Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Management of Emergency Calls
Primary Care Call Center
VA San Diego Healthcare System
San Diego, California

Report No. 11-03074-57 **December 21, 2011**

VA Office of Inspector General
Washington, DC 20420

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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 the management of emergency calls at the Primary Care Call Center (PCCC), VA San Diego Healthcare System (the system), San Diego, CA.

We substantiated the allegations that PCCC agents did not follow established procedures for referring emergency calls for triage. We concluded that the PCCC had serious problems that put patients at risk. However, changes recommended by the Systems Redesign Committee and actions taken made significant improvements in PCCC timeliness in responding to calls and the abandonment rate. We substantiated that PCCC agents were inexperienced and lacked appropriate training. Failure to provide PCCC agents training on the basic competencies such as symptomatic and emergent call documentation and routing, and medical terminology put patients at risk.

We substantiated the allegation that patient event reports were filed, but the Health Administrative Service did not evaluate the root causes of identified on-going problems. Managers were aware of this deficiency and initiated a Root Cause Analysis.

In summary, we concluded there were significant operational problems with the PCCC. However, appropriate Veterans Integrated Service Network and system managers are aware of these issues and are taking actions to rectify them.

We recommended that the System Director ensure that: (1) managers monitor PCCC agents' compliance with procedures, and re-evaluate processes to ensure all emergency calls are routed appropriately, (2) PCCC agents receive initial training on required competencies and that competencies are confirmed annually thereafter, and consistently documented, and (3) Root Cause Analyses in response to patient event reports are completed and appropriate action taken as needed.

The VISN and Medical Center Directors concurred with the findings and 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, Veterans Integrated Service Network (10N22)

SUBJECT: Healthcare Inspection – Management of Emergency Calls, Primary Care Call Center, VA San Diego Healthcare System, San Diego, California

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections performed an inspection to determine the validity of allegations regarding the inappropriate management of emergency calls at the Primary Care Call Center (PCCC), VA San Diego Healthcare System (the system), San Diego, CA.

Background

The system includes a tertiary care hospital and is part of Veterans Integrated Service Network (VISN) 22. It provides healthcare to more than 240,000 veterans in San Diego and Imperial Valley counties. In 1993, the system initiated a telephone advice program which would permit patients to call and speak with a healthcare professional if they were having symptoms or needed advice regarding appointments, prescription refills, and other services. In 2000, VISN 22 expanded access to telephone care with the establishment of a 24 hour, 7 day a week telephone advice program. The program is toll free, network wide, and based at the VA Greater Los Angeles Healthcare System (GLA).

In 2001, the system established the PCCC at a central location in Mission Valley. At that time, Nursing Service had administrative oversight of the registered nurses (advice nurses) and the medical support assistants (PCCC agents) in the call center. In 2008, the Health Administrative Service (HAS) was created and the PCCC agents were realigned under HAS.

PCCC agents answer calls from patients who may want to renew medications, leave messages for primary care providers, discuss symptoms with advice nurses, schedule primary care appointments, obtain laboratory results, or request transfer of care. The

PCCC staff consists of a supervisory medical administration specialist and 20 PCCC agents who provide telephone services during the weekday from 7:00 a.m. to 7:00 p.m.. All week day after hour calls and week-end calls are automatically forwarded to the telephone advice program in GLA.

On May 20, 2011, a complainant contacted OIG with allegations that patients reporting emergency symptoms on the call line were at risk for delays in care and poor clinical outcomes.

Specifically, the complainant alleged:

- PCCC agents were not following established procedures for referring emergency calls for triage.
- The PCCC supervisor instructed an agent to bypass the advice nurses, causing a serious delay in care that could have lead to death.
- The Systems Redesign Committee made operational changes in the PCCC that have placed veterans at risk for delays in care and poor outcomes.
- Shortly after the PCCC supervisor was hired, the supervisor made operational changes that seriously impacted the way veterans received telephonic care.
- Inexperienced and poorly trained PCCC agents, without clinical knowledge or an understanding of basic medical terminology, were managing clinical calls.
- Patient event reports (PERs)[1] were filed, but HAS did not evaluate the root cause of recurrent problems.

