



Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-02676-297

Healthcare Inspection

**Clinical Activities, Staffing, and
Administrative Practices**

**Eastern Oklahoma VA Health Care
System**

Muskogee, Oklahoma

July 10, 2017

Washington, DC 20420

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various Federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoighotline@va.gov

Web site: www.va.gov/oig

Table of Contents

Executive Summary	i
Purpose	1
Background	1
Scope and Methodology	3
Inspection Results	6
Issue 1: Leadership	6
Issue 2: Performance Measure Data	7
Issue 3: Quality, Safety and Value	10
Issue 4: Staffing	16
Issue 5: Access to Care	20
Issue 6: Veterans Choice and Non-VA Care Coordination	23
Issue 7: Quality of Clinical Care	29
Issue 8: Emergency Department	34
Issue 9: Environment of Care	36
Conclusions	38
Recommendations	39
Appendixes	
A. Strategic Analytics for Improvement and Learning Metric Definitions	42
B. Environment of Care Review Topics	43
C. Veterans Integrated Service Network Director Comments	45
D. System Director Comments	47
E. OIG Contact and Staff Acknowledgments	55
F. Report Distribution	56

Executive Summary

The VA Office of Inspector General conducted a healthcare inspection in response to Senator James Inhofe's request to evaluate a range of clinical, staffing, and administrative practices at the Eastern Oklahoma VA Health Care System (System), Muskogee OK. We coordinated this review with The Joint Commission (JC). We evaluated the following areas and practices:

- (a) Stability and permanence of System leaders and leadership's responsiveness to specified deficient conditions requiring corrective action
- (b) Performance measure data, including patient and employee satisfaction, and the facility's follow-up of deficient conditions identified as "priority"
- (c) Quality, Safety and Value (QSV) committee structure and practices including incident identification, reporting, corrective actions, and follow-up
- (d) Staffing in key clinical areas including primary care (PC), mental health (MH), specialty care (SC), Non-VA Care Coordination (NVCC), and nursing
- (e) Access to PC, MH, and SC clinics
- (f) Veterans Choice and NVCC program management and practices including availability of community providers and timeliness of appointment scheduling and consult completion
- (g) Quality of clinical care as determined by documentation in the electronic health record (EHR) of assessment, care planning, and follow-up
- (h) Timeliness of Emergency Department (ED) care, patient dispositions, and System diversion history
- (i) Environment of Care (EOC) including cleanliness and safety

Several of the System's key leadership positions have been in flux in the past few years. The previous System Director retired in July 2015, and the Associate Director was detailed to the acting Director position. The Chief of Staff (COS) took the position in 2014 and also served concurrently as the acting Chief of Surgery in late calendar year 2015. He was temporarily reassigned to a clinical position in March 2016. Several acting COSs have provided short-term coverage in the past 3 months. The current System Director started on June 12, 2016.

We could not determine with certainty the impact of leadership vacancies and short-term coverage; however, we noted a recent decline in multiple quality measures. During most of fiscal year (FY) 2015, the System had a 4-star in Quality ranking (top 30 percent) across all Veterans Health Administration (VHA) health care facilities. During this time, the System was also lower-performing or experienced deteriorating performance in multiple performance measures. In quarter (Q) 4 FY 2015, the System's overall quality performance ranking dropped from a 4-star to a 3-star ranking. At the

time of our review, the System was taking action to improve quality measure scores which influence the overall star ranking.

The System's QSV program, as well as other reporting mechanisms and processes, did not consistently provide the necessary monitoring and oversight to ensure that selected patient care processes were safe and effective. We found that:

- The meeting minutes of subordinate committees did not consistently include information needed to evaluate and correct deficient patient care processes.
- Provider-specific data were not consistently available to support continuation of provider privileges.
- Severity assessment code scoring of unanticipated events did not consistently comply with VHA requirements.
- The Peer Review (PR) Committee did not consistently include appropriate representation or follow VHA guidelines regarding the use of outside peer reviewers.
- The PR policy did not include all required elements and the System did not have a reliable process for tracking, trending, or reporting PR outcomes by provider.
- Processes were not in place to ensure consideration of institutional disclosure in cases involving unanticipated outcomes.

The System has had difficulty recruiting and retaining employees in some areas, reportedly due to its rural location and pay disparity with the private sector. In general, Nursing Service was adequately staffed; however, the System lacked a sufficient number of gastroenterologists, urologists, and psychiatrists. The System used hiring incentives to recruit specialists, and tele-medicine and contracted services to meet patient care needs when in-house specialty care was not available in a timely manner.

Despite staffing challenges, the System largely met access metrics for PC and MH. As of the end of Q2 FY 2016, we found 30 percent of the 1,402 new patient SC appointments were pending greater than 30 days. Gastrointestinal (GI) endoscopy and urology presented the biggest SC access challenges. The System hired a GI provider, who was pending a start date at the time of our review; hired a GI nurse navigator; and started an endoscopy triage process to prioritize appointments in August 2015. All urology consults were sent to Veterans Choice because the System no longer had a urologist.

The System did not meet call center performance targets as of Q1 FY 2016—calls were answered in an average of 135 seconds (goal is 30 seconds), and the abandonment rate was 8 percent (goal is 5 percent). System managers implemented a PC call center at the Tulsa community based outpatient clinic (CBOC) in early April 2016, which was still being staffed at the time of our visit in May 2016.

The System has not consistently met timeliness goals for providing veteran services in the increasingly busy Veterans Choice and NVCC programs. In Q1 FY 2016, the Care in the Community (CIC) program received nearly 4,400 Veterans Choice and NVCC consults combined. In Q2 FY 2016, incoming Veterans Choice and NVCC consults exceeded 6,200. A Veterans Integrated Service Network (VISN) 19 team evaluated the System's CIC program in early 2016 and recommended multiple corrective actions. Staffing has improved recently, and the average time to complete non-VA care consults had also improved as of the end of Q2 FY 2016. However, as of July 6, the System had 7,368 active CIC requests pending greater than 90 days.

We reviewed 567 EHRs of patients who had completed PC appointments from March 6 through March 12, 2016, with an associated primary or secondary diagnosis of hypertension, diabetes mellitus, or congestive heart failure. We found that providers consistently documented patients' relevant histories and presenting problems, treatment plans, follow-up, and medication reconciliation. While providers consistently documented in-house consult completion, the average time to complete some SC consults exceeded 30 days. Also, PC team members notified patients of selected abnormal lab test results within 7 days 89.2 percent of the time, and providers took actions to address clinically significant abnormal lab results 91.6 percent of the time. For MH quality measures, the System's ranking in the MH Domain measure declined (in comparison to 5-star facilities) from the second highest quintile in Q1 FY 2015 to the second lowest quintile in Q1 FY 2016. MH leaders have taken some actions to improve MH staffing and access.

As of our mid-May 2016 site visit, the ED was meeting performance targets for triage and patients leaving without being seen. The System's ED slightly exceeded the length of stay target for patients being discharged. The System was rarely on diversion (patients not accepted for care, services, or beds because they are not available).

