



Factors Contributing to Reductions in Patient Wait Times at Indian Health Service Emergency Department Facilities: A Mixed-Methods Assessment

Since the Indian Health Service (IHS) began systematically monitoring wait time standards, IHS direct service facilities have implemented a variety of strategies associated with decreased wait times in Emergency Departments.

KEY POINTS

- Emergency department wait times decreased over the course of the study period (January 2017 to January 2020), with most of the decrease occurring prior to publication of IHS' emergency department wait time standards.
- We also analyzed primary care appointment scheduling intervals and found that over 90 percent of IHS primary care facilities met the standards for primary care scheduling intervals at all points of the study period.
- Clinical and administrative staff from IHS direct service sites reported that challenges affecting wait times for emergency care and primary care include staffing shortages and limited space/room capacity, both of which are tied, in part, to lack of resources (workforce and funding).
- To improve the timeliness of care, IHS facilities have implemented several strategies such as recruiting permanent clinical providers, optimizing the use of existing emergency department space and staff resources, expanding telehealth access, changing primary care scheduling to allow more same-day appointments, and using data and staff input to drive process improvements.
- Strategies to connect patients with primary care can help IHS facilities manage the number of lower acuity patients seeking care at the emergency department, which affects emergency department wait times.
- Support from IHS Headquarters and Area Offices for developing and maintaining data dashboards can strengthen quality improvement efforts to ensure timeliness of care.

INTRODUCTION

In 2016, the Government Accountability Office (GAO) published a report recommending that the Indian Health Service* establish and communicate agency-wide standards for patient wait times.¹ In response to the GAO recommendations, in September 2017, IHS established and published standards for patient wait times for primary care and urgent care in direct service facilities.[†] This report discusses findings of a mixed-methods assessment that included a quantitative analysis of changes in wait times after the 2016 GAO report and qualitative research to provide context around the findings and identify promising practices that can help improve timely access to care at IHS direct service facilities.

BACKGROUND

Following publication of the 2016 GAO report, IHS announced its policy regarding wait time standards for primary care and urgent care in direct service facilities in September 2017 and standards for emergency department wait times in June 2019. Some IHS facilities began reporting their wait time data prior to 2016, but it was not a formal requirement until IHS Headquarters announced agency-wide wait time standards. IHS Headquarters monitors wait times using the following three measures, with target goals for each as follows:

- Mean appointment wait time for primary care (28 days or less)
- Median time from emergency department arrival time to emergency department departure time for discharged emergency department patients (120 minutes or less)
- Percent of patients who left the Emergency Department without being seen (2 percent or less)

The process IHS used to develop these wait time standards involved examining existing standards, practices, and improvement efforts in IHS; identifying gaps and areas for improvement; benchmarking against industry standards; and reviewing best and innovative practices. IHS also considered factors that influence wait times and patient and staff perspectives.²

IHS Headquarters requested that the Office of the Assistant Secretary for Planning and Evaluation (ASPE) analyze wait time data collected by IHS federal primary care and emergency departments to assess whether wait times had decreased over time.

In addition to performing quantitative analyses of the wait time data, ASPE and IHS staff held discussions with clinical and administrative staff from several IHS direct service sites to help provide context on the quantitative findings and to identify promising practices for IHS facilities.

METHODS

Quantitative analysis. IHS provided ASPE with internal data reported by 99 primary care clinics and 23 emergency departments at IHS direct service facilities. We analyzed wait times for the period of January 2017 through January 2020, which was prior to the COVID-19 Public Health Emergency.

For the primary quantitative analyses of the emergency department and the primary care wait time data, ASPE assessed the percentage of months that facilities fulfilled the standards and calculated the net change of the average cross-facility wait time measures in the last month of the study period (January 2020) compared to the first month of the study period (January 2017).

* The Indian Health Service (IHS), an agency in the U.S. Department of Health and Human Services (HHS), provides a comprehensive health care delivery system for approximately 2.7 million American Indians and Alaska Natives.

[†] Direct service facilities are IHS facilities operated by the federal government.

The number of emergency department facilities reporting data increased from 15 in January 2017 to 23 in January 2020. To assess whether trends observed in the emergency department analysis were not due to entry of new facilities with low baseline wait times, as opposed to reductions in facility wait times, we also calculated the net change of the average median wait times in just those facilities that reported data throughout the study period.

Qualitative analysis. The qualitative component of the study involved conducting focus group discussions with staff from eleven IHS federal direct service facilities located in seven IHS Areas (regions) in July 2021 and in December 2021.[‡] These IHS facilities were intentionally selected based on their performance related to meeting benchmarks for wait times to understand actions the sites have taken to improve wait times and to identify key lessons learned and best practices among the participating sites. They represented a mix of facilities that consistently met the standards and others that did not consistently meet the standards. Because the qualitative discussions were with staff from only a subset of IHS facilities, findings from these discussions are not necessarily representative of the experiences of all the IHS facilities whose quantitative data were analyzed for this study.

For the qualitative analysis, we conducted focus group discussions with clinical and administrative staff from nine emergency department and three primary care IHS direct service sites, soliciting information about their approach to measuring and reducing wait times, and the impact of the COVID-19 public health emergency on patient access and wait times.

The discussion guides for the study focused on the following topics related to emergency department wait times and primary care appointment scheduling intervals:

- Challenges to providing timely access to care (before and after IHS publication of the wait time standards)
- Strategies used to overcome the challenges
- Data systems that are needed to measure and improve wait times and scheduling intervals
- COVID-19 pandemic's effects on wait times

