Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04260-395

Healthcare Inspection

Alleged Quality of Care Issues at the Community Based Outpatient Clinic Casa Grande, Arizona

July 7, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to allegations received by Congresswoman Ann Kirkpatrick's office concerning quality of care issues at the Community Based Outpatient Clinic (CBOC), Casa Grande, AZ, which is part of the Southern Arizona VA Health Care System. Specifically, it was alleged that:

- Twenty-eight of 38 CBOC staff had resigned or transferred.
- A patient was placed "on hold" when calling to schedule an appointment and was never able to reach a scheduler.
- A patient suffered a heart attack, stroke, and pneumonia 3 days after trying to schedule an appointment at the Casa Grande CBOC; had to seek care outside the VA; and was told she would have to wait 6 weeks for the next available follow-up appointment.
- A patient committed suicide the day after being denied a mental health appointment at the Casa Grande CBOC.
- Patients are being "double booked" for appointments for the same provider.
- A scheduler is "overriding the schedule" and overbooking evaluation appointments.

We did not substantiate the allegation that 28 of 38 CBOC staff had resigned or transferred. We found that from August 2012 to the time of our site visit in August 2014, a total of 12 CBOC staff had vacated their positions. Additionally, we found 35 staff presently assigned to the Casa Grande CBOC with vacancies for 1 physician, 1 registered nurse, and 1 licensed practical nurse. We also found one full-time and one part-time locum tenens physicians assigned at the Casa Grande CBOC.

While we could not substantiate the allegation that a patient was placed "on hold" when calling to schedule an appointment and was never able to reach a scheduler, we found that the Casa Grande CBOC's call response time and call abandonment rate did not meet Veterans Health Administration goals.

We could not substantiate the allegation that a patient suffered a heart attack, stroke, and pneumonia 3 days after trying to schedule an appointment at the Casa Grande CBOC and had to seek care outside the VA. We did not substantiate the allegation that the patient was told she would have to wait 6 weeks for a post-hospitalization appointment in 2012. However, we found that there were delays in assessment of the patient's condition prior to two hospital admissions in the community and a delay in follow-up for the patient after one of the two hospitalizations.

We did not substantiate the allegation that a patient committed suicide because he was denied a mental health appointment by the Casa Grande CBOC. The patient had a scheduled appointment with a Tucson mental health provider prior to his death. We found documentation in the electronic health record indicating the patient canceled the appointment.

We did not substantiate the allegation that patients were being "double booked" for appointments for the same provider. We reviewed randomly selected provider appointment schedules from January 2014 through August 2014, and we did not find patients who had appointments that were "double booked."

We did not substantiate the allegation that a scheduler is "overriding the schedule" and overbooking evaluation appointments (generally a 60-minute slot for new patients). We reviewed randomly selected provider appointment schedules from January 2014 through August 2014 and did not find overbooked evaluation appointments. CBOC staff indicated that because these appointments require a 60-minute time slot, they can never be overbooked. However, a provider may request that a patient be scheduled during the provider's lunch period, and this may be what some consider "overriding the schedule."

We recommended that the Southern Arizona VA Health Care System Director ensure that same day access appointments and post hospitalization follow-up appointments at the Casa Grande CBOC are triaged appropriately and timely and ensure processes are strengthened to improve telephone appointment scheduling practices.

COMMENTS

The Acting Veterans Integrated Service Network Director and System Director concurred with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 9–12, for the full text of 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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to allegations received by Congresswoman Ann Kirkpatrick's office concerning quality of care issues at the Community Based Outpatient Clinic (CBOC), Casa Grande AZ. The purpose of this inspection was to determine if the allegations had merit.

Background

The Casa Grande CBOC is a part of the Southern Arizona VA Health Care System (Tucson) in Veterans Integrated Service Network (VISN 18) and is located in Casa Grande, AZ. The Casa Grande CBOC provides outpatient services to approximately 4,000 unique veterans through 23,000 annual outpatient visits. Services provided at the CBOC include primary care, mental health, optometry, audiology, basic radiology services, physical therapy, pharmacy, nutrition, home based primary care, and telehealth services.