We inspected patient care areas including five inpatient units, the ED, and four outpatient clinics located at the Muskogee main healthcare facility. We also inspected the Ernest Childers outpatient clinic (Tulsa), Jack C. Montgomery-East, Tulsa Behavioral, and Vinita CBOCs. We found no deficiencies in selected aspects of medication safety and security, information technology security, and infection prevention risk assessment reviews. We identified compliance deficiencies related to the quality of EOC Committee minutes and other selected privacy, safety, security, and cleanliness requirements.

We made 19 recommendations focusing on leadership stability and performance improvement activities; the meeting minutes of QSV subordinate committees, clinical privileging, SAC scoring and inter-rater reliability, PR activities, and institutional disclosure; recruitment and hiring; SC and MH access, and call center responsiveness; VISN follow-up of CIC improvement actions; notification and follow-up of abnormal lab results, consult completion timeliness, and MH-related quality measure improvements; ED discharges; and EOC-related compliance and improvements.

Comments

The VISN and System Directors concurred with our findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 45–54 for the full text of the comments.) Based on information provided by the VISN and System, we consider Recommendations 2, 3, 4, 5, 6, 8, 9, 10, 14, 15, and 19 closed. For Recommendation 16 marked completed by the System, we will follow up on the System’s action plan to ensure that the corrective actions have been effective and sustained. For the remaining open recommendations with identified target dates, 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) conducted a healthcare inspection in response to Senator James Inhofe's request to evaluate a range of clinical, staffing, and administrative practices at the Eastern Oklahoma VA Health Care System (System), Muskogee, OK. We coordinated this review with The Joint Commission (JC).

Background

The System serves veterans in 25 counties¹ in the eastern region of Oklahoma and is part of Veterans Integrated Service Network (VISN) 19. The System includes the Jack C. Montgomery (JCM) VA Medical Center (VAMC), located in Muskogee, OK, which offers a variety of primary and secondary levels of inpatient medical and surgical care (99 inpatient beds). The System also provides outpatient primary and consultative care in medicine, surgery, and mental health (MH) and oversees community based outpatient clinics (CBOCs) and other clinics located in Hartshorne, Tulsa (two clinics), Muskogee (JCM-East), and Vinita, OK.

Several significant events have challenged the System's ability to function as a high performing organization in some areas. Reportedly, the System has a history of recruitment and staffing difficulties due to its rural location and pay differential. Of note, the long-time Director retired in July 2015 and an "acting" Director filled the position until the new System Director was installed in June 2016. On October 1, 2015, the System was realigned from VISN 16 to VISN 19. Furthermore, in October, two patients died after undergoing surgical procedures. Subsequent to the surgical deaths, the System suspended all intermediate-level surgical procedures in December pending process improvements and corrective actions as recommended by VISN 19 and the National Surgery Office.² Late in the 2nd quarter (Q) fiscal year (FY) 2016, the System was approved to reinstate orthopedic surgery cases only. A new Chief of Surgery was installed in January 2016.

¹ Oklahoma encompasses 77 counties; 63 of the 77 counties are rural.

² The surgical procedures were a laparoscopic nephrectomy and a transverse resection of the colon. The System provided action plans and follow-up from the VISN and NSO is scheduled. We did not review these surgery cases further.

Workload and Budget

Table 1. System Workload and Budget FYs 2013–Q 2, 2016

FY	Total Medical Care Full Time Equivalent	Outpatient Visits	Medical Care Budget
2013	1,201	457,208	\$228,371,500
2014	1,242	454,226	\$267,744,779
2015	1,282	469,192	\$260,809,682
2016	1,326 (FY projected)	234,597 (Qs 1 and 2)	\$268,664,333 (FY projected)

Source: VHA Support Service Center Trip Pack Report II

Previous OIG Reviews

We conducted Combined Assessment Program (CAP) and CBOC reviews at the System and the Hartshorne CBOC the week of January 25, 2016. We also conducted a hotline healthcare inspection in August 2014. These reviews are elements of OIG’s efforts to ensure that our Nation’s veterans receive high quality VA health care services. We made 10 recommendations for improvement in our CAP report, 14 recommendations in our CBOC report, and 8 recommendations in our hotline report. System and VISN leaders provided acceptable action plans to resolve identified issues, and at the time of this review, corrective actions were in process.

Details of these reviews can be found in:

- *Combined Assessment Program Review of the Eastern Oklahoma VA Health Care System, Muskogee, OK, (Report No. 16-00102-253, April 13, 2016),*
- *Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Eastern Oklahoma VA Healthcare System, Muskogee, OK, (Report No. 16-00011-259, April 14, 2016), and*
- *Quality of Care and Access to Care Concerns, Jack C. Montgomery VA Medical Center, Muskogee, OK, (Report No. 14-04573-378, June 16, 2015).*

Concerns

On March 24, 2016, Senator James Inhofe sent a letter to the Deputy Inspector General, OIG, requesting a review of clinical and administrative operations at the System and Oklahoma City VA Health Care System, Oklahoma City, OK.³ In response to Senator Inhofe’s request, we conducted a review of System conditions and

³ Concerns related to the Oklahoma City VA Health Care System, Oklahoma City, OK are addressed in a separate report.

operations at both facilities and their associated CBOCs and outpatient clinics. The review of the Oklahoma City VA Health Care System will be published under separate cover. The review of the System focused on:

- (a) Stability and permanence of System leaders and leadership's responsiveness to specified deficient conditions requiring corrective action
- (b) Performance measure data, including patient and employee satisfaction, and the facility's follow-up of deficient conditions identified as "priority"
- (c) Quality, Safety and Value (QSV) committee structure and practices including incident identification, reporting, corrective actions, and follow-up
- (d) Staffing in key clinical areas including primary care (PC), MH, specialty care (SC), Non-VA Care Coordination (NVCC), and nursing
- (e) Access to PC, MH, and SC clinics
- (f) Veterans Choice and NVCC program management and practices including availability of community providers and timeliness of appointment scheduling and consult completion
- (g) Quality of clinical care as determined by documentation in the electronic health record (EHR) of assessment, care planning, and follow-up
- (h) Timeliness of Emergency Department (ED) care, patient dispositions, and System diversion history
- (i) Environment of Care (EOC) including cleanliness and safety

Scope and Methodology

The period of this review was March 25, 2016 to August 23, 2016. The scope included extensive review of System data, actions, and practices in FY 2015 and Qs 1–3 FY 2016.

We visited the System May 16–20, 2016. To assess the physical environments, we conducted EOC tours of the System and four of the five CBOCs.

We interviewed the acting System Director, acting Chief of Staff (COS), and Associate Director for Patient Care Services (ADPCS); the Chiefs of Medicine, Surgery, Ambulatory Care, the ED, and Pharmacy; the acting Chiefs of Human Resource Management Service (HRMS), MH, and QSV; the Strategic Analytics for Improvement and Learning (SAIL) Coordinator, Infection Control Coordinator, Environmental Management Service supervisors, Business Office managers, and NVCC managers and staff; the Patient Safety Manager, Risk Manager, and lead Patient Advocate; clinical and administrative staff from all five CBOCs; and other staff knowledgeable about the issues. We interviewed more than 70 employees.