FINDINGS

Quantitative Results

Emergency Department Wait Times

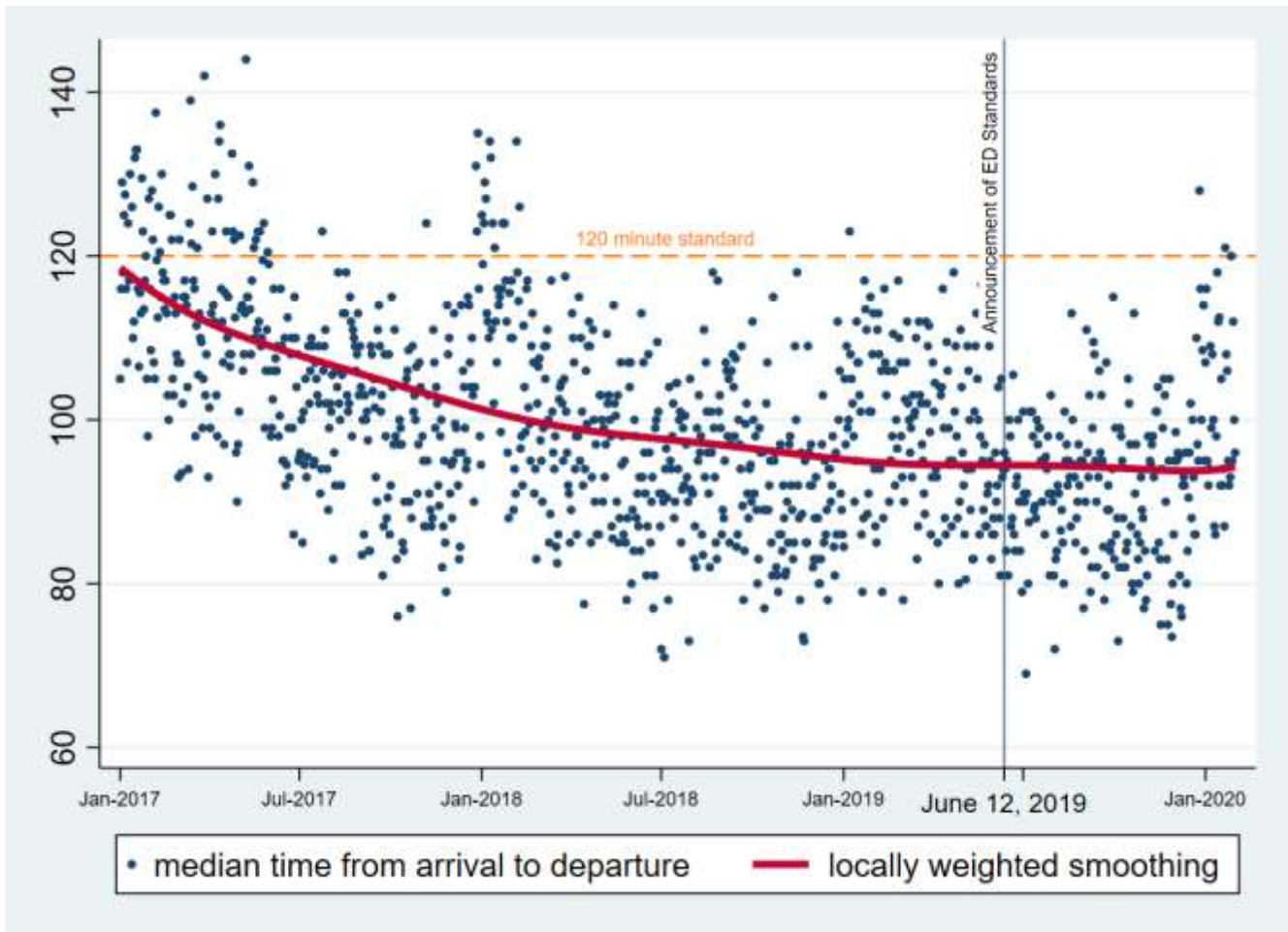
Median Time from Emergency Department Arrival Time to Emergency Department Departure Time for discharged Emergency Department patients: Target 120 minutes or less

When including all facilities regardless of when they started collecting data, there was a 15.6 percent[§] reduction in the average of the median wait times (emergency department OP-18 measure, Figure 1) between January 2017 (mean=128 minutes) and January 2020 (mean=108 minutes). As indicated in Figure 1, much of this reduction occurred prior to the public announcement of the emergency department wait time standards (vertical blue line in Figure 1). This finding is further supported by a facility-level analysis displayed in Figure 2 (blue line) showing that the percentage of emergency department facilities meeting the median wait time standard increased mostly during the beginning of the study period (from 40 percent in January 2017 to 75 percent in September 2017).

[‡] IHS oversees Indian health care programs located in 12 regions called IHS Areas: Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.

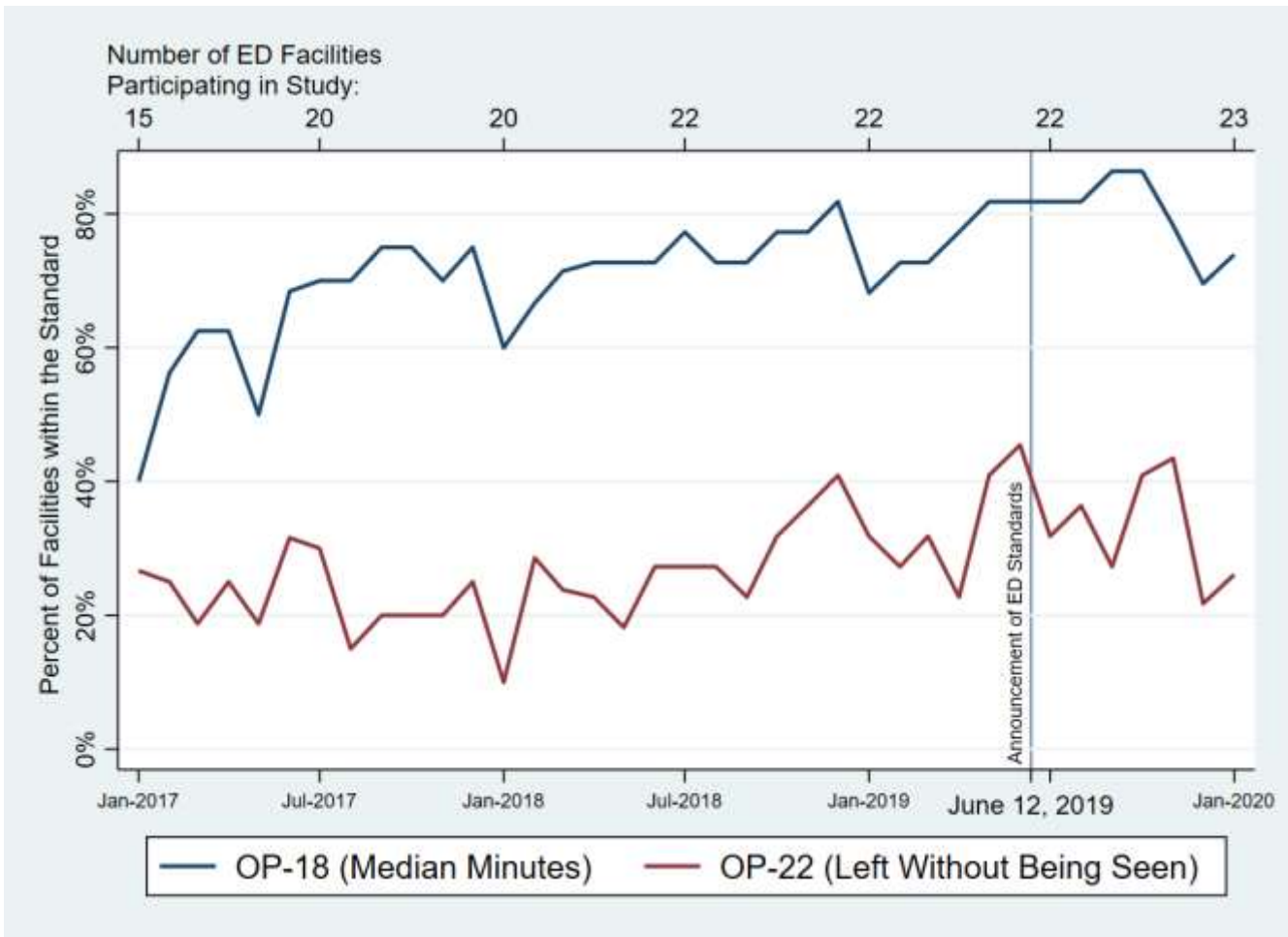
[§] $15.6\% = (128 \text{ min} - 108 \text{ min}) / (128 \text{ min})$

