



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Appointment Scheduling and Access Patient Call Center VA San Diego Healthcare System San Diego, California

To Report Suspected Wrongdoing in VA Programs and Operations:

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding scheduling primary care appointments at the Patient Call Center (PCC), VA San Diego Healthcare System (the system), San Diego, CA. The complainant alleged that a PCC agent refused to schedule a follow-up appointment and an urgent appointment. The complainant also alleged that he was forced to seek medical treatment at a community hospital emergency department (ED) for an infection in his finger, and that he was at risk for amputation of his finger due to lack of medical attention at the system.

We found that the PCC agent informed the complainant that a message would be sent to his primary care team (PCT) according to PCC procedures for follow-up appointments; however, the agent failed to send a message to the PCT notifying them of the complainant's need for an appointment as required.

We determined that the complainant made a second call to the PCC describing a symptom that the system considers as nonurgent; however, the PCC agent did not follow the procedure for managing a non-urgent symptomatic call. The PCC agent sent a message to the complainant's primary care provider instead of the Veterans Integrated Service Network 22 Call Center triage nurse as required.

We determined that the system failed to provide timely follow-up with the complainant, which resulted in his decision to seek treatment at a community hospital emergency department. We also determined that the PCC agents' failure to follow PCC procedure was the primary cause of the delays. While VHA does not require a local policy, we believe that established timeframes for patient follow-up would help to avoid undue waits or delays in care.

We found that the complainant was treated for a mild infection in his finger, which was resolved after 7 days of treatment with antibiotics. While the system failed to provide timely follow-up, we determined that the complainant was not denied access to care; he chose to seek treatment in the local community.

We recommended that the System Director ensures that PCC agents follow standard operating procedures for scheduling follow-up appointments and managing non-urgent symptomatic calls, and that timeframes for the PCTs to follow-up with patients be established.

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.



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

TO: Director, VA Desert Pacific Healthcare Network (10N22)

SUBJECT: Healthcare Inspection – Appointment Scheduling and Access, Patient Call Center, VA San Diego Healthcare System, San Diego, California

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant regarding scheduling primary care appointments at the Patient Call Center (PCC), VA San Diego Healthcare System (the system), San Diego, CA.

Background

The system is part of Veterans Integrated Service Network (VISN) 22 and serves veterans throughout the San Diego and Imperial Valley counties. The system is a Level I tertiary system that provides a broad range of inpatient and outpatient services.

In 2001, the system established the PCC at a central location in Mission Valley. PCC agents answer calls from patients who may want to renew medications, leave messages for primary care providers (PCP), discuss symptoms with the VISN 22 Call Center triage nurses, schedule primary care appointments, obtain laboratory results, or request transfer of care. PCC staffing consists of an acting supervisor and 12 PCC agents; however, 9 positions were vacant. The PCC agents provide telephone services during the weekday from 7:00 a.m. to 7:00 p.m. All symptomatic calls, weekday after hour calls, and weekend calls are automatically forwarded to the VISN 22 Call Center triage nurses.

Allegations

On August 14, 2012, a complainant contacted the OIG with allegations that PCC agents refused to schedule a follow-up primary care appointment and an urgent appointment.

We reviewed the following allegations:

- The complainant called the PCC and requested a follow-up appointment with his PCP but the agent refused to schedule an appointment; instead, he was told that he would receive a call back but never did.
- The complainant called the PCC a second time and a PCC agent refused to schedule an appointment even though the agent was told that the situation was urgent.
- The complainant was forced to seek treatment at a community hospital emergency department (ED) for an infection in his finger near the bone.
- The complainant was placed at risk for amputation of his finger due to lack of medical attention at the system.

Scope and Methodology

We interviewed the complainant by telephone prior to our site visit on September 17–20, 2012. During our visit, we interviewed the System Director, Chief of Staff, Acting Chief of Health Administrative Services, Assistant Chief of Health Administrative Services, PCC’s acting supervisor and agents, and other clinical staff. We reviewed pertinent Veterans Health Administration (VHA) and local policies and procedures, patient event reports,¹ patient advocate reports, PCC agents’ training records, PCC agents’ telephone recordings, Graphical User Interface (GUI)² e-mails, the patient’s electronic health record and community hospital ED discharge documentation.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Primary Care Appointment Scheduling

A. Refusal to Schedule Follow-up Appointment

We partially substantiated the allegation that the complainant called the PCC and requested a follow-up appointment with his PCP but the PCC agent refused to schedule an appointment; instead, told him that he would receive a call back but no one ever called.