We reviewed Veterans Health Administration (VHA) and System data related to the tenure and relative permanence of System leaders; quality and performance data and

corrective actions; QSV reporting structure and operations; staffing and recruitment actions; utilization and management of the NVCC and Veterans Choice Programs; ED care, bed utilization, hospital and ED diversion; select EOC operations and practices; and select CBOC operations and practices. We reviewed VHA and System policies related to the areas noted above.

Nine of the VHA policies cited in this report were expired or beyond the recertification date.

1. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (recertification due date March 31, 2016).
2. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (expired June 30, 2015).
3. VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010 (expired May 31, 2015).
4. VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010 (expired July 31, 2015).
5. VHA Directive 2006-041, *Veterans Health Care Service Standards*, June 27, 2006 (expired June 30, 2011).
6. VHA Directive 2007-033, *Telephone Service for Clinical Care*, October 11, 2007 (expired October 31, 2012).
7. VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011 (expired March 31, 2016).
8. VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011 (expired February 29, 2016).
9. VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012 (expired February 28, 2015).

We considered these policies to be in effect as they had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),⁴ the VA Under Secretary for Health (USH) mandated the "...continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."⁵ The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "...the timely

⁴ VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016.

⁵ VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.

rescission or recertification of policy documents over which their program offices have primary responsibility.”⁶

In addition to reviewing quality and performance metrics, we conducted an independent review of EHRs to determine if clinicians were providing and documenting selected patient care and follow up. We reviewed VA Corporate Data Warehouse data to identify System patients who completed PC appointments⁷ during the period of March 6–12, 2016.⁸ We included 567 patients in our quality of care EHR review.

Further, 304 of about 1,130 System employees responded to a patient risk assessment survey. Of those, 67 employees responded that they had identified a quality of care and/or patient safety issue in the past 12 months that placed a patient at risk or continued to place patients at risk. While 24 of those employees reported that managers had adequately addressed the conditions or concerns, 43 employees reported that managers had not. In some cases, the survey respondent did not provide sufficient details for us to adequately evaluate the issue(s). The remaining cases generally involved patient-specific quality of care concerns, patient education, and staffing deficiencies. We either evaluated and dispositioned the issue(s) while onsite, or, in accordance with OIG guidance, we referred quality and safety concerns identified in the surveys to the OIG’s Hotline Division for further review and possible disposition.

In addition to general privacy laws that govern the release of medical information, disclosure of certain veteran health or other private information may be prohibited by various Federal statutes including, but not limited to, 38 U.S. Code § 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, OIG adheres to the privacy and confidentiality laws and regulations protecting veteran health or other private information. In this report, we have generalized narratives and case scenarios, and we have de-identified protected patient and quality assurance information.

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.

⁶ VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.

⁷ Completed appointments were identified using stop codes within VHA’s primary care clinic group, including 322, 323, and 350.

⁸ Clinical providers included physicians, physician assistants, nurse practitioners, and clinical nurse specialists.

Inspection Results

Issue 1: Leadership

Several of the System's key leadership positions have been in flux in the past few years, which contributed to inconsistent oversight and communication in some areas.

Good leadership is central to the health and success of any organization. JC devotes several chapters to leadership standards in the *2009 Comprehensive Accreditation Manual for Hospitals*, and "Leading Change" and "Leading People" are two of the five executive core qualifications⁹ for senior executives¹⁰ in the Federal government. Leaders establish the organization's culture through their words, expectations for action, and behavior.¹¹ When members of the senior leadership team are permanent in those positions (rather than "acting" in short-term rotations), the organization's mission, goals, and priorities tend to be communicated more consistently to employees. For the purpose of this review, we defined the senior leadership positions as the System Director, Associate Director, COS, ADPCS, and Chief of QSV.

A brief history and status of senior leadership positions is as follows:

- The previous System Director (of more than 3 years) retired in July 2015, and the Associate Director was detailed to the acting Director position. The current System Director started on June 12, 2016.
- During the July 2015 through June 2016 time frame, two administrative Service chiefs rotated as acting Associate Director.
- The COS took the position in 2014 and also served concurrently as the acting Chief of Surgery in late calendar year 2015.¹² He was temporarily reassigned to a clinical position in March 2016. Several acting COSs had provided short-term coverage in the 3 months prior to our visit. It is unclear when the permanent COS will return to that role.
- The ADPCS has been in that role for about 8 years.
- The acting Chief of QSV has been in that role for 2 years.

While we cannot determine with certainty the specific impact of leadership vacancies and short-term coverage, we noted a decline since Q2 FY 2016 in multiple quality

⁹ <http://www.opm.gov/policy-data-oversight/senior-executive-service/executive-core-qualifications/>, retrieved January 7, 2015.

¹⁰ Most medical center/System directors and COSs are senior executives and must meet executive core qualification requirements.

¹¹ Leadership in Healthcare Organizations. A Guide to Joint Commission Leadership Standards. A Governance Institute White Paper, Winter 2009, page 3.

¹² The Chief of Surgery position was covered by a series of acting chiefs for 6 months until a new Chief of Surgery was installed in late January 2016.

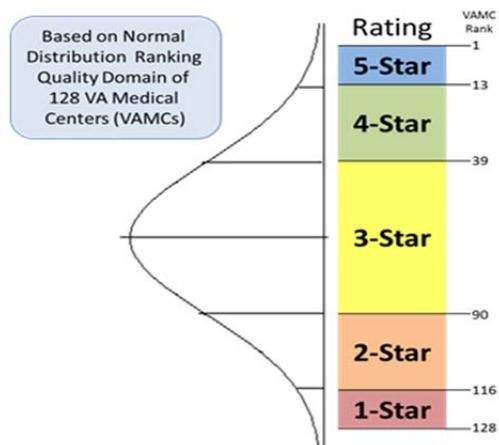
measures and lack of attention to several program areas. Also, according to the new Chief of Surgery (who started in January 2016), two surgical deaths in October 2015 “exposed bad processes.” Details can be found under Issue 2, *Performance Measure Data*, below, and Issue 3, QSV, on page 10.

Recommendation 1. We recommended that the System Director take action to fill key leadership positions with qualified permanent personnel.

Issue 2: Performance Measure Data

VHA’s Office of Operational Analytics and Reporting developed a model for understanding a facility’s performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are comprised of multiple composite measures and the resulting scores permit comparison of facilities within a VISN or across VHA. The SAIL model uses a “star” ranking system to designate a facility’s performance in individual measures, domains, and overall quality. SAIL “estimates the 10th, 30th, 70th, and 90th percentile cut-offs of overall Quality and assigns facilities 1- and 5-Star if their scores fall in the bottom and top 10th percentile, respectively. Facilities in the next bottom and top 20 percent of the distribution are assigned 2- and 4-Star. The remaining 40 percent of facilities are assigned 3-Star.”¹³

Figure 1. SAIL Star Rating



In most measures, the SAIL model reflects the facility’s performance over a rolling 12-month period. SAIL offers a variety of tools and reports to assist facilities in identifying lower-performing areas and opportunities for improvement. A summarized list of the SAIL measures can be found in Appendix A.

Because some SAIL data and reports may be protected by 38 U.S.C. § 5705, *Confidentiality of Medical Quality Assurance Records*, we do not disclose specific quality data in this report.