Allegations

In July 2014, the OIG received a congressional request to review allegations regarding, inadequate staffing, telephone appointment scheduling concerns, delays in care, and manipulation of scheduling practices at the Casa Grande CBOC. Specifically, it was alleged that:

- Twenty-eight of 38 CBOC staff had resigned or transferred.
- A patient was placed "on hold" when calling to schedule an appointment and was never able to reach a scheduler.
- A patient suffered a heart attack, stroke, and pneumonia 3 days after trying to schedule an appointment at the Casa Grande CBOC; had to seek care outside the VA; and was told she would have to wait 6 weeks for the next available follow-up appointment.
- A patient committed suicide because he was denied a mental health appointment at the Casa Grande CBOC.
- Patients are being "double booked" for appointments for the same provider.
- A scheduler is "overriding the schedule" and overbooking evaluation appointments.

We also received, but did not address, an allegation that a patient received an appointment notification letter 1-week after his/her scheduled appointment because the patient was unable to provide us a specific date of the scheduled appointment or a copy of the appointment notification letter.

Scope and Methodology

We conducted a site visit August 11–13, 2014. We interviewed the complainant, CBOC Medical Director, Chief of the Primary Care Service Line, primary care providers (PCPs), registered nurses (RNs), licensed practical nurses (LPNs), Medical Support Assistants (MSAs), Patient Aligned Care Team (PACT) members, and other staff with information relevant to the allegations. We reviewed electronic health records (EHRs), non-VA medical records that had been scanned into the VA EHR by the time of our review, relevant Veterans Health Administration (VHA) and facility policies, call center logs, provider schedules, and other documents pertinent to the allegations.

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: CBOC Staffing

We did not substantiate the allegation that 28 of 38 CBOC staff had resigned or transferred from the Casa Grande CBOC.

We reviewed documentation from August 2012 to August 2014 for all staff who resigned, separated, or transferred, as well as all staff who were presently assigned at the Casa Grande CBOC. We found that 12 staff (5 RNs, 1 LPN, 1 dietician, 1 social worker, 1 MSA, and 3 physicians) had vacated their positions. Additionally, we found 35 staff presently assigned to the Casa Grande CBOC with vacancies for 1 physician, 1 RN, and 1 LPN. We also found one full-time and one part-time locum tenens (a medical practitioner who temporarily takes the place of another) providers assigned at the Casa Grande CBOC.

Issue 2: CBOC Telephone Appointment Scheduling Practices

While we could not substantiate the allegation that a patient was placed "on hold" when calling to schedule an appointment and was never able to reach a scheduler, we found that the Casa Grande CBOC's call response times and call abandonment rates for the time frame we reviewed did not meet VHA goals.[1]

We interviewed all three of the MSAs who schedule appointments at the Casa Grande CBOC. The MSAs indicated that they are assigned on a bi-weekly rotation to schedule appointments for patients calling in to the Casa Grande CBOC. The MSA working in the front office, as well as the office manager, will also take incoming calls if it is noted that there are additional calls on hold in the queue. The queue can hold up to five calls.

VHA's goal is that a caller should first talk to a person (response time) in 30 seconds or less, and the call abandonment rate should be less than or equal to 5 percent.[2] We reviewed monthly logs of calls placed to the Casa Grande CBOC from October 2013 through July 2014. We found that the average wait time until calls were answered was 77 seconds with a monthly range from 41 to 126 seconds, and the average abandonment rate of calls was 9.7 percent with a monthly range from 4 to 20 percent.

Issue 3: Delays in Care

Patient 1—Delay in Receiving Care

We could not substantiate that a patient had a heart attack, stroke, and pneumonia 3 days after trying to schedule an appointment at the Casa Grande CBOC. While the patient was admitted to a community hospital, we could not confirm from the available

[1] VHA Directive 2007-033, *Telephone Service For Clinical Care*, October 11, 2007.
[2] VHA Directive 2007-033.

non-VA records that she had suffered a heart attack or a stroke, and for the time frame at issue the patient had a scheduled appointment at Casa Grande. We did not substantiate that the patient was told by a Casa Grande staff member that she would have to wait 6 weeks for an appointment after a 2012 hospitalization. According to the EHR, the patient called for a post-hospitalization appointment at the end of February, and an appointment was scheduled for 7 days later. We did find, however, delays in assessment of the patient's condition prior to 2012 and 2013 hospitalizations and a delay in the patient's follow-up after the 2013 hospitalization. We reviewed both admissions.

