ADMINISTRATIVE SUMMARY OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN RESPONSE TO ALLEGATIONS REGARDING PATIENT WAIT TIMES

VA Community Based Outpatient Clinic in Lake Havasu City, Arizona March 9, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated in response to a letter sent to Senator John McCain by a Department of Veterans Affairs (VA) employee alleging medical, administrative, and clerical violations, including "paper scheduled appointments," at the VA Community Based Outpatient Clinic (CBOC) in Lake Havasu City, AZ.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** We conducted four interviews.
- **Records Reviewed:** We reviewed a blank copy of an "encounter form" used by CBOC Lake Havasu City.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- A CBOC Lake Havasu City medical support assistant (MSA1) told VA Office of Inspector General (OIG) staff that approximately 30 times during the preceding year, a nurse practitioner and a clinic manager gave her encounter forms that showed a patient's next appointment date that was different from what nurse practitioner had entered into VA's Computerized Patient Record System (CPRS)—a subcomponent of the Veterans Information Systems and Technology Architecture (VistA) software. MSA1 stated that she spoke to the nurse practitioner and clinic manager about the issue. She also said that she was reprimanded several times for scheduling errors but did not provide any documentation when asked. She stated that, at the direction of clinic manager, she would schedule appointments based on the dates listed on the encounter forms, and not what was reflected in CPRS. MSA1 stated that she was being retaliated against, but did not provide a reason for it. When asked by VA OIG staff to provide details of a specific instance in which there were conflicting dates between a patient's encounter form and his/her CPRS record and which led to her being blamed for the inconsistency, she could not cite a single example. Later in the interview, she stated that, in fact, she was not being blamed for errors that were not her own.
- MSA2 stated that new patients at CBOC Lake Havasu City are seen within 2 to 4 weeks and that established patients are seen within 4 weeks. She added that most patients request to be seen on the next available appointment date, which then becomes their "desired date." She stated that she has never directed anyone, nor has she been directed by anyone, to conduct unethical scheduling and that there are no lists/logs or printed

items; only CPRS inputs in accordance with VA regulations. MSA2 advised that, in her opinion, MSA1 did not intentionally do anything wrong, but that MSA1 did not grasp certain things, which led to mistakes. She stated that she has also seen conflicts between the dates listed on the encounter form and those listed in CPRS, and that she rectified those problems by speaking directly with the provider to determine which date was correct.

- A Veterans Integrated Service Network (VISN) 18 senior leader told VA OIG staff that VISN 18 has had a "serious issue with wait times for a very long time." When she first arrived at VISN 18, and probably for 2 to 3 years after that, VISN 18 was near or at the bottom, in terms of access metrics. She viewed this as "good," as it reflected that her facilities were telling the truth. She had many concerns about it being "too easy to make mistakes in the software and in the process," and stated that VistA is a "really miserable software program." She added that, despite hearing from VA facilities within the VISN 18 network that there were no patient access problems, she was aware of many veteran complaints to the contrary. She stated, "If you're getting a lot of veteran complaints, and you're doing okay with access, it means you're gaming." She did not name CBOC Lake Havasu City as a facility with which she had concerns and focused primarily on VAMC Phoenix.[*]

- A clinic manager told VA OIG staff that the wait times for existing patients was approximately 14 days and new enrollees were seen in approximately 30 days. CBOC Lake Havasu City does not use the Electronic Wait List and does not have any wait time issues. In January 2013, the clinic manager had a conversation with MSA1 about proper scheduling and, in March 2013, sent her an email about scheduling "labs" and scheduling with the correct provider. In April 2013, the decision was made to retrain MSA1 in her "core competencies." After the retraining, the clinic manager was not comfortable with MSA1's understanding of scheduling and came to CBOC Lake Havasu City twice more, specifically to train MSA1. The clinic manager informed VA OIG staff of an incident in which MSA1 received an encounter form showing that the patient was to return in 11 weeks while CPRS indicated that he/she should return in 6 weeks. MSA1 brought it to clinic manager, who informed MSA1 that she needed to take the issue to the provider and see which date the provider wanted the patient to return. The next day, MSA1 told the clinic manager that the provider was "out to get her." The clinic manager provided VA OIG staff with an email exchange in which MSA1 admitted to having scheduling problems. In July 2014, MSA1 made the clinic manager aware of only one discrepancy regarding different dates being reflected on encounter forms and in CPRS. She stated that she advised MSA1 to resolve the problem with the provider. The clinic manager also said that MSA1 was never "truly reprimanded" or "written-up," and that she had been retrained.

[*] Any reference to Phoenix in this summary refers to wait time allegations that surfaced at VAMC Phoenix in early 2014.

Records Reviewed

VA OIG staff reviewed a blank copy of an encounter form used by CBOC Lake Havasu City. The review determined that an encounter form is the form given by VA providers to patients to provide the MSA with appointment information; it is not a paper list regarding scheduling.

4. Conclusion

This investigation revealed that the "paper scheduling" alleged by the complainant was actually an encounter form given to patients to provide to an MSA for current appointment and next appointment information. The investigation did not reveal that any CBOC Lake Havasu City personnel were keeping separate scheduling lists and also determined that the alleged "clerical violations" were in fact a misunderstanding between the complainant and other employees.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on February 26, 2015.

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