Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Appointment Scheduling and Administrative Issues
Carl T. Hayden VA Medical Center
Phoenix, Arizona

Report No. 07-00050-146

June 18, 2007

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Executive Summary

The purpose of the review was to determine the validity of allegations regarding delays in appointment scheduling and other administrative issues at the Carl T. Hayden VA Medical Center, Phoenix, AZ.

The complainant alleged he was told to call within 30 days for a follow-up appointment, and if none was available, continue to call each day in case an appointment became available due to a cancellation. We substantiated that at the time of the allegations the appointment scheduling system for primary care caused delays in scheduling appointments, was ineffective, and was problem prone. A high volume (40 percent) of patient complaints during the last quarter of FY 2006 pertained to phone calls not answered/returned and excessive delay in scheduling appointments.

The complainant also alleged the average wait for an operator response was approximately 1–1.5 hours. We did not substantiate the allegation that medical center operators' response time was 1–1.5 hours. The delays in the telephone system occurred once calls to the main number had been transferred to extensions within the medical center.

Finally, allegations by the complainant stated certain staff schedule appointments in advance and beyond 30 days. As a result, some veterans were receiving preferential treatment. We did not substantiate that appointments scheduled beyond the 30 day requirement by their providers demonstrated preferential treatment.

When we visited the facility, a new call center had been operational for 3 weeks. The staff expressed receiving positive feedback from veterans but could not assess the impact of the changes at that time. Therefore, we recommended that the medical center establish and monitor performance improvement measures for the call center to assess primary care appointment improvements and patient satisfaction with these services. 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, Veterans Integrated Service Network (10N18)

SUBJECT: Healthcare Inspection – Appointment Scheduling and Administrative Issues, Carl T. Hayden VA Medical Center, Phoenix, AZ

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of allegations regarding delay in appointment scheduling and administrative issues at the Carl T. Hayden VA Medical Center (medical center), Phoenix, AZ.

Background

The OIG Hotline Division received allegations regarding long wait times for medical center telephone operators to respond when a patient calls to schedule a primary care appointment. Specifically, the complainant alleged he was told to call within 30 days for a follow-up appointment, and if none was available, continue to call each day in case an appointment became available due to a cancellation. He also alleged it was extremely difficult to speak to a "live person," and the average wait for an operator response was approximately 1–1.5 hours. He further alleged certain staff schedule appointments in advance and beyond 30 days. As a result, some veterans were receiving preferential treatment.

Scope and Methodology

The OHI conducted a telephone interview with the complainant, followed by a site visit to the medical center. We examined the appointment scheduling process and reviewed local policies and procedures for scheduling appointments, access to care data, operator response times, and patient wait times. We interviewed the patient advocate, outpatient clinic clerks/schedulers, operators, telephone system supervisor, and outpatient clinic manager.

We also reviewed patient complaints to determine if there had been other allegations regarding preferential treatment and the related Survey of Health Expectations of Patients scores to validate patient complaints during fiscal year (FY) 2006.

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

Results

Issue 1: Long Wait Times

We substantiated that there had been long patient wait times when scheduling primary care appointments. The FY 2006 patient advocates' report revealed 40 percent of patient complaints during the last quarter pertained to phone calls not answered/returned and excessive delay in scheduling. Medical center staff and managers told us the appointment process for primary care was not efficient. Patients experienced long delays – up to an hour – after their calls were transferred by operators to the primary care scheduling staff. Once the patient reached a clinic scheduler, appointments within the required 30 days were rarely available. As a result, patients were required to call the primary care clinic schedulers each day until they were able to obtain an appointment within the Veterans Health Administration's (VHA's) 30 day requirement.

The medical center director established a work group comprised of VA employees in the primary care clinics and veterans. The group identified causes for delay in clinic schedulers answering telephones and patients' inability to obtain appointments. They provided their findings and recommendations to the Medical Center Director. Process changes suggested were to: (1) acquire more staff to improve timeliness of clinic schedulers answering response and (2) open more appointment slots to improve availability within the 30 day requirement. In response, the Medical Center Director authorized five additional patient telephone appointment scheduling agents. The number of appointment slots held for emergencies was decreased to allow more available follow-up appointment slots for each provider. In addition, a call center was established to centralize all scheduling and enhance the efficiency of the appointment process.

Issue 2: Operator Response Time

We did not substantiate the allegation that medical center operators' response time was 1–1.5 hours. We inspected the main switchboard area and observed the telephone operators receiving incoming telephone calls, which were promptly directed to other extensions. The delays in the telephone system occurred once calls to the main number had been transferred to extensions within the medical center, where calls are placed on hold until the clinic schedulers answer. (As discussed in Issue 1.)

