology studies and tests, are automatically loaded to the Patient Care Encounter (PCE) database from other VistA packages.

(15) **Count.** The term **"**count" refers to workload that meets the definition of an encounter or occasion of service.

(16) **Count versus Non-Count Clinics**. In the creation of Clinic Profiles, clinics are designated as either Count Clinics or Non-Count Clinics. Count Clinics are transmitted to PCE as encounters. Non-Count Clinics are not transmitted to PCE. There are generally two reasons why a clinic might be designated as non-count: if the clinic is administrative in nature and therefore not providing patient care; and if the workload associated with the clinic is transmitted to PCE automatically through another means (a VistA package other than Scheduling) then the clinic is setup as non-count to avoid sending duplicate workload to PCE (for example, occasions of service.)

(17) **DSS Identifiers.** DSS Identifiers are used to measure workload for all outpatient encounters. They are the single designation by which VHA defines clinical work units for costing purposes. In some, but not all cases, DSS Identifiers are defined to be used only for specific Non-Count Clinics assigned to a clinic profile. In these cases, DSS rules must be followed. As a specific example: when a clinic's Primary Stop Code is 674, that clinic is explicitly defined to be a Non-Count Clinic and that is the only way it should be used.

(a) Primary Stop Code. The first three numbers of the DSS Identifier represent the primary stop code. The primary stop code designates the main clinical group responsible for the care. Three numbers must always be in the first three characters of a DSS Identifier for it to be valid.

(b) Secondary Stop Code. The last three numbers of the DSS Identifier contain the secondary or credit stop code, which the VA medical center may use as a modifier to further define the primary work group. For example, a flu vaccination given in Primary Care is designated by 323710. The secondary stop code modifier may also represent the type of provider or team. For example, a Mental Health Clinic run by a social worker can be designated 502125.

(c) Credit Pair. A DSS Identifier Credit Pair is the common term used when two DSS Identifiers, a primary code and a secondary code, are utilized when establishing a clinic in the VistA software. Some specific credit pairs are listed in the DSS Identifier References.

3. POLICY: It is VHA policy that all outpatient clinic appointments, meeting the definition of an encounter, are made in Count Clinics using the VistA Scheduling software in a fashion that best suits patients' clinical needs and preferences; this includes, but is not limited to: appointments made for clinic visits; VA provided home care; consultations; and medical, surgical, dental, rehabilitation, dietetic, nursing, social work, and mental health services and procedures.

NOTE: *The Count Clinic requirement does not include: non-VA care paid through VistA Fee; procedures performed in the operating room and recorded in the VistA Surgery Software; instances where encounters are generated based on unscheduled telecommunication; and occasions of service, such as clinical laboratory, radiology studies, and tests that are automatically loaded to the PCE database. An exception from the requirement of using VistA*

Scheduling software is also extended to providers and programs such as Care Coordination Home Telehealth when encounters are generated based on unscheduled communication.

4. ACTION

a. **Director of Systems Redesign.** The Director, VHA Systems Redesign, within the Office of the Deputy Under Secretary for Health for Operations and Management (10N), is responsible for oversight of implementation of requirements of this Directive, to include measurement and monitoring of ongoing performance.

b. **Veterans Integrated Service Network (VISN) Director.** The VISN Director, or designee, is responsible for the oversight of enrollment, scheduling, processing, consult management, and wait lists for eligible Veterans.

c. **Facility Director.** The facility Director, or designee, is responsible for:

(1) Ensuring that when outpatients are seen for what constitutes an encounter on a "walk-in" basis without an already scheduled appointment, an appointment is recorded in a Count Clinic with the "Purpose of Visit" entered in the VistA Scheduling Software as "unscheduled." ***NOTE:*** *Since unscheduled visits include no entry of "desired date" for wait time measurement, desired date is equated to appointment creation date. In addition, applicable profiles need to be designed to ensure sufficient capacity to accommodate unscheduled "walk-in" patients. Unscheduled encounters that occur via telephone will not be used in the VistA Scheduling Software.*

(2) Ensuring outpatient appointments for diagnostic laboratory and imaging services are not made using count clinics. Non-Count clinics may be used to schedule laboratory and imaging appointments. Requests for laboratory and imaging services must be made by provider orders (not consult requests). Orders transmit directly to the laboratory or radiology software applications. Work performed in response to such orders triggers transmission of encounter data via the VHA PCE software application. ***NOTE:*** *The use of Count Clinics for diagnostic services is inappropriate in part because it would generate duplicate workload reports.*

(3) Defining "standard work" for the clinic teams to most efficiently operate the clinic. This work includes:

(a) Ensuring clinic flow occurs in a standardized manner including patient check-in with scheduling staff, nurse interview, provider visit, and check-out.