Figure 1. Median Minutes from Arrival to Departure in All Emergency Department Facilities throughout Study Period



Source: ASPE analysis of IHS administrative data

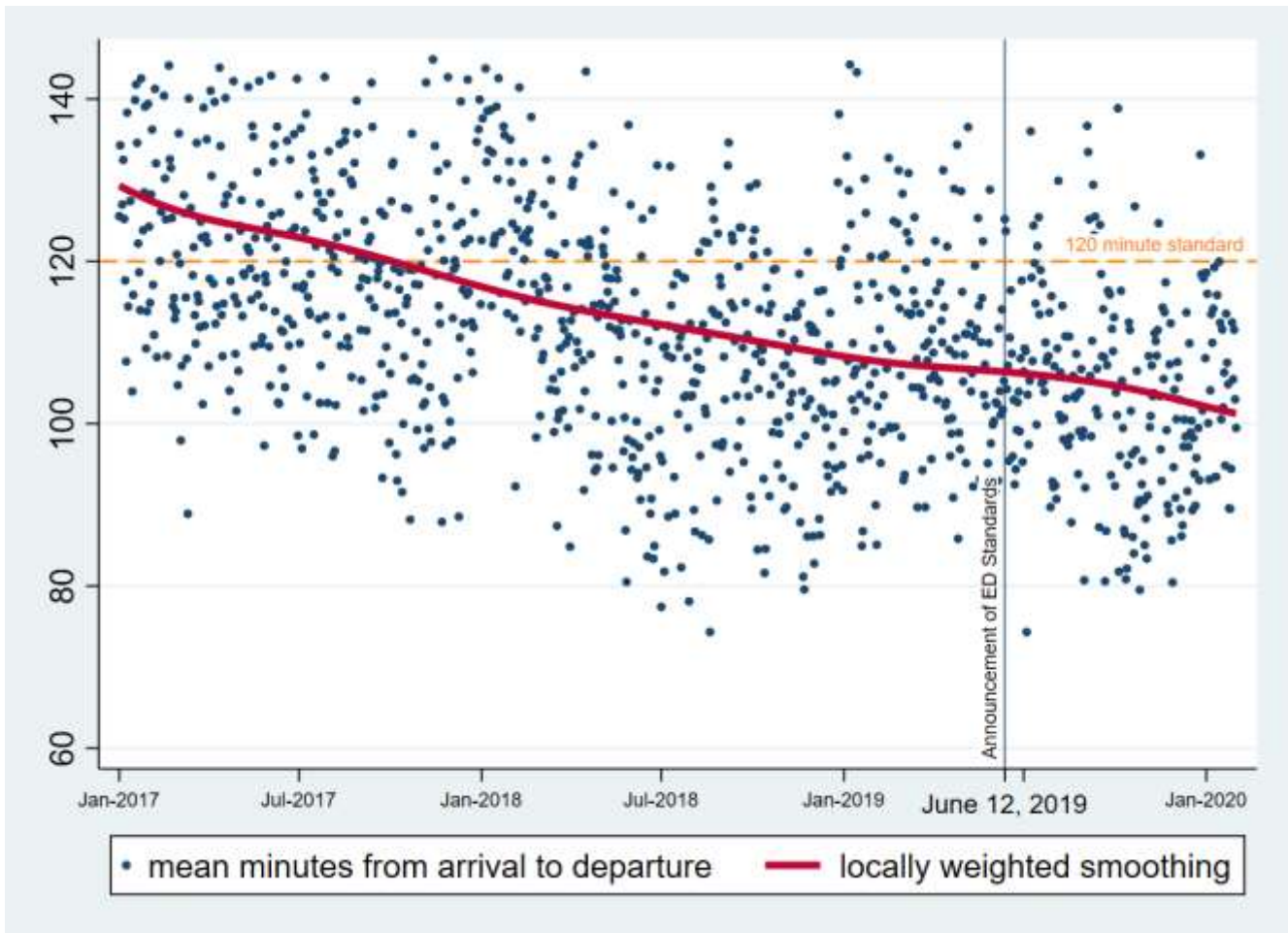
Figure 2. Percent of Emergency Department Facilities Meeting Standards throughout Study Period



Source: ASPE analysis of IHS administrative data

The number of facilities reporting data in each month increased over the study period. This could bias the results if new facilities had low baseline wait times. Figure 3 illustrates the decrease in median minutes only in those facilities that reported data throughout the full study period. This figure illustrates that across this subset of facilities, there was a relatively steady decline in wait times throughout the study period, even after the ED standards were announced.

**Figure 3. Median Minutes from Arrival to Departure
in Emergency Department Facilities Reporting through Full Study Period**