First Admission (2012). The patient was a veteran in her late 50s with a history of chronic low back pain. The patient had been receiving both primary and specialty care from the Tucson VA since 2001. In early 2012, she contacted the Casa Grande CBOC, told the MSA that she "threw out her back and shoulder" and asked that someone contact her. The CBOC RN returned the call a few days later. The patient told the RN about the shoulder pain and an inability to clear mucous. The RN spoke with the patient's primary care provider (PCP) who recommended x-rays and a clinic visit in 2 weeks. The next day, the PCP placed an order for low back x-rays and the CBOC RN left a voice message about the plan of care. An appointment was already on the books for the patient to see the PCP a few weeks later for unrelated issues. She also had an appointment scheduled a few weeks later with her MH provider.

Spine x-ray results for this time frame are not in the EHR. The patient did not attend and did not cancel (no-showed) the appointment that was on the books with the PCP. However, she did attend the appointment with her MH provider. After the MH appointment, the patient left a message with the CBOC MSA. The CBOC RN attempted to return the call the same day but was unsuccessful; he left a message for the patient to call the clinic with any ongoing concerns.

A few weeks later, the patient contacted the CBOC staff to inform them that she had been admitted to a community hospital with a heart attack and needed a follow-up appointment within 7 days. The CBOC staff scheduled an appointment within 1 week.

During that evaluation, the PCP noted in the EHR that the patient had been hospitalized secondary to an altered level of consciousness. According to non-VA records that had been scanned into the VA EHR a few weeks before, the patient had been admitted to the community hospital a few weeks before with normal brain imaging and an abnormal chest x-ray. The PCP notified the patient's psychiatrist of the most recent evaluation, treated the patient with moxifloxacin for pneumonia, ordered a chest x-ray, and scheduled a 1-hour follow-up appointment in approximately 3 weeks.

At the time of the hour-long appointment, the PCP noted that the patient's cardiac enzymes done at the time of the community hospitalization had been elevated. The PCP referred the patient to the cardiology department. The cardiologist evaluated the patient, reviewed the community hospital records, and determined that the patient's tests showed evidence of a heart attack and decreased heart muscle function

(cardiomyopathy). Cardiac testing a few months later, however, showed normal heart muscle function.

We found that the patient experienced a delay because she had an acute issue (shoulder pain and difficulty in clearing mucous) in early 2012 and was not offered an appointment for 2 weeks. Shoulder pain can, in some patients, be angina, or pain that originates from the heart. Triage notes did not contain enough information to determine whether the shoulder pain appeared more related to movement of the joint or whether it could possibly be related to the patient's heart. For example, these notes did not document whether pain increased with movement of the shoulder, or just with general exertion. Scheduling an appointment in 2 weeks in the absence of that information would be inappropriate.

VHA now requires that all PCPs and RNs have same day access (unless it is too late in the day as determined by the individual facility) for face-to-face encounters, telephone encounters, and when required by VHA guidance or policy, other types of encounters.[3]

Second Admission 2013. The patient called the Casa Grande CBOC in early 2013 and informed the RN who returned her call that she thought she had pneumonia and complained of chest pain from coughing and shortness of breath. The nurse told the patient to come in for a chest x-ray and "possibly a same day appointment." The patient came in, and a chest x-ray was done which showed no active lung disease. No further documentation was entered into the EHR for that day.

The patient was scheduled to see her MH provider 4 days later; however, the patient did not attend and did not cancel the appointment. The MH clinic staff called the patient 6 days later, and the patient agreed to an appointment in a few weeks.

Before the newly scheduled MH appointment occurred, the patient was evaluated at a community hospital ED where a chest x-ray showed an abscess or necrotic area in her right lung. The ED physician treated her with intravenous antibiotics and advised admission. The patient declined admission but returned the following day with the same complaints.