Scope and Methodology

We interviewed the complainant prior to conducting site visits on July 25–26 and August 4, 2011. We visited the PCCC in Mission Valley. We interviewed the Acting System Director, Associate Director for Patient Care Services, Chief of Quality and Performance Improvement, risk manager, patient safety manager, and the PCCC's managers and staff. We reviewed pertinent Veterans Health Administration (VHA) and local policies and procedures, PERs, training records, and 27 patient medical records (this included the 12 patients referred by the complainant).

[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.

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: Failure to follow PCCC Procedures

We substantiated the allegation that PCCC agents did not follow established procedures for referring emergency calls for triage. We could neither substantiate nor refute the allegation that a PCCC supervisor instructed an agent to bypass the advice nurses or that there was a serious delay in care that could have lead to a patient's death (Case 3 below).

We reviewed the PERs and medical records for 27 patients who called the PCCC during November 1, 2010–August 4, 2011, and complained of symptoms listed on the emergent symptoms list.[2] We found that none of these patients were referred to the advice nurse's emergency line as required by policy. The PCCC agents either sent computer messages to primary care teams or transferred calls to the advice nurse non-emergent line. Below are three example cases that PCCC agents did not refer to the advice nurse's emergency line as required:

- Case 1: A clinic nurse was unable to reach a patient who had called the PCCC and complained of chest pains until the following day, at which time the patient was advised to go to the emergency room. The patient was admitted to the coronary intensive care unit and was discharged 14 days later in stable condition.

- Case 2: A patient called the PCCC and reported that his blood sugar was in the 500's [mg/dl]. A clinic nurse's attempts to reach the patient were unsuccessful and the veteran was not seen until 3 days later at a scheduled appointment. The patient reported that he had been seen and treated by his private physician on the day he called the PCCC.

- Case 3: A patient called the PCCC and reported a blood sugar reading of 589. The agent attempted to transfer the call to an advice nurse at the GLA call center instead of a local advice nurse as per established procedures. While the agent waited to speak to the GLA advice nurse the patient hung up. The agent subsequently notified a local advice nurse who called the

[2] Emergent symptoms list is a list of acute medical or psychiatric illnesses or injuries for which there is a pressing need for treatment to manage pain or prevent deterioration of condition where delay might impair recovery.

patient and left a voice message for him to go to the emergency room. The patient was seen in the system's emergency room that same day and treated and released in stable condition.

Issue 2: PCCC Operational Changes

A. Systems Redesign Committee

We did not substantiate the allegation that the Systems Redesign Committee made operational changes in the PCCC that placed patients at risk for delays in care and poor outcomes.

The Acting System Director reported that the Systems Redesign Committee became involved in the PCCC due to concerns regarding timeliness in responding to calls and an increased abandonment rate.[3] VHA uses the Utilization Review Accreditation Committee Health Call Center Standards as a benchmark for performance.[4] This standard recommends an average speed of answering a call was 30 seconds or less[5] and an abandonment rate of less than 5 percent. In July 2010, the PCCC average speed to answer a call was 13 minutes and the abandonment rate was 45 percent.

We reviewed the Systems Redesign Committee minutes and found that the following changes were made: (1) December 2010, the system began hiring additional full-time equivalent PCCC agents, (2) April 2011, the advice nurses were relocated to the Mission Valley Primary Care Clinic and continued to receive emergency calls, and (3) May 2011, the system established a direct line between PCCC agents and the GLA advice nurses' emergency line and directed PCCC agents to transfer all emergency calls to a GLA advice nurse and all non-emergent calls requesting registered nurse advice be transferred to the local advice nurses. Patients who call the PCCC and do not request clinical advice, are to be given appointments for primary care and the primary care team is to be notified of the appointment date, reason for the appointment, and veteran's symptoms.

