Department of Veterans Affairs

Office of Inspector General

Healthcare Inspection

Clinic Appointment Scheduling Issues VA San Diego Healthcare System San Diego, California

Report No. 08-01299-144

June 11, 2008

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network 22

SUBJECT: Healthcare Inspection – Clinic Appointment Scheduling Issues, VA San Diego Healthcare System, San Diego, California

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections reviewed an allegation regarding appointment scheduling at the VA San Diego Healthcare System (VASDHS). The purpose of this inspection was to determine whether the allegation was valid.

Background

The complainant is a veteran in his mid 20's with diagnoses of cancer and post-traumatic stress disorder. He has received primary and oncology care at the VASDHS since 2005. He wrote a letter complaining about his VA treatment to the Chairman, House Veterans' Affairs Committee, who forwarded the letter to the OIG for review; the letter was received February 26, 2008.

The VASDHS is a tertiary medical center with 242 beds and 2,132 employees. It has an operating budget close to $320 million. The VASDHS is part of Veterans Integrated Service Network (VISN) 22.

Scope and Methodology

We interviewed the complainant by phone. We conducted a site visit at the VASDHS March 18–20, 2008, and interviewed physicians and call center managers. We reviewed documents, including medical records, policies, and reports. The complainant's original letter included concerns about his medical care and his difficulty in scheduling clinic appointments. At the time of our interview, however, he told us that he is pleased with his primary and oncology providers and the care they give him, so we did not include a review of his current medical care. The complainant's letter also included issues involving Veterans Benefits Administration, which were referred elsewhere and are not further dealt with here.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

We substantiated that there were problems with appointment scheduling. The complainant expressed frustration with the poor service provided by the VASDHS scheduling call center. Specifically, he experienced long holding times (as much as 45 minutes), hang-ups, and the inability to leave messages due to the voice message box being full. From October 2007 through February 2008, scheduling call center data showed a call abandonment rate of more than 30 percent, while the goal is less than 10 percent. The scheduling call center manager acknowledged the problems. A separate call center, the primary care call center, showed data that indicated much better performance over the same timeframe. The scheduling call center manager told us that a corrective action plan had been developed to combine the two call centers.

The complainant expressed frustration about receiving automatic appointment notices for days and times when he had conflicts, such as college classes. The scheduling call center manager told us that the computerized scheduling package does not allow for blocking automatic appointments for certain days and times when a patient has conflicts.

The VASDHS can assign nurse case managers to assist patients with multiple medical problems or patients with multiple missed appointments to coordinate care needs and services across the VASDHS. Several months ago, when the complainant was experiencing difficulties obtaining care, the primary care clinic's nurse case manager position was vacant. We discussed the complainant's situation with the attending physician, and a nurse case manager was assigned to him during our visit.

Recommendation

We recommended that the VISN Director require that the VASDHS Director ensures follow-through on the action plan to improve the scheduling call center's performance.

Comments

The VISN and VASDHS Directors concurred with the findings and recommendation and responded that actions taken over the past several months have reduced the dropped call rate to below 5 percent. Supervision was increased, performance measures were established, and call center data was more closely monitored. The corrective actions are acceptable, and we consider the recommendation closed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 20, 2008

From: VISN 22 Director (10N22)

Subject: **Healthcare Inspection – Clinic Appointment Scheduling Issues, VA San Diego Healthcare System, San Diego, California**

To: Director, Management Review Service (10B5)

1. In response to the report received as a result of the site visit conducted by Ms. Julie Watrous, OIG, March 18–20, 2008, the following response is provided, which addresses the inspection results and recommendation.

2. RECOMMENDATION: We recommended that the VISN Director require that the VASDHS Director ensures follow-through on the action plan to improve the scheduling call center's performance.

CONCUR

3. RESPONSE: Since January 2008, increased emphasis has been placed on the timely and appropriate management of patient calls in the Call Center. The Call Center averages greater than 11,000 calls per month, and the dropped call percentage currently remains well below 5 percent. In October of 2007, several significant actions were taken to reduce wait times and dropped calls to achieve this high level of performance.

4. First, an onsite Medical Administrative Officer was placed in the call center that had direct supervisory authority over personnel. Second, performance standards for the number of calls each operator should receive and handle daily were established. Third, a cancellation line was established so patients could expedite their requests for clinic cancellations, which also had the additional benefit of freeing two operators to handle appointment calls. Finally, the Medical Administrative Officer began reviewing call volume, dropped calls, and wait times daily using Symposium. The result is the average answering time for calls is now 30 seconds, with a maximum wait time of 12 minutes. The improvement in

reduction of dropped calls and answering times has created enhanced customer satisfaction and improved care.

5. The VA San Diego Healthcare System will continue to monitor answering time for calls and dropped call rate in order to maintain this significant improvement in service so that we may maintain the best care possible for the nation's veterans.

6. If you have questions, please contact Skye McDougall, Ph.D., Chief Medical Officer, at phone number (562) 826-5963.

(original signed by:)

Ronald B. Norby

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	Julie Watrous, RN, Director Los Angeles Office of Healthcare Inspections (213) 253-2677 ext.4972

Appendix C

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