The community hospital made plans to transfer the patient to the Phoenix Health Care System (HCS), but during transport, the patient developed low blood pressure and had to be diverted to a second community hospital that could provide intensive care services. Within 3 days, she was stable for transfer to the Phoenix HCS. A chest x-ray after transfer confirmed pneumonia and consolidation in the middle lobe of the right lung. The patient improved rapidly and was discharged 2 days later.

A physician from the Phoenix HCS called the Casa Grande CBOC on the day of the patient's discharge to discuss her care and need for follow-up with one of the CBOC nurses. The nurse noted a plan to follow up in 1 week. The nurse attempted to call the

[3]VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

patient 1 week later but was unable to connect with her. He left a voice message. The nurse's note documenting the call from the Phoenix physician was acknowledged by the PCP 12 days after hospital discharge. On that same day, the patient received an appointment for a follow-up that was 19 days after being discharged from the Phoenix HCS.

We found that the CBOC staff did not provide an adequate evaluation of the patient in early 2013, when she called complaining of chest pain and shortness of breath. Chest pain and shortness of breath may indicate an urgent problem, such as cardiac chest pain or a blood clot to the lung. A provider should have seen and examined the patient to determine whether the patient's symptoms would be consistent with cardiac chest pain, a blood clot, or other serious disorders that would not show up on a chest x-ray. Additionally, the patient did not receive an appointment at the Casa Grande CBOC until 19 days following a recent hospitalization despite documentation that the Phoenix provider recommended follow-up within 1 week.

Patient 2—Suicide

We did not substantiate the allegation that a patient committed suicide because he was denied a MH appointment at the Casa Grande CBOC. A review of the patient's EHR indicated that the patient had a scheduled appointment with his assigned Tucson MH provider prior to his death.

The patient was a veteran in his 50s with major depressive disorder, anxiety, and several chronic medical conditions. The patient had received primary and mental health care at the Casa Grande CBOC for many years. Approximately 4 years ago, however, he made threats to a CBOC staff member. The facility's Disruptive Behavior Committee reviewed the incident and recommended transfer of the patient's care to Tucson. The patient saw his newly assigned Tucson primary care provider in late winter 2011.

The patient initially did not want to pursue MH care at Tucson but eventually agreed to see a psychiatrist although he declined individual psychotherapy. After a visit in fall 2011, the psychiatrist noted that the patient denied suicidal or homicidal ideation but described an episode 2 weeks earlier of depression, confusion, and some obsessive thoughts over a hospital bill. The MH provider determined that the patient was, however, relatively stable and made no medication changes.

Around the time of the fall 2011 visit, the patient submitted an appeal to return to the Casa Grande CBOC. Multiple notes over the next few days documented several contacts with the patient. The patient had two appointments scheduled at Tucson—one with a MH provider and one with a PCP. In early winter, during a conversation with a Tucson care provider, the patient told a Tucson staff member that he did not have suicidal or homicidal thoughts and verbalized understanding about crisis resources including the MH clinic, any ER, and the Crisis Hotline. The next day, the patient called the Tucson clinic staff and reported that he had been informed that he needed to continue his MH care in Tucson. He agreed to keep the upcoming appointment with the Tucson MH provider but called the next day to cancel his appointment with the Tucson

PCP. On the morning of his scheduled appointment with the Tucson MH provider, the patient called the Tucson clinic and left a message that he was not feeling well, did not want to travel to Tucson, and was cancelling that day's MH appointment. The appointment was rescheduled for mid-January. The patient was notified of the new appointment before midday.

According to a police report, the patient was found dead in his home 2 days after the patient was notified of the newly scheduled appointment. A note blaming the VA for his death was found in his home.

We found that the patient had access to MH services including a scheduled MH appointment with the Tucson facility a few days prior to his death and that after he canceled that appointment, Tucson staff communicated the newly scheduled appointment to the patient in a timely manner.

Issue 4: Manipulation of Scheduling Practices

Double Booking

We did not substantiate the allegation that patients were being "double booked" for appointments for the same provider.

We reviewed randomly selected PCP appointment schedules from January 2014 through August 2014. We did not find patients who had appointments that were "double booked."