System leaders reported a significant improvement in the PCCC performance due to these changes. The May 2011 PCCC performance data showed a 34 second average speed of answering calls and a 2.5 percent abandonment rate.

[3] Abandonment rate is the percentage of calls coming into a telephone system that are terminated by the person originating the call before being answered by a staff person.
[4] VHA Directive 2007-033, *Telephone Service for Clinical Care*, October 11, 2007.
[5] Average speed of answering a call is the average delay in seconds that inbound telephone calls encounter waiting in the telephone queue of a telephone service system before answered by a staff person.

B. PCCC Supervisor

We did not substantiate the allegation that shortly after the PCCC supervisor was hired, the supervisor made operational changes that seriously impacted the way patients received telephonic care.

The PCCC supervisor was hired in August 2008. The supervisor reported implementing changes in September 2010 that were approved by the Systems Redesign Committee. The changes included work schedules, agent performance standards for receiving calls, and other daily office activities. We found no evidence that these changes adversely affected patient care.

Issue 3: PCCC Agent Training and Competencies

We substantiated the allegation that inexperienced and poorly trained PCCC agents, without an understanding of basic medical terminology, were managing clinical calls.

We found that 15 of the 20 PCCC agents had been hired within the past 12 months. We interviewed seven PCCC agents and four were new hires. All the agents described their orientation as two weeks of on-the-job training that included how to receive calls, transfer calls, and schedule appointments. However, we did not find documentation of this training for the new hires. In the December 2010, Systems Redesign Committee minutes managers discussed developing a training program for PCCC agents, to include medical terminology. We did not find any indication that the program was ever initiated.

We reviewed the position description for PCCC agents. We noted that while there is no requirement for clinical knowledge, an understanding of medical terminology is required. However, only one agent had documentation of medical terminology training.

Core competencies for PCCC agents includes proficiencies in customer service and telephone etiquette, appointment scheduling, call documentation, primary care practitioner message delivery, suicide call procedure, and proper telephone operation. Our review of 20 PCCC agents' Record of Employee Competence forms found that none of the forms were completed as required. System policy states that managers will ensure competence of all new employees through a competence base assessment conducted as part of the service-specific orientation, including completion of a Record of Employee Competence or other equivalent assessment documents. In addition, policy requires annual verifications of competence.

PCCC agents told us that they were not properly trained on the use of the emergent symptoms list. We found that symptomatic and emergent call documentation and routing was one of the PCCC agents' core competencies; however, we did not find evidence that training was provided or that this competency was assessed for any of the PCCC agents.

Issue 4: System Leaders Response to PCCC Issues

We substantiated the allegation that PERs were filed but HAS did not evaluate the root causes of recurrent problems.

Our review of the PERs found 18 "close call" events. The "close calls" were forwarded to HAS managers for review, and recommendations were made for re-training staff. However, we did not find evidence that the re-training occurred. We found that the system revised the emergent symptoms list, but could not determine if PCCC agents were trained on the revised list.

System managers reported that there was an increase in PERs related to the call center during implementation of the operational changes and that these issues were addressed in the Systems Redesign Committee. However, committee minutes did not include documentation related to the inappropriate routing of emergency calls. VHA requires facilities to review close calls to identify underlying causes and implement changes to reduce the likelihood of recurrence.[6] We were informed while on site that a Root Cause Analysis[7] related to two PERs had been initiated.

Conclusions

We substantiated the allegations that PCCC agents did not follow established procedures for referring emergency calls for triage and that the agents were inexperienced and lacked appropriate training. We concluded that the PCCC had serious problems that put patients at risk. However, changes recommended by the Systems Redesign Committee and actions taken made significant improvements in PCCC timeliness in responding to calls and the abandonment rate.

We substantiated the allegation that PCCC agents were inexperienced and lacked appropriate training. Failure to provide training on the basic competencies such as symptomatic and emergent call documentation and routing, and medical terminology put patients at risk.

We substantiated the allegation that PERs were filed, but HAS did not evaluate the root causes of identified on-going problems. Managers were aware of this deficiency and initiated a Root Cause Analysis.