(b) Ensuring providers document orders in CPRS and explain rationale and timeframes for medications, diagnostic tests, laboratory studies, return appointments, consultations, and procedures before the patient leaves the examination room.

(c) Ensuring a check out process occurs following each clinic visit. The check-out process may consist of: nurse-administered patient education; clinical pharmacist education and review of prescription orders; collection of patient feedback; scheduling of diagnostic studies; consultations; and follow-up visits. The check-out process must also include verifying that the

disposition of the appointment in the VistA Appointment Management system has been completed.

(d) Ensuring standardized systems are in place to balance supply and demand for outpatient services including continuous forecasting and contingency planning.

(e) Ensuring each clinic follows these additional business rules for standardizing work.

1. Schedules must be open and available for the patient to make appointments at least three to four months into the future. Permissions may be given to schedulers to make appointments beyond these limits when doing so is appropriate and consistent with patient or provider requests. Blocking the scheduling of future appointments by limiting the maximum days into the future an appointment can be scheduled is inappropriate and is disallowed.

2. Synchronize internal provider leave notification practices with clinic slot availability to minimize patient appointment cancellations.

3. Strive to make follow-up appointments "on the spot" for patients returning within the 3 to 4 month window.

4**.** Use the Recall/Reminder Software application to manage appointments scheduled beyond the 3 to 4 month scheduling window.

NOTE**:** *Backlog must be eliminated and demand and supply balanced for the above suggestions to be successful.*

(f) Using the preferred strategy for initiating scheduling which involves:

1. Having the referring providers' team schedule clinical consultation appointments as soon as possible on the day the consult is ordered, before the patient leaves the referring provider team area.

2. Having the treating provider's team either schedule an appointment or, if the timeframe specified by the provider is several months into the future, record in the Recall/Reminder Software application the need for the patient to return to clinic, before the patient leaves the treating provider team area.

a. When a patient needs a follow-up appointment but cannot be immediately scheduled, this need is to be recorded in the Recall/Reminder Software application.

b. The patient must be advised to expect to receive a reminder to contact the clinic to actually schedule an appointment a few weeks prior to the return to clinic timeframe that the provider has specified.

c. The patient needs to be provided information for contacting the clinic at the appropriate time to make the appointment.

3. Having registration or enrollment staff obtain contact information and initiate scheduling action while in direct contact with a newly enrolled or newly registered patient.

(4) Ensuring correct entry of "desired date" for an appointment. The goal is to schedule an appointment on, or as close to the desired date as possible.

(a) For New Patients

1. The scheduler needs to ask the patient: "What is the first day you would like to be seen?" The date the patient provides is the desired date.

2. The desired date is defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date.

3. The third step is to offer and schedule an appointment on or as close to the desired date as possible.

(b) For Established Patients' Return Appointments: A specific or a general timeframe is communicated by the provider and the actual desired date is established by the patient.

1. In order for the provider and scheduler to have a clear understanding of the intent for a return appointment, the provider must document the return date in CPRS, preferably through an order. The provider must specify if the return appointment request is for a specific day, or a general timeframe.

2. In order to establish the actual desired date correctly, the scheduler needs to tell the patient that the provider wants to see them again, giving the patient either the provider's specified date or general timeframe, and asking when the patient would like to be seen. The date the patient provides is the desired date.

3. The desired date needs to be defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date.

4. The scheduler is to offer and schedule an appointment on or as close to the desired date as possible. If there is a discrepancy between the patient and provider desired date, the scheduler must contact the provider for a decision on the return appointment timeframe.