Rather, we identify in broad terms how a facility has been performing in key domains and measures, and whether: (a) the facility has a process for identifying and prioritizing quality deficiencies, and (b) corrective actions have been implemented and are being tracked to ensure that they are having the desired effect(s).

Overall SAIL Performance as of Q1 FY 2016

While the System was ranked as a “3-star in Quality” in Q1 FY 2016, several measures have deteriorated in the past year, and corrective action plans have only recently been initiated.

¹³ Retrieved from the data definitions section of the VHA SAIL website on May 12, 2016.

When reviewed collectively, SAIL data reflects that the System has consistently performed well in the Length of Stay (LOS) and Utilization Management domain, as well as in several of the individual Transitions in Care and Employee Satisfaction measures. During most of FY 2015, the System had a 4-star in Quality SAIL ranking. However, during this time, the System was also lower-performing or experienced deteriorating performance in multiple Acute Care Mortality, Performance Measurement, Access to Care, MH, and Avoidable Adverse Events measures. In Q4 FY 2015, the System's overall quality performance ranking dropped from a 4-star to a 3-star ranking.

Reportedly, the System tracked and monitored some performance measures but did not have SAIL measure-specific workgroups until Q2 FY 2016, after the System's quality ranking dropped. We found that the key measures selected by the SAIL workgroup for priority evaluation and intervention were reasonable and appropriate given the performance deficits in those areas. However, because of the "rolling" nature of the data and the time required to affect change, the effectiveness of System managers' efforts to improve performance scores and overall quality ranking may not be seen until FY 2017.

Senator Inhofe's letter referenced concerns about mortality rates; feedback to veterans and family members; and employees' work environments. We are therefore specifically reporting on the System's performance in Acute Care Mortality, Patient Satisfaction, and Employee Satisfaction. Additional performance measure data are also reported under Issue 3, QSV; Issue 5, *Access to Care*; and Issue 7, *Quality of Clinical Care*.

The Acute Care Mortality domain is a composite measure comprised of an in-hospital (acute care wards and intensive care unit [ICU]) standardized mortality ratio (SMR)¹⁴ and a 30-day SMR (SMR30).¹⁵ These scores are calculated by dividing the actual (observed) number of deaths by the expected number of deaths. The ratio of observed deaths to expected deaths (referred to as "O/E ratio") is used to assess whether the hospital had more deaths than expected (ratio > 1.0), the same number of deaths as expected (ratio = 1.0), or fewer deaths than expected (ratio < 1.0).¹⁶ Lower numbers are desirable. For Q1 FY 2016, data reflect:

- Acute Care SMR = 1.120
- Acute Care SMR30 = 0.958

¹⁴ SMR is the actual number of deaths within 1 day of hospital discharge for patients who were admitted to acute care wards divided by the sum of the expected deaths determined using the risk adjusted mortality model for patients admitted to acute care wards. Retrieved from the SAIL Model Data Definitions link on May 3, 2016.

¹⁵ The 30-day SMR is the actual number of patients admitted to acute care wards who died within 30 days of hospital admission divided by the sum of the expected deaths of all acute care ward patients using the risk adjusted mortality model that predicts death at 30 days. Retrieved from the SAIL Model Data Definitions link on May 3, 2016.

¹⁶ <https://www.cms.gov/Medicare/Mortality>. Retrieved on June 9, 2016.

While the ICU-specific SMR exceeded 1.0, the SMR30 was less than 1.0 and fell below the VHA average. We reviewed the EHRs of all 10 ICU and Progressive Care Unit patients who died in Q1 FY 2016. Many of the patients had severely advanced or incurable diseases such as advanced stage cancers. In addition, Do Not Resuscitate orders and consultations for palliative care were documented in the EHRs. Per our review, we found it was more likely that the deaths were due to the severity of the patients' diseases rather than poor quality or a lack of care during their ICU stay.

The Chief of Medicine told us that transfer coordinators sometimes have difficulty arranging interfacility transfers when patients require a higher level of care not provided by the System. According to the Chief of Medicine, "When patients cannot be transferred timely, mortality is affected." We reviewed Q1 FY 2016 transfer data and found that when patients were not accepted for transfer to some facilities, alternate arrangements were promptly made. Of the nearly 200 transfers attempted during the review period, 37 were declined; in several instances, patients were declined by multiple facilities due to simultaneous diversion status. According to transfer logs, transfers were initially declined due to diversion status, lack of [specialty] beds or services, or unstable patient condition. In all cases, patients were either transferred to a different facility or hospitalized at the JCM VAMC. Further, EHR documentation showed consistent communication between System transfer coordinators and other health care facilities, with regularly documented status updates and treatment/transfer plans. While two of the patients whose transfers were declined during Q1 FY 2016 have since died, their deaths occurred months after the transfers were initially declined.

To improve mortality scores, clinical leaders have undertaken efforts to develop an outpatient palliative care clinic to provide more coordinated outpatient care to patients with chronic diseases and to hire a clinical coding specialist to educate providers on correct coding practices and provide real-time coding assistance.

The Patient Satisfaction domain is a composite measure comprised of patient survey responses related to both inpatient and outpatient care encounters. Survey questions relate to access, communication, and care coordination. In Q1 FY 2015, the System was performing solidly in the 3-star range in patient satisfaction domain. As of Q1 FY 2016, however, the System's performance ranking amongst all VHA facilities in the patient satisfaction domain dropped from a mid- to a low-performer. The SAIL Coordinator attributed the decrease in patient satisfaction scores to (1) VHA's new opioid prescription management guidelines and (2) inefficiency of, and frustration with, Veterans Choice care options. We noted that two fairly new measures—rating your PC provider and rating your SC provider—were added in FY 2015, and the System has performed poorly in both measures.

System managers told us that they are implementing a customer service campaign. In the outpatient area specifically, a licensed practical nurse (LPN) initiates a conversation with the patients after they have completed their appointments. The LPN provides a comment card where the patient can state whether the facility met his/her expectations and make any additional remarks. The patient drops the card into a designated box, and System employees follow up with patients a few days later to discuss the patient's

encounter and address concerns, if applicable. This outpatient customer service effort was initiated in April 2016. Additionally, managers told us that the Veteran and Family Advisory Council meets once per month and Council members participate in performance improvement activities throughout the System.

Employee Satisfaction is reported, in part, through the Best Places to Work (BPTW) measure. On an annual basis, the VA All Employee Survey (AES) is sent to VA employees and includes questions about job satisfaction, psychological safety, work/life balance, and recognition, among others. Employee feedback gained through the AES results are used to calculate a BPTW composite score ranging from 0–100 points. BPTW is based on the annual ranking of U.S. government agencies by the Partnership for Public Service using Federal Employee Viewpoint Survey data. The System ranked in the top 20 percent of all VHA facilities from 2013–2015 in BPTW.

However, during our interviews, some CBOC employees voiced concerns or were otherwise not satisfied with certain aspects of their jobs or work environments. Of the 29 respondents:

- 46 percent did not feel supported by the JCM VAMC (isolation and staffing concerns);
- 59 percent did not feel there was adequate follow-up of concerns (staffing, management, and space concerns noted);
- 55 percent did not feel there was adequate dissemination of information between the CBOC and the JCM VAMC (general communication concerns); and,
- 69 percent did not feel the CBOC was a safe working environment (no police/security onsite, an [inefficient] emergency notification system where panic alarms alert the medical support assistant (MSA) who then calls 911, and/or lack of panic alarms in exam rooms).