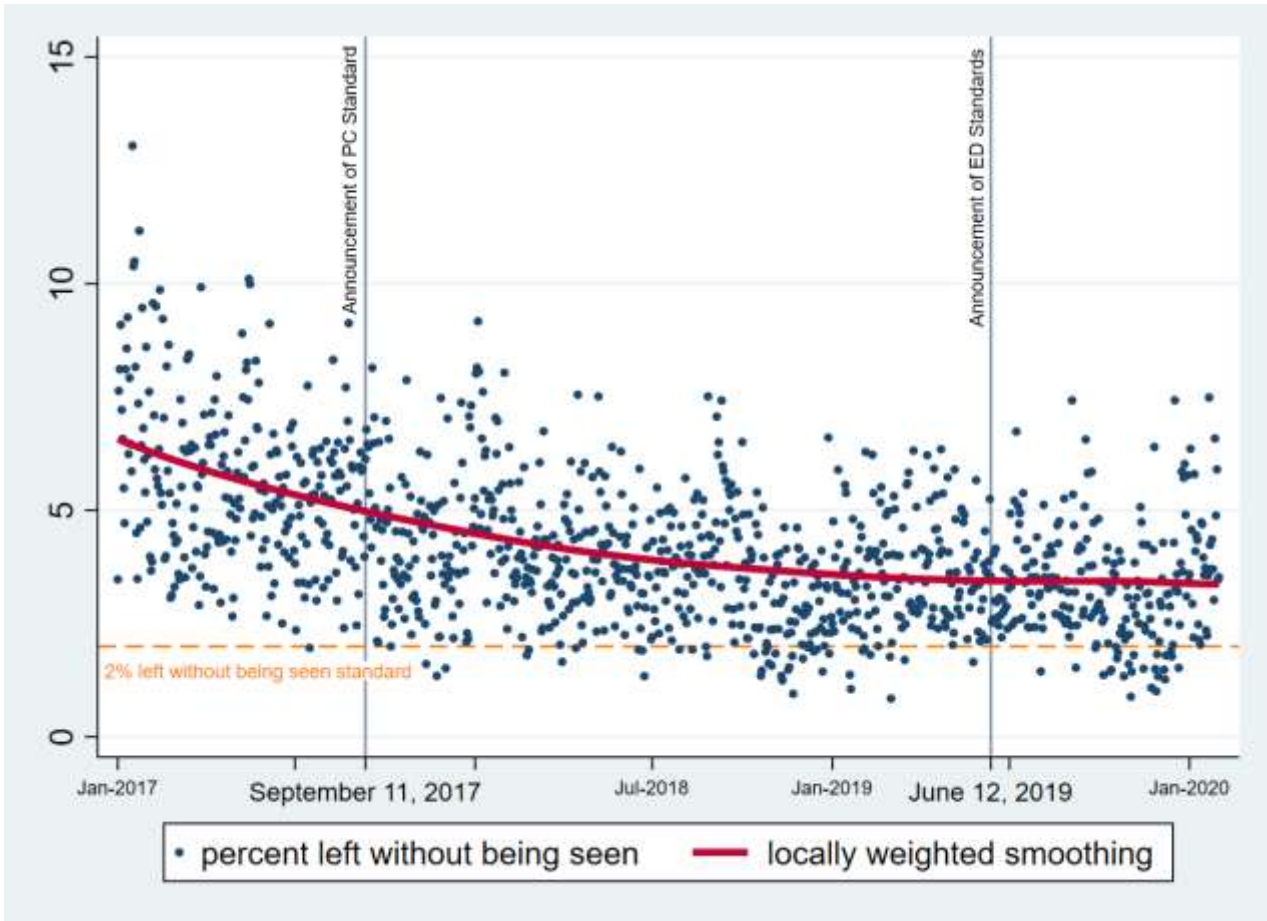


Source: ASPE analysis of IHS administrative data

Percentage of Patients Who Leave the Emergency Department Without Being Seen: Target 2% or Less

There was a 44.2 percent reduction in the average percentage of patients who left an emergency department without being seen (emergency department OP-22 measure, Figure 4) between January 2017 (when 7.4 percent of patients left without being seen) and January 2020 (when 4.1 percent of patients left without being seen). However, the majority of observations had greater than 2 percent of individuals leaving without being seen throughout the study period, despite improvements. The percentage of facilities meeting the standard peaked at 45.5 percent in June 2019, the month the standard was announced, and ranged between 20 percent and 40 percent during most of the study period (Figure 3).

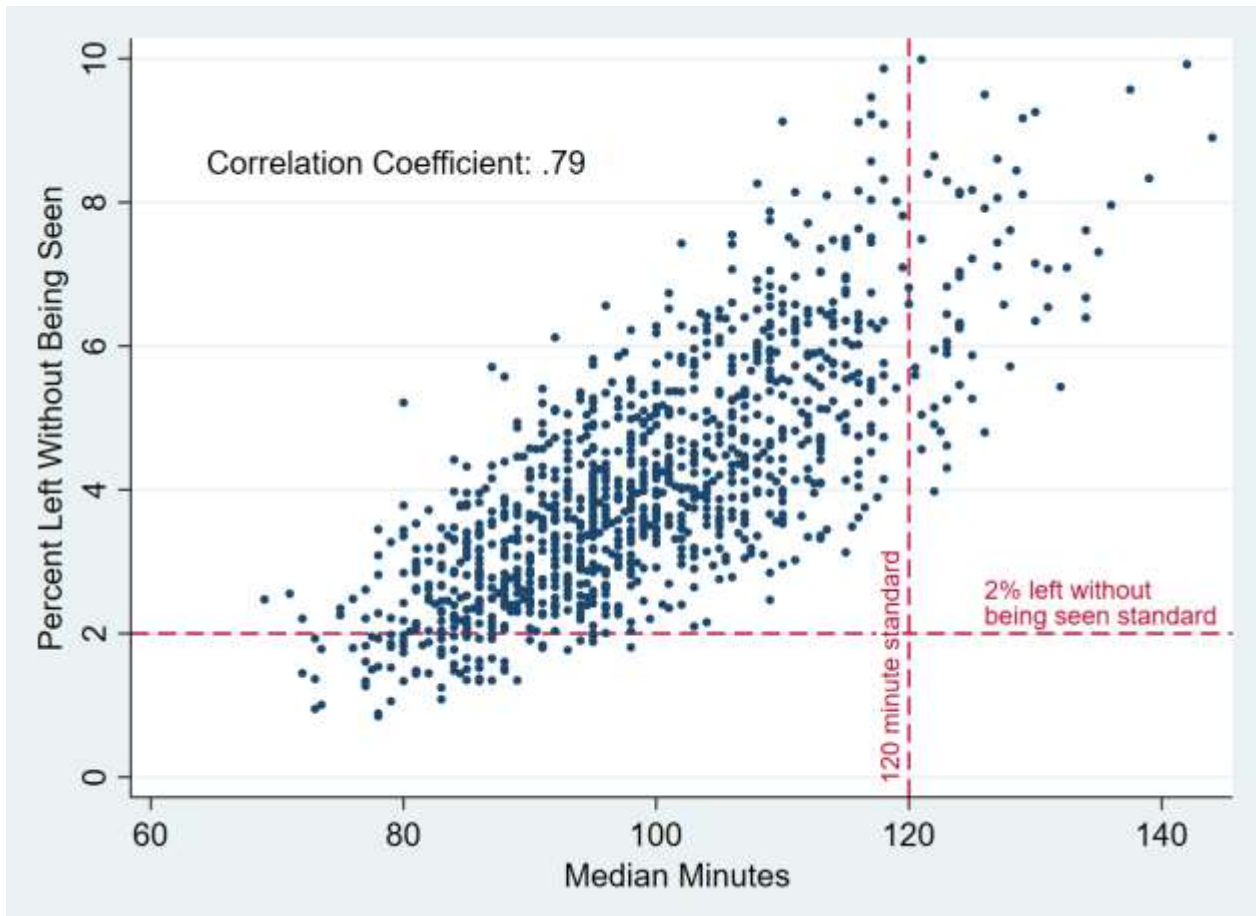
Figure 4: Percent of Patients Who Left Without Being Seen in All Emergency Department Facilities



Source: ASPE analysis of IHS administrative data

As expected, this measure is positively correlated with the median wait time measure; that is, on average, facilities with lower median wait times had fewer patients who left without being seen, with a correlation coefficient of 0.79 (Figure 5).