In summary, we concluded there were significant operational problems with the PCCC. However, appropriate VISN and system managers are aware of these issues and are taking actions to rectify them.

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[6] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

[7] Root Cause Analysis is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with close calls.

Recommendations

Recommendation 1. We recommended that the System Director ensure managers monitor PCCC agents compliance with procedures, and re-evaluate processes to ensure all emergency calls are routed appropriately.

Recommendation 2. We recommended that the System Director ensure that PCCC agents receive initial training on required competencies and that competencies are confirmed annually thereafter, and consistently documented.

Recommendation 3. We recommended that the System Director ensure that Root Cause Analyses in response to PERs are completed and appropriate action taken as needed.

Comments

The VISN and Medical Center Directors concurred with the findings and recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 25, 2011

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

Subject: **Healthcare Inspection – Management of Emergency Calls, Primary Care Call Center, VA San Diego Healthcare System, San Diego, CA**

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

Thru: Director, Management Review Service (10B5)

1. The 2011 VA San Diego Healthcare System CBOC review recommendations for OIG items 1-3 have been provided in the attached status update. I have reviewed and concur with the facility updates and request closure of all recommendations based on the evidence provided.

2. If you have questions, please feel free to contact me at the Network Office at (562) 826-5963.

(*original signed by*:)
Stan Q. Johnson, MHA, FACHE
Director, VA Desert Pacific Healthcare Network (10N22)

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 23, 2011

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

Subject: **Healthcare Inspection – Management of Emergency Calls, Primary Care Call Center, VA San Diego Healthcare System, San Diego, CA**

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

1. Please see the attached status update on OIG's recommendations 1-3 for the VA San Diego Healthcare System CBOC review conducted in 2011. Updated responses have been provided for each recommendation. We request closure of all recommendations on the evidence provided.

2. If you have questions, please feel free to contact Sue Hollis, Acting Chief, HAS, at (858) 552-8585 extension 3980.

(*original signed by*:)
Robert M. Smith, MD
Acting 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 ensure managers monitor PCCC agents compliance with procedures, re-evaluate processes to ensure all emergency calls are routed appropriately.

Concur **Target Completion Date: 10/1/2011**

Facility's Response:

Every month, Health Administration Service and Nursing Service will participate in case reviews of symptomatic calls. The PCCC supervisor will randomly select one to two symptomatic calls each week for case review by the Medical Director of the Call Center. Likewise, Nursing Service will select two symptomatic calls each week for case review by the Medical Director of the Call Center. Thus, approximately 12-16 calls per month will be reviewed. These reviews will include patient reported symptoms, timeliness of call transfer, and the appropriateness of transfer and interaction between staff.

Changes in the Phone Tree Menu associated with the Call Center has resulted in a 50% reduction in symptom-associated calls reaching the agents. These calls are then routed to clinical staff for management.

Status: Completed with ongoing audits.

Recommendation 2. We recommended that the System Director ensure that PCCC agents receive initial training on required competencies and that competencies are confirmed annually thereafter, and consistently documented.

Concur **Target Completion Date: 10/4/2011**

Facility's Response:

PCCC agent competencies have been added to all call center staff evaluations, and initial competency assessments completed. Ongoing assessments will be completed on a yearly basis. Additional training on medical terminology and customer service has been conducted and will be continued on an ongoing basis.

Status: Completed

Recommendation 3. We recommended that the System Director ensure that the Root Cause Analysis in response to PERs are completed and appropriate action taken as needed.

Concur **Target Completion Date: 10/1/2011**

Facility's Response:

The Root Cause Analysis addressing the routing of symptom-based calls has been completed. All actions are complete or in progress, including ongoing review call quality and appropriateness of transfer to clinical staff. The outcome of the action items will be tracked as part of the RCA followup.

Status: Completed with ongoing assessment of RCA action items.

Appendix C

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 Jerome Herbers, MD, Medical Consultant Derrick Hudson, Program Support Assistant

Appendix D

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