As of Q4 FY 2016, the System's BPTW ranking had dropped to the third quintile.

Recommendation 2. We recommended that the System Director ensure that established workgroups continue efforts to improve Strategic Analytics for Improvement and Learning-related metrics, and that progress be monitored.

Issue 3: QSV

Most of the System's QSV programs have been functioning adequately; however, some improvements are needed in key areas.

VHA requires implementation of a QSV program to ensure compliance with VHA standards, regulations, and policies; integration under an organizational structure that promotes the exchange and flow of quality information; and, avoidance of organizational

silos.¹⁷ To help determine the effectiveness of the System's QSV program in meeting this requirement, we reviewed VHA and local policies related to selected QSV functions and corresponding FY 2015 and Q1 and Q2 FY 2016 meeting minutes. The functions included in our review were:

- QSV committees and processes
- Provider privileging
- Patient safety events
- Peer review
- Institutional disclosure
- Operative and other procedure review
- Resuscitation and its outcomes
- Medical record reviews
- Blood and blood usage review
- Restraints and seclusion
- Mortality and morbidity review
- Reusable medical equipment
- Infection control

We identified System deficiencies in the following five areas.

QSV Committees and Processes

The basic QSV committee structure, including incorporation of VHA and System policies and communication processes, appeared functional. However, the meeting minutes of QSV subordinate committees did not consistently contain elements required by VHA that are needed to evaluate and correct deficient patient care processes. We found the following deficiencies:

Data Collection and Analysis. Subordinate committee meeting minutes did not consistently include data gathering and critical analysis, ensuring data was valid and reliable, comparing data to internal or external benchmarks, identifying specific opportunities for improvement, and implementing and evaluating actions until problems were resolved.^{18,19} Data consisted of "raw" numbers and informational summaries. The minutes of quality-related committees contained minimal evidence of data evaluation, discussion, or actions.²⁰

¹⁷ VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

¹⁸ Ibid.

¹⁹ Medical Center Memorandum (MCM)-00-32, *Quality, Safety and Value*, January 31, 2014. This Memorandum was modified with pen and ink changes several times in 2015; it was rescinded and replaced by MCM 00-32, *Quality, Safety and Value*, March 31, 2016. The 2014 and 2016 documents contain the same or similar language related to the issue(s) discussed in this report.

²⁰ Ibid.

Action Identification and Tracking. Committee minutes did not consistently include identification of measurable actions or assignment of responsibility.^{21,22} We noted issues reported without documentation of discussions, conclusions, recommendations, or actions.

Provider Privileging Practices

The System did not follow VHA policy when completing provider practice evaluations during the privileging process.²³ In addition, the Service-level privilege lists of approved procedures exceeded the System's surgical complexity level.

VHA policy defines clinical privileging as the method by which System leaders grant a provider privileges to perform specified medical or other patient care within the scope of the provider's license and within the System's mission.²⁴

Focused Professional Practice Evaluation (FPPE) is a time-limited oversight period allowing the credentialed provider²⁵ to independently practice during performance evaluation of the requested privileges.²⁶ The provider's conversion to Ongoing Professional Practice Evaluation (OPPE) is dependent upon the successful completion of the FPPE.

OPPE of privileges requires monitoring and evaluation of a provider's professional performance and competency to ensure delivery of safe and high-quality patient care.²⁷ In order to determine the provider's level of competence and evaluate the outcomes of care, the System must collect and maintain relevant provider-specific data in the provider's Service-level OPPE folder.

We selected a sample of 10 currently privileged providers across 5 clinical specialties and reviewed Service-level provider folders to evaluate FPPE and OPPE processes. We found that the two FPPE folders contained data to support continuation of privileges. However, we noted that none of the eight OPPE folders included required provider-specific data to support the continuation of privileges.

The System's approved Service-level privilege lists included complex surgical procedures during FY 2015 although the System's designation was intermediate

²¹ Medical Center Memorandum (MCM)-00-32, *Quality, Safety and Value*, January 31, 2014. This Memorandum was modified with pen and ink changes several times in 2015; it was rescinded and replaced by MCM 00-32, *Quality, Safety and Value*, March 31, 2016. The 2014 and 2016 documents contain the same or similar language related to the issue(s) discussed in this report.

²² MCM 00-01, *Publication of Medical Center Administrative Issues*, April 23, 2013; This Memorandum was rescinded by MCM 00-01, *Publication of Medical Center Administrative Issues*, March 30, 2016. The 2013 and 2016 documents contain the same or similar language related to the issue(s) discussed in this report.

²³ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

²⁴ Ibid.

²⁵ Credentials include a combination of licensure, education, training, experience, competence, and health status.

²⁶ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

²⁷ Ibid.

surgery complexity level. VHA policy requires the Service Chief to ensure that appropriate resources are available to support requested privileges.²⁸ The Chief of Surgery told us he was aware that these lists had procedures beyond the complexity of the System and was in the process of updating all Service-level privilege lists to accurately reflect procedures within the scope of services at the System.

Patient Safety Events

The System's patient safety program did not consistently process and catalog events to ensure accuracy and consistency of information. VHA has established policy and procedures for the review and analysis of patient safety events.²⁹ The System provided patient safety event reporting logs for FY 2015 and Q1 and Q2 FY 2016 (retrieved from the Patient Safety Information System [PSIS]) for our initial review of events. We found the following deficient area:

Severity Assessment Code Score Appropriateness. The System did not follow VHA policy when evaluating patient safety events. The System's Patient Safety Manager is responsible for the evaluation of patient safety events using the severity assessment code (SAC)³⁰ methodology and recording the results for further trending and analysis.³¹ The System must address patient safety events with an actual and potential SAC score of 1 or 2³² and perform a root cause analysis (RCA)³³ for all patient safety events with an actual or potential SAC score of 3. Table 2 provides the methodology used to determine the SAC score.

²⁸ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

²⁹ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This VHA Handbook was scheduled for recertification on or before the last working date of March 2016; it has not been recertified.

³⁰ Ibid.

³¹ Ibid.

³² Actions can include no action or, if indicated, an RCA.

³³ RCA is a process used to identify the basic or contributing factors associated with a patient safety event.

Table 2. SAC Scoring Methodology

		SEVERITY			
		Catastrophic	Major	Moderate	Minor
PROBABILITY	Frequent	3	3	2	1
	Occasional	3	2	1	1
	Uncommon	3	2	1	1
	Remote	3	2	1	1

Source: VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook

During the initial review of the patient safety event logs, we identified several events that did not appropriately reflect severity and/or probability of the event (scored lower), and as a result, did not undergo further review as required.³⁴ For example, we identified incorrect lab results entered into the medical record, resulting in delayed care.