¹ Patient Event Reports are electronic patient incident reports used to determine if a root cause analysis of the adverse event is justified, and to develop aggregated data reports required by external regulatory agencies.

² Graphical User Interface e-mail is a secure, electronic message system used for communication with primary care clinical staff.

We listened to the initial telephone recording of the conversation between the complainant and a PCC agent. The complainant reported sustaining a laceration on the small finger of the right hand during a surfboard accident and received treatment in the ED at a local community hospital. The complainant informed the PCC agent that seven sutures were required to close the laceration and he was advised to follow-up with his PCP within 7 days for wound evaluation and suture removal. The PCC agent told the complainant that a message would be sent to his primary care team (PCT) and someone would call him back with further instructions.

The PCC standard operating procedures state that when a PCC agent receives a call for a follow-up appointment, the agent will send a GUI message to the patient's PCT for a call back. We reviewed all GUI messages sent from the PCC on the date the complainant called and found that none were sent to the complainant's PCT regarding his need for a follow-up appointment.

B. Refusal to Schedule an Urgent Appointment

We partially substantiated the allegation that the complainant called the PCC a second time and a PCC agent refused to schedule an appointment even though the agent was told that the situation was urgent.

We listened to the second telephone recording of the conversation between the complainant and a PCC agent. The second call was made 6 days from the complainant's initial call. The complainant reported removing the sutures since no appointments were available and a call back was not received. The complainant informed the PCC agent that his finger appeared to be infected; therefore, he returned to the community hospital ED and was prescribed Septra (antibiotic to treat infection), for a 7 day treatment. The complainant stated, "It was cut so bad; I cannot feel the tip of my finger; I may have severed a nerve and possibly need a referral to a hand surgeon."

The PCC agent told the complainant that his PCP was on vacation and the next available appointment was in 2 weeks. The complainant asked if there were any urgent or emergency slots available. The PCC agent replied that none were available and told the complainant that a message would be sent to his PCT and that he would receive a call back. The complainant requested to speak with a supervisor, who stated the same. Prior to ending the call, the complainant was told "If you think it is an emergency, go to the ED."

Local policy states that if a patient has a symptom to follow the "symptomatic call" procedure, which requires PCC agents to use the Immediate Action Guidelines³ to determine if a symptomatic call is urgent or not. The policy also states that if the

³ The Immediate Action Guidelines includes symptoms that need to be brought to the attention of the VISN 22 Call Center triage nurse immediately (call hand-off directly to the triage nurse).

symptom is not urgent to send a TeleCare Record Manager (TRM)⁴ note to the VISN 22 Call Center triage nurse listing the symptoms. We reviewed the Immediate Action Guidelines and determined that the complainant's symptoms were not considered urgent. We found that the PCC agent sent a GUI message to the PCP instead of sending a TRM note to the triage nurse as required.

In addition, we found that the PCC agent advised the complainant to go to the ED. The agents we interviewed reported that they were not allowed to advise a patient to go to the ED. Although the local policy does not specifically address this issue, the policy does state how symptomatic calls should be managed.

Issue 2: Access to Care Primary Care Clinic

A. Complainant forced to seek treatment at community hospital

We did not substantiate the allegation that the complainant was forced to seek treatment at a community hospital ED for an infection in his finger near the bone.

We found that the complainant returned to the community hospital ED for an infection in his finger 5 days after the initial call to the system's PCC; however, he did not further attempt to contact the PCC for an appointment or report to the system's ED prior to the second community hospital visit. We did, however, determine that the system failed to provide timely follow-up with the complainant to address his need for treatment.