Issue 3: Preferential Treatment

We did not substantiate the allegation that some veterans received preferential treatment when scheduling their appointments. Staff interviewed denied having knowledge of or giving preferential treatment to patients. Two primary care providers acknowledged scheduling patients for a follow-up appointment beyond 30 days at the exit of their last encounter for the provider's convenience. However, we did not substantiate that appointments scheduled beyond the 30 day requirement by their providers demonstrates preferential treatment.

Conclusion

We concluded that at the time of the allegations, the appointment scheduling system for primary care was ineffective and problem prone. For example, a high volume (40 percent) of patient complaints during the last quarter in FY 2006 pertained to phone calls not answered/returned and excessive delay in scheduling appointments. However, a work group comprised of VA employees and veterans, supported by management, identified the need for additional staff and resources to improve the primary care appointment scheduling system. When we visited the facility, a new call center had been operational for 3 weeks. We were provided with the call center's standard operating procedures and interviewed various appointment schedulers. The staff expressed receiving positive feedback from veterans but could not assess the impact of the changes at that time.

Recommendation

Recommendation 1. We recommend the VISN Director ensure the Medical Center Director takes action to establish and monitor performance improvement measures for the call center to assess primary care appointment improvements and patient satisfaction with these services.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendation and provided acceptable improvement plans. Performance improvement measures have been established for the call center (VA Helpline) to assess primary care appointment improvements and patient satisfaction with these services. Furthermore, they have specified measures and monitoring mechanisms. Patient Satisfaction will be monitored by reviewing and trending data in the Patient Advocate report. (See Appendixes A and B, pages 5–9, for the full text of their comments.) We will follow up on the planned actions until they are completed.

(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: February 15, 2007

From: Network Director (10N18), VA Southwest Health Care Network, Mesa, AZ

Subject: Healthcare Inspection — Appointment Scheduling and Administrative Issues, Carl T. Hayden VA Medical Center, Phoenix, Arizona

To: Assistant Inspector General for Healthcare Inspections

THRU: Director, Management Review Service (10B5)

I concur with the facility response. See Medical Center Director's Comments for specific actions. Please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18 at 602.222.2692, for any questions.

Patricia A. McKlem

Patricia A. McKlem

Network Director

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

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

OIG Recommendation

We recommend the VISN Director ensure the Medical Center Director takes action to:

Recommendation 1. Establish and monitor performance improvement measures for the call center to assess primary care appointment improvements and patient satisfaction with these services.

Concur **Target Completion Date:** March 15, 2007

See Medical Center Director's Comments for specific actions

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 13, 2007

From: Medical Center Director (644/11Q), Carl T. Hayden VA Medical Center, Phoenix, AZ

Subject: Healthcare Inspection — Appointment Scheduling and Administrative Issues, Carl T. Hayden VA Medical Center, Phoenix, Arizona

To: Network Director (10N18), VA Southwest Health Care Network, Mesa, AZ

1. The recommendations made as a result of the Healthcare Inspection visit to the Carl T. Hayden VA Medical Center regarding the allegations of the delay in appointment scheduling and other administrative issues have been reviewed and our comments and implementation plan are noted below.

2. If you have any questions, please contact Sally Compton, QM Program Manager, Quality Management Department at 602.277.5551, ext. 6777.

(original signed by:)

DONALD F. MOORE, RPh, MBA

Medical Center Director

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

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

OIG Recommendation

We recommend the VISN Director ensure the Medical Center Director takes action to:

Recommendation 1. Establish and monitor performance improvement measures for the call center to assess primary care appointment improvements and patient satisfaction with these services.

Concur **Target Completion Date:** March 15, 2007

Performance improvement measures have been established for the call center (VA Helpline) to assess primary care appointment improvements and patient satisfaction with these services. The measures and monitoring mechanisms are specified below.

(a) Phone calls to the scheduling agents from veterans who want to make or cancel an appointment will be answered within five (5) minutes 90% of the time when the call is placed into the appointment phone queue. Scheduling agents will make primary care appointments for 85% of answered calls. When the appointment cannot be made according to VHA guidelines, the veteran will be placed on the Electronic Wait List. These measures will be monitored by tracking times for calls that are answered by scheduling agents via data from Symposium software and VistA, and monitoring the number of patients on the primary care appointment Electronic Wait List.

(b) Patient Satisfaction will be monitored by reviewing and trending data in the Patient Advocate report (see OIG reference under Issue 1 on page 2 of this report) related to patient complaints regarding telephone calls not answer/returned and excessive delay in scheduling.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Wilma Reyes, Healthcare Inspector Dallas Office of Healthcare Inspections (214) 253-3334
Acknowledgments	Linda DeLong, Director Karen Moore, Associate Director Marilyn Walls Roxanna Osegueda

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network 18
Director, Carl T. Hayden VA Medical Center

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction and Veterans Affairs
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction and Veterans Affairs
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate:
  Jon Kyl
  John McCain
U.S. House of Representatives:
  Ed Pastor

This report is available at http://www.va.gov/oig/publications/reports-list.asp.