The intent of the patient safety event and RCA processes is to prevent future occurrences of similar events. While neither VHA policy nor the System's process required a secondary review to ensure accurate SAC scoring of events, we noted that other national QSV programs have implemented inter-rater reliability processes. For example, peer review (PR) and utilization management both include validation of a percentage of specified cases to ensure consistent and accurate rating determinations.^{35,36}

PR

The System's PR process did not ensure appropriate PR Committee (PRC) representation or provider tracking, and the local PR policy did not define all minimum requirements. VHA requires facilities to establish and maintain a PR process for quality management purposes that include activities of the PRC.³⁷ We reviewed the PRC meeting minutes during FY 2015 through Q2 FY 2016 and found that the PRC did not align the following activities with VHA requirements.

Appropriate PRC Representation and Case Referral. VHA policy requires the presence of appropriate peers at the PRC meetings³⁸ and for peers to withdraw from PR participation during discussion of a case for which they have had direct involvement. In addition, outside PRs must be conducted when a local qualified peer is not available.

³⁴ VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, March 4 2011.

³⁵ VHA Directive 1117, Utilization Management Program, July 9, 2014.

³⁶ VHA Directive 2010-025, Peer Review for Quality Management, June 3, 2010. This VHA Directive expired June 30, 2015 and had not yet been updated.

³⁷ VHA Directive 2010-025, Peer Review for Quality Management, June 3, 2010.

³⁸ A peer is defined as health care professional with comparable education, training, experience, licensure, or similar clinical privileges that possess the clinical expertise needed to make accurate and fair decisions related to the case under review.

We found that appropriate peer representation was not present during the PRC discussions to determine final designations. We also found instances where providers who were directly involved in the case under review were present during the discussion and we found that the System did not use an outside peer reviewer when appropriate.

Provider Tracking Process. VHA policy defines PRC responsibility for quarterly provider PR summaries including the number of completed PR levels.³⁹ We found that the System did not have a reliable process for tracking, trending, or reporting PR outcomes by provider.⁴⁰ During interviews, staff responsible for the PR data reported that a new process was recently implemented.

VHA also requires a local PR policy that defines specific required elements.⁴¹ We found that the System's PR policy did not include PRC membership by title; a local process to request outside peer reviews; the role of PRC member substitutes and their voting rights; the method for selecting and defining roles of PRC ad-hoc reviewers; and the definition of a PRC quorum.⁴²

Institutional Disclosure

The System did not have processes in place to ensure consideration of institutional disclosure in cases involving unanticipated outcomes. VHA and JC require that patients, and when appropriate, their families, be informed of unanticipated outcomes related to an adverse event that occurred during care.^{43,44,45} The explicit intent of institutional disclosure is to inform patients and their families about substantive issues related to their care and options for redress, when appropriate.

During our review of QSV functions, including patient safety event logs and other quality of care reviews, we found instances meeting the definition of an unanticipated outcome. For example, we identified a case of a delayed response to abnormal lab results and a case of delayed response to a surgical event that resulted in unanticipated outcomes. However, we found no evidence of consideration of institutional disclosure for these cases.

Recommendation 3: We recommended the System Director ensure that the Quality, Safety and Value's subordinate committee minutes comply with Veterans Health Administration policy.

³⁹ VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

⁴⁰ MCM 11-13, *Peer Review for Performance Improvement*, December 15, 2015.

⁴¹ VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

⁴² MCM 11-13, *Peer Review for Performance Improvement*, January 27, 2014. This Memorandum was rescinded and replaced by MCM 11-13, *Peer Review for Performance Improvement*, December 15, 2015. The 2014 and 2015 documents contain the same or similar language related to the issue(s) discussed in this report.

⁴³ This includes those events that resulted in, or were reasonably expected to result in, death or serious injury; prolonged hospitalization; or life-sustaining intervention or intervention to prevent impairment or damage.

⁴⁴ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012.

⁴⁵ <http://vawww.oqsv.med.va.gov/functions/integrity/accred/jointcommission.aspx>. Accessed July 26, 2016.

Recommendation 4: We recommended that the System Director ensure professional practice evaluations include performance data to support provider privileges and are conducted as outlined in Veterans Health Administration and local policy.

Recommendation 5: We recommended that the System Director ensure that Service-level privilege lists are relevant to the care provided in the Service.

Recommendation 6: We recommended that the System Director ensure use of the correct methodology to determine the severity assessment code for all reported patient safety events.

Recommendation 7: We recommended that the Veterans Integrated Service Network Director consider an inter-rater reliability system or second-level review to ensure the correct application of the severity assessment code criteria.

Recommendation 8: We recommended that the System Director ensure the local peer review policy includes all Veterans Health Administration policy requirements.

Recommendation 9: We recommended that the System Director ensure adherence to all national peer review program requirements, including the use of suitable peers in Peer Review Committee processes, and monitor for compliance.

Recommendation 10: We recommended that the System Director ensure a process is in place to identify and review cases where institutional disclosure may be indicated, and complete as appropriate.

Issue 4: Staffing

The System has difficulty recruiting and retaining employees in some areas. The System uses hiring incentives, tele-medicine, and contracted services to meet patient care needs.

Adequate staffing levels are a key component to meeting the demands for patient care and services. A comparison of authorized full time equivalent (FTE) employees to actual FTE for FYs 2014–2016 (through May 14, 2016) for the selected Services reflected that the actual FTE was often below the authorized FTE as shown in Table 3.

Table 3. Comparison of Authorized FTE Staffing Versus Actual FTEs FYs 2014–2016⁴⁶

Service	FY 2014		FY 2015		FY 2016 (as of May 14, 2016)	
	Authorized FTE	Actual FTE	Authorized FTE	Actual FTE	Authorized FTE	Actual FTE
Nursing	337	308	288.5	286	288.5	271.5
PC	166.7	130.7	257.8	221.8	250.8	214.8
SC	82	68	88.3	76	88.3	77.1
MH	108.6	59	139.6	78	132.1	98.9
Laboratory/Pathology	48	45	48	45	48	46
Pharmacy	52.5	52.5	53.5	53.5	53.5	51.5
HRMS	17	17	19	19	22	19

Source: System provided comparison table of authorized versus actual FTEs. Numbers have been rounded to the nearest tenth decimal.

We reviewed staffing status and hiring plans for Nursing Service, PC, SC, and MH as of May 14, 2016. We also reviewed System planning documents that included a nursing standard operating procedure,^{47,48,49} VHA policies and procedures^{50,51,52} and interviewed key staff. We found that several factors influenced the System's ability to recruit and retain staff in key areas.

Geography and Compensation

We were told repeatedly by System, HRMS, and clinical leaders that the System's rural location (in Muskogee) and the lack of competitive pay make recruiting difficult. Reportedly, clinicians and other potential employees choose to work in more urban areas with better salaries. For example, according to VHA's Workforce Planning Report 2015, "[t]he singular common theme in review of the 21 VISN workforce plans is that the VHA cannot compete with the competitive, robust private sector hiring of PAs [physician

⁴⁶ Physician assistants and nurse practitioners are included in the authorized and actual FTE for PC, SC, and MH Services.

⁴⁷ JCMVAMC, *Plan for Provision of Care Primary Care Service*, June 2, 2016.

⁴⁸ JCMVAMC, *Behavioral Medicine Service Plan of Care*, April 16, 2016.