VHA policy states that it is VHA's commitment to provide clinically appropriate quality care for eligible veterans when they want and need it.⁵ This requires the ability to create appointments that meet the patient's needs with no undue waits or delays. We determined that the complainant never received a follow-up call from the PCT; although, the VISN 22 Call Center triage nurse called the complainant 13 days after his initial call to the PCC. While we were unable to determine when a TRM message from the PCC was sent to the triage nurse, the VISN 22 Nurse Advice Line Program Manager told us that "a symptomatic call will be acknowledged from the triage nurse within 30 minutes and a call returned to the patient within 2 hours."

Although VHA does not require a local policy, we found that the system did not have a defined call back timeframe for the PCTs to follow-up with patients. System leaders reported that patients should receive a call back from the PCT within 72 hours.

⁴ The TeleCare Record Manager is a computer program designed to provide health care facilities with a user-friendly interface for Windows Telephone Triage providers. The system collects and maintains documentation created upon receipt of telephone calls received from patients.

⁵ VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.

B. Complainant at risk due to lack of medical attention

We did not substantiate the allegation that the complainant was at risk for amputation of his finger due to lack of medical attention at the system.

We determined that the complainant was not denied access to care at the system. While the system failed to provide timely follow-up with the complainant, we found that the complainant chose to seek treatment in the local community.

We reviewed the ED physician's discharge documentation which states, "Given how deep the laceration was by report and the fact that he has mild infection I have ordered an x-ray. Also will start on Septra. Will refer to hand surgery although I would be surprised if they offered a digital nerve repair as he seems to have at least protective sensation."

The results from the community hospital radiology department of an x-ray of the complainant's right hand revealed, "The soft tissues are normal, no acute displaced fracture or dislocation, and no bony or joint abnormalities are present."

The complainant was seen on day 14 of his initial call to the PCC at the system's primary care clinic. A PCP documented the following in the electronic health record:

Laceration, right 5th finger – healing, with residual swelling and tenderness. Patient is still on antibiotics and will finish course. The numbness probably is partially related to the swelling but the possibility that the nerve was cut remains. Since it is the finger of his dominant hand, will refer to hand surgery for evaluation and advice.

The PCP referred the complainant to the system's hand clinic for an evaluation. An appointment was scheduled; however, the complainant cancelled the appointment. The complainant was seen by his PCP 6 days later. The PCP wrote:

Finger infection resolved. Proximal finger cut with numbness along medial nerve distribution. Unsure if surgery or other therapy would have benefit at this point. Orthopedic hand referral placed for advice. X-ray prior to appointment.

Conclusions

We partially substantiated the allegation that the complainant called the PCC and requested a follow-up appointment with his PCP but the PCC agent refused to schedule an appointment; instead, told him that he would receive a call back but never did. We found that the PCC agent informed the complainant that a message would be sent to his PCT according to PCC procedures for follow-up appointments; however, the agent failed to send a GUI message to the PCT notifying them of the complainant's need for an appointment as required.

We partially substantiated the allegation that the complainant called the PCC a second time and a PCC agent refused to schedule an appointment even though the agent was told that the situation was urgent. We determined that the complainant's symptom was non-urgent and the PCC agent offered a clinic appointment date; however, the patient wanted to be seen that day. We did find that the PCC agent failed to follow PCC procedures for managing a "symptomatic call." The agent sent a GUI message to the provider instead of a TRM message to the VISN 22 Call Center triage nurse as required.

We did not substantiate the allegation that the complainant was forced to seek treatment at a community hospital ED for an infection in his finger near the bone. We determined that the system failed to provide timely follow-up with the complainant, which resulted in his decision to seek treatment at a community hospital emergency department. We also determined that the PCC agents' failure to follow PCC procedures was the primary cause of the delays. While VHA does not require a local policy, we believe that established timeframes for patient follow-up would help to avoid undue waits or delays in care.

We did not substantiate the allegation that the patient was at risk for finger amputation due to lack of medical attention at the system. We found that the complainant was treated for a mild infection in his finger, which was resolved after 7 days of treatment with antibiotics. While the system failed to provide timely follow-up, we determined that the complainant was not denied access to care; he chose to seek treatment in the local community.

Recommendations

Recommendation 1. We recommended that the System Director ensures that Patient Call Center agents follow policy and procedures for scheduling follow-up appointments and managing non-urgent symptomatic calls.