(c) For Patients Scheduled in Response to Intra and Inter Facility Consults

1. The provider specified timeframe for the appointment needs to be the date of the provider request, unless otherwise specified by the provider.

2. In order to establish the actual desired date correctly, the scheduler informs the patient of the provider's specified date or general timeframe and asks the patient "What day would you like to be seen?" The date the patient provides is the desired date.

3. The desired date needs to be defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date.

4. The scheduler offers and schedules an appointment on or as close to the desired date as possible. If the provider has specified a desired date (or "soonest appropriate date") and there is a discrepancy between the patient and provider specified desired date, the scheduler must contact the provider for a decision on the appointment timeframe.

5. In creating an appointment in response to a CPRS consult request, the scheduler must use VistA menu options to link the CPRS consult request to the scheduled appointment.

(5) Ensuring that when an appointment is cancelled and rescheduled by the clinic, the scheduler enters as the desired date for the new appointment the desired date for the original appointment.

(6) Ensuring that if the patient must be contacted to create an appointment, policies are in place that outline actions to be taken to make contact, the number of attempts necessary, and documentation required.

(7) Monitoring telephone access and taking action, as needed, to minimize patient problems in accessing providers, teams, and schedulers by phone.

(8) Implementing standardized processes for enrollment, and the scheduling, processing, and management of appointments, consults, and wait lists for eligible Veterans.

(9) The creation and maintenance of a Master List of all staff members that have any of the VistA Scheduling options that may be used for scheduling patients: PCMM menu options for primary care team or for provider assignments, menu options for entries onto the EWL, and the direct supervisors of all such individuals.

(10) Ensuring successful completion of VHA Scheduler Training by all individuals on the Master List. Menu options for creating outpatient appointments are not to be provided to new schedulers without proof of their successful completion of this training. To retain these menu options, all individuals must complete newly released training for schedulers within 120 days of it being announced. ***NOTE:*** *Details regarding the availability of this training will be posted on the Mandatory Training Web page located at: http://vaww.ees.lrn.va.gov/mandatorytraining . This is an internal Web site and is not available to the public.*

(11) Ensuring all individuals on the Master List have their position description or functional statement include specific responsibilities relative to scheduling, PCMM assignments, and entries into EWL.

(12) Ensuring all individuals on the Master List have, on file with their supervisor, an annual competency assessment that includes their responsibilities relative to scheduling, PCMM assignments, and entries into EWL.

(13) Ensuring completion, using VISN-approved processes and procedures, of a standardized yearly scheduler audit of the timeliness and appropriateness of scheduling actions, and of the accuracy of desired dates.

(14) Ensuring that identified deficiencies in competency or performance, identified by the annual scheduler audit, are effectively addressed.

(15) Ensuring that all clinic profiles are current at all times and subject to an annual review. This review must include compliance in requirements for use of Count versus Non-Count clinics.

(16) Ensuring full compliance by all involved services with Service Agreements. Service agreements must be reviewed and, if necessary, re-negotiated regularly (at least annually).

(17) Measuring and tracking all unused outpatient appointments in count clinics including those from no shows, patient cancellations, and unscheduled appointment slots.

(18) Ensuring that when appointments become available and the facility has at least 3 days to give patients notice, scheduling personnel offer appointments to patients who are either on the EWL waiting for appointments, or currently have appointments more than 30 days past the desired dates of care. ***NOTE****: This applies to management of scheduling in Count Clinics.*

(19) Ensuring that the following Business Rules for Scheduling Outpatient Clinic Appointments are followed.

(a) Patients with emergent or urgent medical needs must be provided care, or be scheduled to receive care, as soon as practicable, independent of SC status and whether care is purchased or provided directly by VA.

(b) Generally, patients with whom the provider does not yet have an established relationship and cannot be scheduled in target timeframes must be put on electronic waiting lists (EWL). VHA's EWL software is used to manage these requests, which usually consist of newly registered, newly enrolled, or new consult requests for patients waiting for their first scheduled appointment. No other wait list formats (paper, electronic spreadsheets) are to be used for tracking requests for outpatient appointments. When patients are removed from the EWL, except for medical emergencies or urgent medical needs, Veterans who are SC 50 percent or greater, or Veterans less than 50 percent SC requiring care for a SC disability must be given priority over other Veterans.