Figure 5: Correlation between Measures: Daily Percent Left Without Being Seen by Daily Median Wait in All Emergency Department Facilities



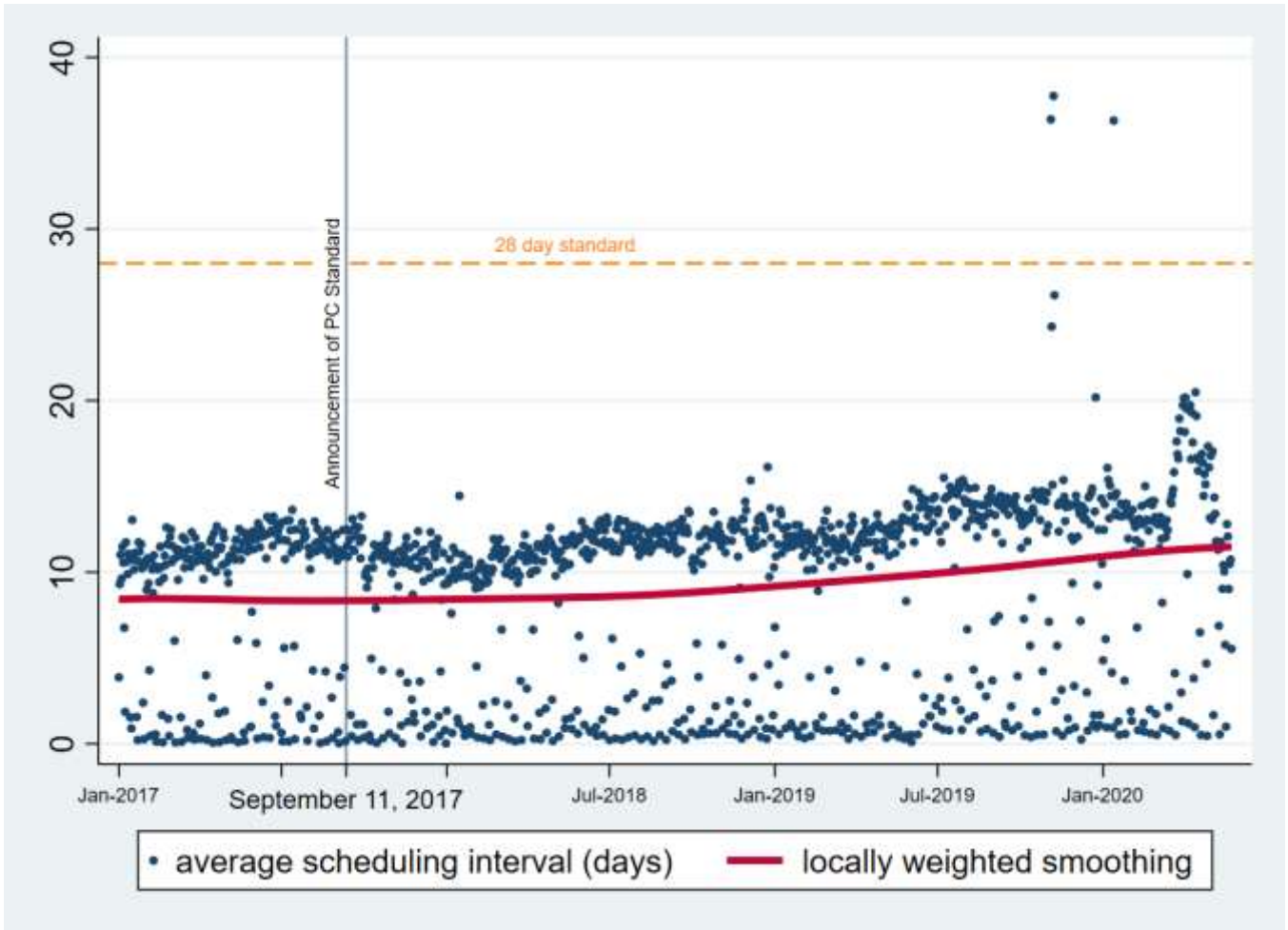
Source: ASPE analysis of IHS administrative data

Primary Care Facility Results

Mean Appointment Wait Time for Primary Care: Target 28 days or less

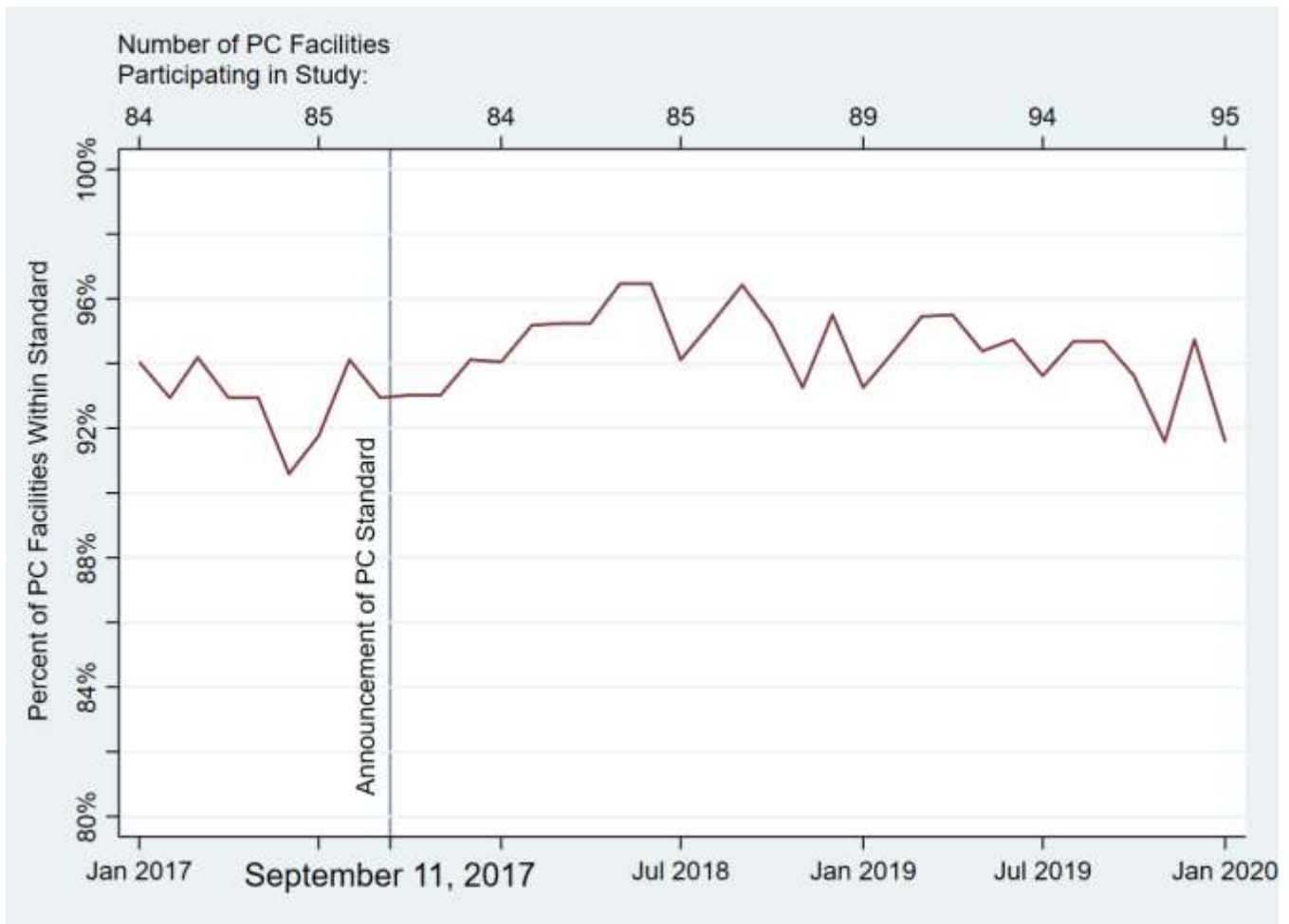
Analysis of the primary care data shows that the average scheduling interval across all individual facilities was within the standard for the majority of the study period, but there was also little change in mean scheduling intervals over time, with only a slight uptick in the average scheduling interval towards the end of the study period (Figure 6). Analysis of facility level data also supports the finding that most facilities were meeting the standard throughout the study period. Figure 7 shows that over 90 percent of all individual facilities were within the scheduling interval standard at all points of the study period, but with no clear improvement after the announcement of the waiting time standard. Additionally, the average scheduling interval in eight of the nine IHS Areas were within the standard for the entirety of the study period.