We interviewed Casa Grande CBOC PCPs and support staff who indicated that "double booked" meant that a patient has a scheduled appointment in the same time slot as another patient and with the same provider. The staff members indicated that the schedules are checked daily to ensure that no appointments are "double booked." However, one provider mentioned that he tried to bring patients in as quickly as they want to be seen and, in the past, had requested on occasion that patients be "double booked" on his schedule. The provider indicated that this request is more infrequent now since they have three full-time PCPs on staff and two locum tenens providers.

Overriding the Schedule and Overbooking

We did not substantiate the allegation that a scheduler was "overriding the schedule" and overbooking evaluation appointments.

We reviewed randomly selected PCP appointment schedules from January 2014 through August 2014. We did not find any evaluation appointments that had been overbooked.

We interviewed the Casa Grande CBOC PACT staff who indicated that only the MSAs can schedule appointments. The staff further indicated that evaluation appointments are for new patients or patients reestablishing their care with the VA, require a 1-hour time slot, and can never be overbooked. However, it was indicated that a PCP may

request that a patient be scheduled during the PCP's lunch period, and this may be what some consider "overriding the schedule."

Conclusions

We did not substantiate the allegation that 28 of 38 CBOC staff had resigned or transferred from the Casa Grande CBOC. We found that 12 staff members had vacated their positions from August 2012 to August 2014. However, we found 35 CBOC staff presently assigned to the Casa Grande CBOC in addition to 1 full-time and 1 part-time locum tenens providers.

We could not substantiate the allegation that a patient was placed "on hold" when calling to schedule an appointment and was never able to reach a scheduler; however, we did find that the Casa Grande CBOC's call response time and call abandonment rate did not meet VHA goals.

We could not substantiate the allegation that a patient suffered a heart attack, stroke, and pneumonia and had to seek care outside the VA. We did not substantiate the allegation that the patient was told she would have to wait 6 weeks for a post hospitalization appointment in 2012. However, we found delays in assessment of the patient's condition prior to two hospitalizations and a delay in follow-up for the patient after one of the two hospitalizations. Further, when the patient called with symptoms of chest pain and shortness of breath, performing a chest x-ray alone did not constitute adequate assessment of the patient's condition, nor access to appropriate care.

We did not substantiate the allegation that a patient committed suicide because he was denied a MH appointment at the Casa Grande CBOC. We found documentation in the EHR indicating the patient had an appointment with his assigned Tucson MH provider prior to his death but canceled it on the morning of the appointment.

We did not substantiate that patients were being "double booked" for appointments for the same provider or that a scheduler was "overriding the schedule" and overbooking evaluation appointments.

Recommendations

Recommendation 1. We recommended that the Southern Arizona VA Health Care System Director ensure that same day access appointments and post hospitalization follow-up appointments at the Casa Grande Community Based Outpatient Clinic are triaged appropriately and timely.

Recommendation 2. We recommended that the Southern Arizona VA Health Care System Director ensure that processes are strengthened to improve telephone appointment scheduling practices.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: February 24, 2015

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

Subj: Healthcare Inspection - Alleged Quality of Care Issues at the Community Based Outpatient Clinic, Casa Grande, AZ

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

Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I concur with the attached facility responses and action plans contained in this report of the Healthcare Inspection of Alleged Quality of Care Issues at the Community Based Outpatient Clinic, Casa Grande, AZ.

2. If you have additional questions or concerns, please contact Jennifer Kubiak, VISN 18 Quality Management Officer, at (480) 397-2781.

Kathleen R. Fogarty

Acting Network Director

Appendix B

System Director Comments

Department of Veterans Affairs

Memorandum

Date: February 18, 2015

From: Director, Southern Arizona VA Health Care System (678/00)

Subj: Healthcare Inspection - Alleged Quality of Care Issues at the Community Based Outpatient Clinic, Casa Grande, AZ

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

1. The Southern Arizona VA Health Care System concurs with the findings and recommendations from the above healthcare inspection.
2. Please find attached our response to the recommendations provided in the report.
3. If you have any question regarding the response to the recommendations in the report, please contact Katie A. Landwehr, Assistant Director, at (520) 629-1821.

(original signed by:)
Jonathan H. Gardner, MPA, FACHE

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Southern Arizona VA Health Care System Director ensure that same day access appointments and post hospitalization follow-up appointments at the Casa Grande Community Based Outpatient Clinic are triaged appropriately and timely.