⁴⁹ JCMVAMC SOP #118-46, *Staffing Effectiveness Plan*, February 7, 2014.

⁵⁰ VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013.

⁵¹ VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010. This Directive expired May 31, 2015, and has not been updated.

⁵² VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010. This Directive expired July 31, 2015, and has not been updated.

assistants], as starting pay is traditionally 20–30% higher than VHA for new PA graduates.”⁵³

The System does use recruiting incentives and direct hiring authority⁵⁴ to address staffing shortages and fill critical vacancies, but hiring challenges remain. To meet the demand for specialty services, the System uses telemedicine and contracts with provider groups in the community. A System leader voiced frustration at the inability to recruit providers despite continuous vacancy announcements.

HRMS Management and Processes

During the course of this review, we learned that HRMS was in disarray after several personnel changes in the past 2 years. The acting HRMS Chief has been in the role since January 2014 and was previously a staffing supervisor at the System for about 2 years. The acting HRMS Chief told us that the previous HRMS Chief stepped down, and two subsequent acting chiefs and the long-term administrative officer left. Reportedly, HRMS was in a disorganized state, lacking routine information and documentation of staffing needs and hiring actions. At the time of our review in May 2016, the acting HRMS Chief was still working to understand System-wide staffing deficiencies and hiring gaps.

The acting HRMS Chief reported that the Service was “down” three employees, which posed processing time challenges. VA has established a Speed of Hire goal of 60 days, and as of late May 2016, the System’s Speed of Hire was 82.84 days. The acting HRMS Chief reported that the System’s current hiring priorities include PC, SC, Care in the Community (CIC), and psychiatrists.⁵⁵

Staffing Status and Hiring Plans

Nursing Service. Despite the rural designation and pay disparity issues noted earlier, the System is able to recruit nurses. At the time of our review in May 2016, Nursing Service had 20 vacancies.⁵⁶ The Nurse Recruiter told us that 13 nursing staff were in the process of being hired. The System has a successful recruitment program using the education debt reduction program and offering “on the spot” interviews at the time a nurse inquires about employment. Nursing Service implemented a float pool 2 years ago that reportedly helped recruitment because it allows a nurse to “try” the job.

⁵³ VHA Workforce Planning Report 2015, Healthcare Talent Management, Workforce Management & Consulting Office, Veterans Health Administration, page 49.

⁵⁴“A Direct-Hire Authority is an appointing (hiring) authority that the Office of Personnel Management can give to Federal agencies for filling vacancies when a critical hiring need or severe shortage of candidates exists.”
<https://www.opm.gov> Accessed June 24, 2016.

⁵⁵ Psychiatrists also known as Physical Medicine and Rehabilitation physicians “treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons.”
<http://www.aapmr.org/about-physiatry> Accessed June 28, 2016.

⁵⁶ Actual Nursing Service FY 2016 FTEs may have fluctuated with gains and losses between pay periods.

PC. We noted the current PC vacancies in Table 4, including the departure of two providers. The acting HRMS Chief reported that staffing for the Patient Aligned Care Team (PACT) PC is a current hiring priority.

Table 4. PACT PC Staffing by Location⁵⁷

Location	Number of PACTs	Composition of each PACT	Clinical Vacancies		Hiring Status/in Process	
			Providers	Nurses	Providers	Nurses
JCM VAMC	13	1 physician, 1 registered nurse (RN), 1 LPN, 1 MSA	5	0	3	NA
Ernest Childers VA OPC	20	1 physician, 1 RN, 1 LPN, 1 MSA	3	5	2	3
Vinita CBOC	2	1 physician or mid-level, ⁵⁸ 1 RN, 1 LPN, 1 MSA	0	0	NA	NA
Hartshorne CBOC	2	1 physician or mid-level, 1 RN, 1 LPN, 1 MSA	0	0	NA	NA

Source: The System provided the PACT PC staffing level as of May 16, 2016; provider clinical vacancies as of June 28, 2016, nurse vacancies as of June 15, 2016; and Hiring Status/in Process data as of June 15, June 20, and July 17, 2016, respectively.

SC. SC hired two part-time cardiologists in May 2016, and a pulmonologist is scheduled to start in October 2016. As of mid-May 2016, System managers were continuing efforts to recruit for urologists and gastroenterologists and were setting up tele-ICU because they had not been able to recruit intensivists.⁵⁹ Reportedly, no budgetary constraints were placed on hiring, but recruitment remained difficult due to pay and rural locale. To meet patient care needs, the System uses memoranda of understanding with local hospitals and community-based providers. System leaders reported ongoing efforts to recruit specialists.

MH. HRMS reported that MH was authorized 28.5 FTEs and had 20.5 actual prescribing provider⁶⁰ FTEs; all 8 vacancies were in the CBOCs or outpatient clinics and the positions were advertised. Managers told us that the 14-bed inpatient unit was fully staffed.

In addition to location and pay considerations, MH leaders reported that they have difficulty recruiting because a limited pool of psychiatrists and mid-level MH providers is available in the community. The System uses tele-MH providers to meet patient care

⁵⁷ Data provided as part of OIG’s data request from the System on June 15, 2016. Between the time of OIG’s data request and publication of this report, actual FY 2016 FTEs may have fluctuated with gains and losses in the various Services.

⁵⁸ Mid-level providers include Advanced Practice RNs and PAs.

⁵⁹ “An intensivist, also known as a critical care physician, is a medical doctor with special training and experience in treating critically ill patients.” <http://www.theintensivistgroup.com> Accessed June 24, 2016.

⁶⁰ Prescribing providers are authorized to prescribe medications and treatments within their scopes of practice.

needs in understaffed clinics. While the System is starting a new psychiatry residency program, the staffing benefits may not be realized for several years.

Recommendation 11: We recommended that the System Director continue efforts to recruit and hire for vacancies, and ensure that, until optimal staffing is achieved, alternate methods are consistently available to meet patient care needs.

Issue 5: Access to Care

The System is not meeting several access measures; however, the System has identified opportunities for improvement and begun implementing corrective actions.

VHA requires that routine (non-urgent) care appointments be scheduled as soon as possible but no later than 30 days from the patient's desired or the provider's clinically indicated date.⁶¹ For new patients (those who do not have an established relationship with a specified clinic or provider), appointments are typically requested through a consult to the specialist or to the specialty clinic. Consults remain open until the results are available in the EHR. One of VHA's access-related performance measures is the number of consults open greater than 30 days. VHA reports consults open greater than 90 days on its consult switchboard.⁶²

VHA uses the Scheduling Trigger Tool to identify scheduling-related issues. The Data Compliance score identifies potentially erroneous scheduling practices used to increase performance, and the Scheduling Compliance score indicates possible non-compliance with scheduling policies and the need for training.⁶³ For the review period, the System consistently met overall data and scheduling compliance targets.

Clinical Care Timeliness Measures

SC Access. The System did not complete routine SC appointments within the 30-day timeframe in some clinics. We noted that timely completion of SC appointments declined when comparing Q1 FY 2015 (97 percent) to Q1 FY 2016 (90 percent). At the end of Q2 FY 2016, several SC clinics exceeded the 30-day timeframe to complete new patient appointments. See Table 5 on the next page.