Figure 6: Average Scheduling Interval (Days) Until an Appointment in All Primary Care Facilities



Source: ASPE analysis of IHS administrative data

Figure 7: Percentage of Primary Care Facilities within the Standard



Source: ASPE analysis of IHS administrative data

Qualitative results

Findings from the qualitative component of this study are summarized below, highlighting common themes from the discussions with IHS staff who participated in the study; the discussions took place in July 2021 and December 2021. Findings were similar across all eleven IHS federal facilities in the qualitative component of this study.

Emergency Department Wait Times

Challenges to providing timely access to care

Staffing shortages

The most common challenge affecting emergency department wait times mentioned by study participants was maintaining adequate numbers of clinical staff (physicians, physician assistants, nurse practitioners, and nurses) proficient in providing emergency medical care. Some study participants explained that their ability to handle emergency department volumes in a timely matter was strongly linked to their ability to keep positions filled. Hiring practices and the ability to fill open staff positions varied by site. Some IHS facilities relied heavily on outside agencies to provide contract physicians and nurses. The reliance on contract staff was generally

linked to being located in a rural area, with a limited local labor market and few incentives for clinicians to relocate to live near the facility. Several respondents in the study noted the larger issue of a shortage of nurses in the U.S. compared to the demand for nurses. Looking ahead, a few respondents speculated that workplace stress and market demands on nurses created by COVID-19 will continue to exacerbate IHS facilities' challenges hiring nurses.

Limited space and equipment for patient care

A challenge related to physical capacity cited by most respondents was that certain patients took longer to discharge or move out of the emergency department, either because they required longer courses of treatment or because they were waiting to be transferred to another facility. For example, staff at sites with limited subspecialty services and geographically remote sites noted that the time to discharge could be longer for patients requiring medical air transportation, which takes time to arrange. Another reason that transferring patients might require several hours or even days in the emergency department was the lack of capacity at receiving facilities, particularly for mental and behavioral health services or for COVID-19 treatment.

In addition to limited space in the emergency department setting, one respondent noted other resource limitations, such as having inadequate numbers of patient monitoring equipment, can affect the ability to provide efficient care and thus affect wait times in the emergency department setting.

Low acuity patients in the emergency department

Most study participants described lower-acuity patients—a population that often overlaps with primary care and urgent care settings—as the ones most likely to leave the emergency department without being seen. They discussed the tension between wanting to treat any patient who comes to the emergency department while also understanding that some needs would be more appropriately met in a primary care setting.

Reasons that low-acuity patients may go to the emergency department for regular or routine care include limited numbers of primary care appointment slots and that the hours of operation for the primary care clinic may not be the most convenient for some patients. Respondents at the emergency departments described the culture in the emergency department of wanting to immediately care for all presenting patients as a key barrier to establishing routinized referral systems to primary care for low acuity patients who may be equally or better served in that setting. Due to the Emergency Medical Treatment & Labor Act (EMTALA) requirement to conduct an appropriate medical screening examination of all individuals who come to the emergency department, and the close connections that many emergency department clinicians have within their local community, there is a tendency among many patients to use the emergency department as the primary place to obtain their health care.

Strategies used to overcome the challenges

Hiring permanent employees who are board certified in emergency medicine

Some IHS facilities have been able to shift from relying on temporary contractor staff to hiring permanent staff. Study participants described benefits of employing community members who are familiar with the local area and culture. They noted the importance of helping permanent staff and their families feel welcome and integrated into the community because strong social ties and a supportive environment can help support the provision of high-quality care.

Study participants believed that hiring IHS employees who are experienced and/or board certified in emergency medicine facilitates efficient patient flow, and they described how operational changes (such as direct bedding, utilizing a provider in the triage process, and segmenting lower-acuity patients into a “fast track” process) decreased wait times at their sites. Respondents perceived a direct relationship between

hiring emergency medicine physicians and having a safe and efficient emergency department because residency training in emergency medicine results in physicians who understand the need to make decisions quickly and to focus on the most urgent problems. In contrast, respondents perceived physicians without emergency medicine training to be more likely to order tests or additional examinations (that were perceived as unnecessary for the emergent issue), thus creating bottlenecks that were frustrating to nurses.

Optimizing use of existing staff

Respondents at some sites noted an effective strategy to handle patient volume is sharing clinical staff across departments or clinics, or cross-training nursing staff in other hospital units to be able to work in the emergency department. Another strategy several sites described to efficiently use staff resources is the Provider in Triage, or PIT model. In this approach, a provider—usually an advance practice nurse but sometimes a physician—would see patients upon triage to address lower acuity issues. Having experienced staff conduct triage helped get lab orders or imaging started earlier so that the results would be available when the patient saw the attending provider for treatment after initial assessment/triage.