(c) Facilities are required to provide initial triage evaluations within 24 hours for all Veterans either self-requesting or being referred for mental health or substance abuse treatment. Additionally, when follow-up is needed, it must include a full diagnostic and treatment

evaluation within 30 days. ***NOTE:*** *VHA leadership may mandate specific timeframes for special categories of appointments.*

(d) PCMM Coordinators or Scheduling Coordinators must check the Primary Care EWL daily and act on requests received. Schedulers in all clinics at all locations (substations) must review the EWL daily to determine if newly enrolled or newly registered patients are requesting care in their clinic at their location.

(e) A wait list for hospice or palliative care will not be maintained as VHA must offer to provide or purchase needed hospice or palliative care services without delay.

(f) A patient currently or formerly in treatment for a mental health condition, who requests to be seen outside of the clinician desired date range, needs to be seen or contacted within 1 working day by the treatment team for evaluation of the patient's concern.

(g) The VHA Class I Recall/Reminder Software application is used for patients with whom the service has an established relationship. This software application is typically used when the requested follow-up appointment date is more than 3 to 4 months into the future. These patients include those that have either been seen initially in a given VA clinic and need to return in the future; or those who have been seen initially through purchased non-VA care with a plan to be seen in follow-up at the VA clinic. ***NOTE:*** *Even though a patient seen initially through purchased non-VA care may be new to a facility clinic, the organization has committed to this relationship, so Recall/Reminder scheduling may be appropriate.*

(h) Non-VA care may be utilized in accordance with regulatory authority when service is not available in a timely manner within VHA due to capability, capacity, or accessibility. Availability of non-VA care and access to VA care must be taken into account before non-VA care is authorized. An analysis of costs of care needs to be undertaken at appropriate intervals to determine if services could be more efficiently provided within VA facilities. Use of purchased care may only be considered when the patient can be treated sooner than at a VA facility and the service is clinically appropriate and of high quality. Purchased care must only be considered when the request for care can be resolved efficiently, including having results available to the referring facility in a timely manner.

(i) Patients provided authorization for continued non-VA care need to be tracked and brought back within VHA as capacity becomes available. This needs to be from the oldest authorization moving forward, as clinically indicated.

(j) Clinic cancellations, particularly when done on short notice, are to be avoided whenever possible. If a clinic must be canceled or a patient fails to appear for a scheduled appointment, the medical records need to be reviewed to ensure that urgent medical problems are addressed in a timely fashion. Provisions need to be made for necessary medication renewals and patients need to be rescheduled as soon as possible, if clinically appropriate.

(k) When a patient does not report (“no-show”) for a scheduled appointment, the responsible provider, surrogate, or designated team representative needs to review the patient’s

medical record, including any consult or procedure request received or associated with the appointment and then determine and initiate appropriate follow-up action. ***NOTE:*** *It may be useful for the facility to assign a case manager to the patient with multiple "no-shows" to determine the best method to manage the patient's pattern of repetitive "no-shows."*

(l) Facility leadership must be vigilant in the identification and avoidance of inappropriate scheduling activities. ***NOTE:*** *For further guidance, please see the Systems Redesign Consultation Team Guidebook available on the Systems Redesign Web site at Systems Redesign Consultation Team Guide 2008 (https://srd.vssc.med.va.gov/Pages/default.aspx) . This is an internal VA Web site not available to the public.*

(20) Providing annual certification through the VISN Director to the Director, Systems Redesign, in the Office of the Deputy Under Secretary for Health for Operations and Management, of full compliance with the content of this Directive. Initial certifications are due 6 months following issuance of this Directive and then annually thereafter.

5. REFERENCES

a. Public Law 104-262.

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b. Title 38 United States Code (U.S.C.) Sections 1710, and 1703, 1705.

c. Code of Federal Regulations, § 17.52, 17.100, 17.36, 17.37, 17.38, and 17.49.

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 the Director, Systems Redesign Program at 605-720-7174.

7. RESCISSIONS: VHA Directive 2009-070 is rescinded. This VHA Directive expires June 30, 2015.

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Under Secretary for Health

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