Recommendation 2. We recommended that the System Director ensures that timeframes for the primary care teams to follow-up with patients be established.

Comments

The VISN and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 7–10 for the Directors' comments.) We will follow up on the planned actions until they are completed.



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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 21, 2012

From: Director, VA Desert Pacific Healthcare Network (10N22)

Subject: **Healthcare Inspection – Appointment Scheduling and Access,
Patient Call Center, VA San Diego Healthcare System, San
Diego, CA**

To: Director, San Diego Office of Healthcare Inspections (54SD)

Thru: Director, VHA Management Review Service (VHA 10AR
MRS OIG Hotlines)

1. I concur with the responses to the recommendations in the draft Office of inspector General's report of Appointment Scheduling and Access, Patient Call Center Review.
2. If you have any questions regarding our response, please contact Robert M. Smith, M.D., Acting Chief medical Officer, at (562) 826-5963.

(original signed by:)

Stan Q. Johnson, MHA, FACHE

Director, VA Desert Pacific Healthcare Network (10N22)

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 19, 2012

From: Director, VA San Diego Healthcare System (664/00)

Subject: **Healthcare Inspection – Appointment Scheduling and Access,
Patient Call Center, VA San Diego Healthcare System, San
Diego, CA**

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. Enclosed are the responses to the recommendations in the draft Office of Inspector General's report of Appointment Scheduling and Access, Patient Call Center Review.
2. If you have any questions or wish to discuss the report, please contact me at (858) 642-3201.

(original signed by:)

Jeffrey T. Gering, FACHE

Director, VA San Diego Healthcare System (664/00)

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the System Director ensures that Patient Call Center agents follow policy and procedures for scheduling follow-up appointments and managing non-urgent symptomatic calls.

Concur

Target Completion Date: 1/31/2013

Facility Response:

Planned Action: The following plan has been developed to address the recommendation that PCC agents follow policy and procedures for scheduling, follow up appointments, and managing non-urgent symptomatic calls.

VASDHS will ensure that the Standard Operating Procedures (SOPs), including the Call Handling Procedures SOP, for the call center clearly define the steps for scheduling, follow-up appointments, and managing non-urgent calls. In addition, the SOP regarding callers who voice medical symptoms has been modified to include language (written out script) that if a patient (caller) expresses symptoms is automatically referred to the VISN 22 Nurse Call Center either through a warm handoff or through a TRM message which will trigger an advice nurse to call the patient back. This will provide improved guidance for agents so they are able to refer all symptomatic calls to the VISN 22 Nurse Call Center. VASDHS will distribute the revised training manual, including updated SOPs, to new and existing staff by December 31, 2012.

Beginning January, 2013, the Call Center supervisor will randomly audit agent calls on a bi-weekly basis. Calls will be audited for agent adherence to SOP guidelines. Feedback will be given to agents during bi-weekly performance meetings. These meetings have been conducted since September 17, 2012.

Beginning February, 2013, results of these audits will be reported to the Telephone Care System's Redesign Committee on a monthly basis. This committee includes the facility Director and other key leaders.

Recommendation 2. We recommended that the System Director ensures that timeframes for the primary care teams to follow-up with patients be established.

Concur

Target Completion Date: 1/14/2013

Facility Response:

Planned Action: The following plan has been developed to address the recommendation that PCTs have an established time frame for responding to messages left with the San Diego Primary Care Call Center. A member of the patient's PACT team (Primary Care Provider, RN, LVN) will be responsible for responding to messages taken by VASDHS Call Center for primary care. A new internal policy will be developed that identifies that standard for the PACT Team to contact the patient regarding messages taken by the VASDHS Call Center. The new policy will allow PCTs two business days to respond to messages from the Call Center.

Beginning January 14, 2013, the Primary Care Leadership Team will oversee monthly audits measuring compliance. The results of the audits will be discussed and addressed at the monthly Primary Care Leadership Team meeting. The audits will be performed until the Primary Care Leadership Team achieves a 90% success rate for calls returned in the targeted time.

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Deborah Howard, RN, Project Leader Elizabeth Burns, MSSW Judy Montano, MS Robert Yang, MD, Senior Medical Consultant Derrick Hudson, Program Support Assistant

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