Using input from staff to drive process improvement

Some respondents suggested that utilizing an incident command structure (including input from community members and hospital staff) helps with patient flow in the emergency department, and evaluating data informs how staff can implement changes and meet resource needs. Implementing an Emergency Department Improvement Team generates ideas from all hospital departments to streamline processes and get patients the services they need, encouraging communication among staff to work on solutions to improve patient care.

Optimizing use of existing facility space

Some respondents noted factors related to emergency department capacity and space availability can affect their productivity and increase wait times. In some cases, respondents described undersized facilities relative to their annual volumes or as a ratio of size of the community that they serve.

One approach described by several study participants regarding maximizing patient flow within the emergency department was direct bedding, or placing patients in open beds upon triage, so that they are waiting to be seen inside the emergency department rather than in the waiting room. One respondent noted that direct bedding is an evidence-based practice that has been shown to reduce Left Without Being Seen rates. In addition to getting patients in front of clinical staff faster, the patients perceive moving from the waiting room to an exam room as progress towards their goal, thereby improving their experience.

Connecting patients with primary care

Some emergency department respondents had processes in place to connect patients to primary care, either to divert non-emergency cases from the emergency department or to arrange follow-up care. Several respondents noted that they saw connecting patients to primary care as a strategy to reduce emergency department volumes and improve continuity of care. One respondent reported that increasing primary care capacity by making same-day appointments available was a strategy that reduced wait times in the emergency department. A respondent at one facility noted that emergency department patients who do not have a usual source of primary care can be directed to a walk-in primary care clinic or referred directly from the emergency department to an IHS primary care provider for follow up care. Leveraging the emergency department as an “on ramp” to an ongoing primary care relationship has the potential to improve uptake of primary care services and rebalance the types of care patients seek in emergency department settings.

Data systems needed to measure wait times

Emergency department respondents in the study stressed the need to develop and maintain data dashboards to monitor wait times. Dashboards allow for regular review of the data at the leadership and front-line

clinician-level. Some respondents reported that, to reduce wait times, their hospitals increased nursing staff to get emergency department patients triaged faster and adjusted workflow processes based on information from their emergency department dashboards. A few respondents noted difficulties extracting data from IHS' electronic health record system, the Resource and Patient Management System (RPMS), to use for population health management. Only a few respondents were familiar with iCare, the population management component of RPMS. Other respondents mentioned using the IHS Emergency Department Dashboard, which draws on RPMS emergency department data to support emergency department operations and management. However, respondents discussed needing to manually abstract data from the EHR or from patient charts to support their analyses of wait times. Respondents at two facilities in the study noted the benefit of being able to access QlikView, a business intelligence and data analytics tool procured by one IHS Area that captures emergency department data, because it allows creation of custom measures to monitor over time — but QlikView access for emergency department data is limited and not available to all staff. In general, respondents wanted additional support to extract actionable data and build dashboards for regular data monitoring.

COVID-19 pandemic's effects on wait times

Information about IHS activities that occurred after the study period for the quantitative data analysis indicated that at many IHS sites, COVID-19 infection control protocols became a catalyst for using spaces differently to improve patient flow and patient triage while maintaining a safe environment.

Respondents in the study noted that in some ways, COVID-related procedures and sanitation protocols created bottlenecks in emergency departments that were already facing challenges associated with limited clinical and administrative space. Respondents at some facilities described seeing sicker non-COVID-19 patients in the emergency department as the pandemic went on, suggesting that patients who had deferred care created a demand on the emergency department that would not otherwise have occurred if these patients had sought care earlier in the course of their illness or had received care for chronic illness rather than avoiding health care altogether during the pandemic while trying to avoid potential exposure to COVID-19 at health care provider offices.

Emergency department wait times were affected during the COVID-19 public health emergency because of several reasons: the time needed for staff to test/screen patients for COVID; nurses were pulled away from providing care in order to answer hotline calls and answer questions about COVID-19; sanitizing protocols limit the time that rooms can be available for patients; and using monoclonal antibody treatment tied up the rooms and impacted patient flow and increased emergency department wait times. Respondents also noted that emergency department wait times increased during COVID-19 surges when many patients were not stable enough to send home. When there was an increase in the number of patients requiring transfer to a different facility for treatment, the difficulty finding available beds resulted in holding patients in emergency department rooms ("ED boarding"). ED boarders included individuals with mental health conditions and COVID patients, staying for days.

Primary Care Appointment Scheduling Intervals

Challenges to providing timely access to care

Target for Appointment Scheduling Intervals

Respondents noted that scheduling intervals for primary care appointments are not necessarily measuring timeliness of care. Some patients prefer to schedule an appointment for more than 28 days away; some prefer seeing a certain provider even when other providers are available sooner; and some patients like the convenience of knowing a follow-up or preventive care appointment is scheduled in advance. Such situations

make the wait times appear to be long because when patients schedule appointments far in advance, the fact that it was intentional is not captured in the reported scheduling interval data. Respondents emphasized that the correct appointment scheduling interval for a patient should be the one the patient prefers, which could be longer than the IHS standard of 28 days. Several respondents noted that scheduling intervals are also affected by limited provider availability as well as the fact that some primary care appointments take longer than others, depending on a patient's condition. For primary care, some patients need care more often; and appointments for chronic care patients are sometimes longer with a physician provider than appointments with the mid-level providers.

Staffing shortages

Regarding primary care, respondents expressed similar concerns as emergency department respondents related to having adequate numbers of well-trained staff. Several primary care clinics in the study utilize contractor staff, and respondents described how some contract providers placed at IHS clinics were not a good fit for the clinics' needs, resulting in high turnover and constant struggles with obtaining adequate staffing.

Limited space for patient care

Similar to the challenge cited for emergency department settings, physical space is also a concern in the primary care setting because the lack of rooms for patient visits limits the number of providers and patients that a clinic can accommodate in a given day. These issues limit the flexibility to be able to schedule patients for immediate same-day appointments versus follow up, chronic care appointments in the future.

Strategies used to overcome the challenges

Optimizing use of existing staff

Respondents in the study described striving to use their staff more efficiently by utilizing all members of the patient centered medical home (PCMH) care team and ensuring staff are working at the top of their license. Updating internal scopes of practice (as determined by an IHS facility's medical staff in accordance with IHS credentialing policies) allows nurse practitioners and other clinicians to work more fully to the top of their license. The PCMH model of care is designed to use provider teams to improve continuity and access to a familiar provider. However, preferences among some patients to see only one specific provider on a care team can affect the wait time because getting scheduled for an appointment depends on the specific provider's availability. In response to staffing challenges, primary care sites worked to recruit more providers; however, facility location, contracting requirements, and availability of funding to hire additional providers can be a challenge to recruitment efforts.