Concur

Target date for completion: August 2014

Facility response: Patient care access at the Casa Grande CBOC has been enhanced significantly since 2012 (the timeframe of the allegations). We have improved nursing telephone triage and walk-in triage, expanded same day appointment access and increased clinic staffing.

All nurses have been retrained on Brigg's Telephone Triage Protocols for Nurses, and additional acute and chronic care nursing protocols were developed and approved by the Nurse Executive and Medical Executive Boards prior to implementation. Standard Operating Procedures for Telephone Triage were revised to include a new CPRS template note. A walk-in patient sign-in sheet was developed with primary complaint and history, which expedited care by the nurse and Primary Care Provider (PCP). In addition, four appointments were added to each PCP's schedule, every day, to ensure appointment availability for triaged patients needing same day access.

The PACT teams have also been trained to provide 'Wave' appointments for simple acute needs increasing patient access for same day care. At the SAVAHCS, the RN and provider work together to accomplish a Wave appointment. The RN uses PACT protocols to gather information and order labs/imaging per protocol. After the RN assessment is complete and any diagnostic tests results are available, the information is provided to the PCP for their final clinical decision. The PCP is required to see the patient by completing a focused assessment to verify the diagnostic and RN assessment findings. If any new treatment or medications will be ordered, the PCP discusses this with the patient during this focused appointment. The RN then documents all findings from their own assessment, diagnostic results (if available), and the PCP's plan of care. Both the RN and PCP are signers on the CPRS note.

We recognized access was impacted during provider staffing gaps and have consistently utilized Locum Tenens to cover provider vacancies during recruitment. In 2013, we added a permanent Nurse Practitioner (NP) to specifically focus on new patient exams. This improved new patient access significantly. We are currently in the process of adding a full PACT team (RN, LPN, MSA) to partner with the NP which will

create capacity for an additional 1,000 patients in the Casa Grande area. At this time, the only staffing vacancies at the Casa Grande CBOC are the new MSA, RN and LPN positions. Selections are pending for these two positions and we expect a full complement of staff in the very near future.

Daily appointment availability for post-hospitalization care has also been built into the PCP schedules. Inpatients being discharged from a VA hospital have their post-hospitalization appointment made prior to the hospital discharge so the patient has appointment in-hand at discharge. All patients are called by their PACT registered nurses within two days post-hospitalization. Our post-hospitalization calls have been very successful with the most recent data (FY15 Q1) showing a 91.67% success contact rate. In addition, the nurses have sole access to the same day appointments to ensure any patient who needs a post-hospital PCP appointment has access (without overbooking the PCP).

We request closure of this recommendation based on the evidence provided above.

Recommendation 2. We recommended that the Southern Arizona VA Health Care System Director ensure that processes are strengthened to improve telephone appointment scheduling practices.

Concur

Target date for completion: June 2015

Facility response: We concur that the Casa Grande CBOC did not achieve VHA goals of a 30-second response time, or a less than 5% call abandonment rate, during the time period reviewed (October 2013 through July 2014). We further concur with the average and range data reported by the OIG related to this period of time. To better serve our Veterans, a Management Action Plan to improve the response time and call abandonment rate at the Casa Grande CBOC is set forth below:

1. The addition of one Medical Support Assistant (MSA) to the Casa Grande CBOC will increase the personnel available to answer incoming calls.
2. The implementation of a SAVAHCS Centralized Call Center which will be responsible for making Casa Grande CBOC outgoing/recall reminder calls, thus freeing up the Casa Grande CBOC MSAs to focus on incoming calls.
3. Training Focus Areas:
    a. Telephone Customer Service
    b. Timeliness in call response
    c. Abandonment rate
    d. Use of scripting
    e. Simplify communication with clinical staff for patient call handoff
4. Continue to monitor phone metrics to evaluate MSA workload, determine the effectiveness of new staffing model and adjust call workload throughout the business day to ensure telephone accessibility for our Veterans.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Glen Pickens, RN, BSN, MHSM, Team Leader Andrea Buck, MD, JD Deborah Howard, RN, BSN, MSN Alan Mallinger, MD Judy Montano, MS Derrick Hudson, Program Support Assistant

Appendix D

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