Balancing scheduling flexibilities

Some respondents noted they were able to make changes to primary care scheduling processes, allotting time for a greater number of immediate care appointments. Respondents described a "balancing act" between holding space for same-day appointments while ensuring adequate access for routine primary care, all while managing overall staffing and resource shortages.

Promoting staff communications and buy-in regarding quality improvement

Respondents mentioned the importance of attitudes among the staff and leadership towards innovation, quality improvement, and interdisciplinary cooperation across hospital departments. Respondents believed that effective communication—vertically, between management and front-line staff, and horizontally, among doctors, nurses, and administrative staff—was critical to successful quality improvement. Respondents at several facilities emphasized the importance of collaborating with nursing and other staff who interact with patients (e.g., receptionists) to design, implement, and refine approaches to efficient, safe patient care. At some sites, nurses and providers met regularly to discuss trends and review patient registrations, and if time slots that were allocated for chronic and acute appointments were not taken, then staff filled those available

slots with appointments. They also suggested that using telehealth in a hybrid model helps ensure primary care accessibility and that their use of telehealth increased during the pandemic. Respondents considered staff buy-in to the goal of quality improvement and shared motivation to improve the patient experience to be essential for implementing changes to reduce wait times.

Data systems needed to measure scheduling intervals

Respondents who participated in this study suggested primary care sites may find it beneficial to monitor indicators of appointment demand and appointment availability (e.g., missed appointments, which type of appointments are in greater demand) in an attempt to balance access to appointment types while meeting patients' needs. Several respondents suggested it would be helpful to have the ability to adjust parameters in RPMS to accommodate unusual or irregular provider availability (e.g., if a provider is onsite only twice a month); have a code built into the scheduling package to indicate the provider's limited schedule is the reason why the wait time is affected; and enhance RPMS to allow RPMS to flag a patient's request to schedule in advance so that it does not count against the wait time metrics (i.e., flag that long-range appointment scheduling greater than 28 days for chronic care patients is intentional based on their circumstance).

COVID-19 pandemic's effects on appointment scheduling intervals

Several respondents in the primary care settings noted that because patients had not been seen in person during much of the pandemic, the duration of many primary care visits increased as providers needed to spend more time with their patients to assess their health needs. Infection control protocols also increased the length of each appointment to make sure patients coming in person do not have COVID-19, and that resulted in fewer slots being available for primary care visits. Respondents described using telehealth as one way to help address routine care needs during the COVID-19 pandemic, with facilities varying in their speed of implementing telehealth. Some respondents noted that due to the COVID-19 public health emergency, their primary care clinic transitioned to telehealth, which reduced appointment no-show rates. Study participants believed the growth in the use of telehealth during the COVID-19 pandemic was a silver lining of the pandemic and that offering telehealth as an option will facilitate greater access to care for their patients.

DISCUSSION

Findings from this analysis indicate that IHS federal facilities have experienced decreases in wait times since IHS first began monitoring wait times system-wide and in fact, decreases at some facilities began before IHS established wait time targets. Emergency department facilities, in particular, showed a sustained decrease in the average median minutes from arrival to departure. Although this study was not designed to determine the precise reasons why such reductions occurred, facilities reported a number of interventions they implemented to reduce wait times including efforts to improve timeliness of care prior to the publication of the wait time standards. Based on the findings from this study, strategies that might help reduce wait times in emergency department settings include recruiting more clinical providers, updating internal scopes of practice so clinicians work more fully to the top of their license, using additional hospital spaces to care for emergency department patients, or using existing emergency department space differently.

Analysis of the quantitative data for primary care settings showed there were no substantial changes in mean scheduling intervals at the Area level during the study period, and eight out of nine Areas already had average scheduling intervals within 28 days. Respondents emphasized that the correct appointment scheduling interval for a patient was the one the patient preferred, which could be longer than the IHS standard of 28 days. This suggests the current primary care wait time standard does not measure wait times in a way that is necessarily aligned with patient preferences and could, in fact, discourage facilities from scheduling follow-up appointments far in advance even when preferred by patients. Several IHS staff who participated in the

discussions for this study suggested IHS should develop and adopt alternative measures in the future to monitor timeliness of primary care. Other research regarding appointment availability reporting measures describes challenges in tracking appointment scheduling information.³ Examples of potential alternative measures of primary care wait time include CAHPS “Getting Timely Appointments, Care, and Information” patient survey items.⁴

Qualitative findings showed that staffing shortages and space constraints are two of the key challenges in reducing wait times. These two factors, in turn, are tied to the lack of adequate financial resources for IHS to meet the health care needs of the population. One estimate is that the IHS’s current funding addresses only 48.6 percent of the estimated need, and in response, the President’s Budget proposed additional funding to address this shortfall.⁵

LIMITATIONS

One limitation of this analysis is that because IHS system-wide data on scheduling intervals were not available when the GAO published its recommendations, it is not possible to compare whether the number of IHS facilities or Areas that meet the wait time standard has changed since 2016, when the GAO report was released. It is also not possible to determine the extent to which the 2016 GAO report, anticipation of the standards, or some other overarching factor, may have contributed to reductions in Emergency Department wait times, but the GAO report and IHS staff participating in this study noted that several IHS facilities had implemented initiatives to improve timeliness of care prior to the establishment of agency-wide wait time standards.

As noted above, the measure used for the primary care wait time standard is a limitation because longer scheduling intervals sometimes occur due to patient preferences and are therefore not necessarily an indicator of timeliness of care. Some facilities allowed patients to schedule future follow-up appointments many weeks in advance to suit patient preferences, while other facilities did not allow patients to schedule a follow-up visit beyond a certain amount of time in advance even if this would have been more convenient and preferred by patients. Several staff at the facilities participating in our study reported their concern that the current primary care wait time measure is not meaningful as a true measure of patient access to care.

CONCLUSION

IHS facilities are diverse in size, staffing models, patient volume and acuity, regional context, and other attributes, and there is no “one size fits all” solution to the challenge of improving access to care within the IHS system. Analysis of IHS data showed emergency department wait times decreased over the course of the study period, with most of the decrease occurring prior to publication of the emergency department wait time standards, and on average, most IHS Areas met the primary care scheduling interval standards throughout the study period. To improve the timeliness of emergency department care, IHS facilities have implemented several strategies such as recruiting more clinical providers, updating internal scopes of practice so clinicians work at the top of their license, using additional hospital spaces to care for emergency department patients or using existing emergency department space differently, expanding telehealth access, and changing primary care scheduling to allow more same-day appointments. IHS staff participating in the study suggested that additional analytics support from IHS Headquarters and Area Offices for developing and maintaining data dashboards would be helpful for ongoing quality improvement efforts to ensure timeliness of care. Furthermore, to assess progress in improving primary care wait times, new metrics will be required to address limitations of the current measures. Finally, enhanced funding for IHS can play an important role in helping build the staff and physical spaces necessary to promote optimal access to timely care.

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