⁶¹ VHA Directive 2006-041, *Veterans Health Care Service Standards*, June 27, 2006. This VHA Directive expired June 30, 2011, and has not yet been updated.

⁶² The consult switchboard is a central location for new consult business rule information and to access documentation, tasks, reporting, and help.

⁶³ Facilities that fall within the bottom 20th percentile of composite scores for overall Data Compliance or Scheduling Compliance are identified as having potential access issues.

Table 5. Q2 FY 2016 SC Appointments – Average Days to Completion

Clinic Consult Location	Average days to completion
Gastrointestinal (GI) Endoscopy	79
Amputation Clinic	66
Urology Clinic	49
Infectious Disease ⁶⁴	46
Orthopedics	43
Physical Medicine and Rehabilitation	38
Hand Surgery	38
Pacemaker	34
Ophthalmology	32

Source: Corporate Data Warehouse

Across all SC clinics, we found 424 (30 percent) of the 1,402 new patient appointments pending greater than 30 days.⁶⁵

We found that SC clinics had 190 clinical consults open greater than 90 days with the two highest: GI endoscopy (69) and urology (47).⁶⁶ As of May 31, 2016, the System improved with 90 SC clinical consults open greater than 90 days with the highest: GI endoscopy (29).

The System hired a GI provider, who was pending a start date at the time of our review, and hired a GI nurse navigator and started an endoscopy triage process to prioritize appointments in August 2015.⁶⁷ All urology consults were sent to Veterans Choice because the System no longer had a urologist.

MH Access. The System generally completed routine MH appointments within the 30-day timeframe. As of the end of Q2 FY 2016, we found 10 of 125 new patient appointments pending greater than 30 days. MH did not have any consults open greater than 90 days.

⁶⁴ Infectious Disease had two of four consults scheduled beyond 30 days; neither of the EHRs included an explanation for the delay. The small denominator (four); however, means that the average can be easily skewed by outliers and should therefore be considered in that context.

⁶⁵ An appointment is considered pending when there is an appointment date entered, but no check-out, no-show, or cancel date; deceased patients are excluded. These appointments were scheduled for in-house services.

⁶⁶ VHA considers clinical consults as any consult service classified as Inpatient, Outpatient, Inter-Facility, and Future Care services.

⁶⁷ The GI nurse navigator tracks positive colorectal cancer screening results and coordinates colonoscopy prep and scheduling.

While MH care was generally provided in a timely manner, the System had difficulty recruiting psychiatrists. Staff reported that wait times to see a psychiatrist ranged up to 45 days. The System implemented a psychiatry residency program in July 2016; however, the first year rotations occur in medicine and neurology. Residents will start their psychiatry rotations in 2017 as long as the attending psychiatrists have adequate administrative time to provide appropriate resident supervision. The System also implemented a “consult hour” for each provider to have open access for 1 hour per day to address urgent consults.

PC Access. The System typically completed routine PC appointments within the 30-day timeframe, as required. As of the end of Q2 FY 2016, 6 of 149 new patient appointments were pending greater than 30 days.

We were told that to further enhance access, the System hired two mid-level providers for float coverage and a fee basis physician to cover providers with planned leave.⁶⁸ System managers also added appointment slots for walk-in patients and same-day appointment access.⁶⁹ The System reported providing refresher training to scheduling staff and conducting weekly audits to identify errors.

Call Center Responsiveness

VHA established a goal to provide access to telephone care 24-hours-a-day, 7-days-a-week.⁷⁰ The System’s PC call center performance is measured by a call answer speed within 30 seconds and a call abandonment rate no greater than 5 percent.⁷¹ In Q1 FY 2016, calls were answered in an average of 135 seconds, and the abandonment rate was 8 percent. System managers implemented a PC call center at the Tulsa CBOC in early April 2016 which was still being staffed at the time of our visit.

Recommendation 12: We recommended that the System Director continue efforts to enhance access to care for Specialty Care and Mental Health clinics and monitor outcomes for continued improvement.

Recommendation 13: We recommended that the System Director continue efforts to enhance call center timeliness and monitor outcomes for continued improvement.

⁶⁸ A Fee Basis provider works, as needed, to provide coverage when the team provider is not on duty.

⁶⁹ Two additional slots were added, per day, for each provider.

⁷⁰ VHA Directive 2007-033, *Telephone Service For Clinical Care*, October 11, 2007. This VHA Directive expired October 31, 2012, and has not yet been updated.

⁷¹ The abandonment rate is the percentage of calls that are terminated by the persons originating the calls before being answered and the speed of answer is the average delay that inbound telephone callers wait in the telephone queue before being answered.

Issue 6. Veterans Choice and NVCC

The System has not consistently met timeliness goals for Veterans Choice and NVCC care. Several factors affected the System's ability to ensure timely non-VA care including a changing demand for services, an inadequate number of trained staff to process consultation requests, and a limited number of community-based providers.

When a VA facility cannot provide needed medical care due to lack of a service or specialists, high demand for care, geographic inaccessibility, or other limiting factors, eligible patients may use non-VA care.⁷² Veterans Choice and NVCC programs are organizationally aligned under the CIC Program and are the primary non-VA care avenues utilized by the System. The System's CIC employees provide administrative and clinical coordination of Veterans Choice and NVCC services.

Veterans Choice is a program initiated in August 2014 through the Veterans Access, Choice, and Accountability Act. Veterans Choice offers several options including Choice First (when the service is not available at the System, such as mammograms) and Choice 30 (when the patient cannot be scheduled with System providers within 30 days).⁷³ Tri-West Healthcare Alliance (TriWest) is the VA-contracted third-party administrator in the System's region with responsibility for coordinating patient care and maintaining a "network" of providers to meet specialty, geographic, or other patient care needs.

NVCC may be used when services cannot be delivered by VA providers, Veterans Choice does not cover the needed specialty care (such as dialysis home care, emergency, or dental services), or the patient declines to participate in Veterans Choice.

The process for obtaining non-VA care begins when a provider initiates a consult request. CIC clinical staff review the consult for medical necessity,⁷⁴ and administrative staff verify the patient's eligibility.⁷⁵ CIC staff contact the patient, explain the non-VA care process, and ask the patient if he or she wants to "opt in"⁷⁶ to Veterans Choice.

⁷² VHA Directive 1601, *Non-VA Medical Care Program*, January 23, 2013; *Choice First Standard Operating Procedure (SOP): Non-VA Medical Care Referral Process for Services Unavailable and 30-Day Wait Time*, November 2, 2015 (Version 15); and VHA Consult Management Business Rules.

⁷³ Choice 40 can be used when patients reside greater than 40 miles from a VA facility that can provide the needed care. Choice 40 permits patients to coordinate their care directly through TriWest. Patients can still elect to be seen at the System even if they live outside the 40-mile radius.

⁷⁴ Medical necessity is defined as health care services provided for the evaluation and treatment of a disease, condition, illness, or injury.

⁷⁵ All patients must meet eligibility requirements to participate in the non-VA care program.

⁷⁶ To "opt in" refers to the patient choosing to use the Veterans Choice Program and having their care and services coordinated by TriWest.

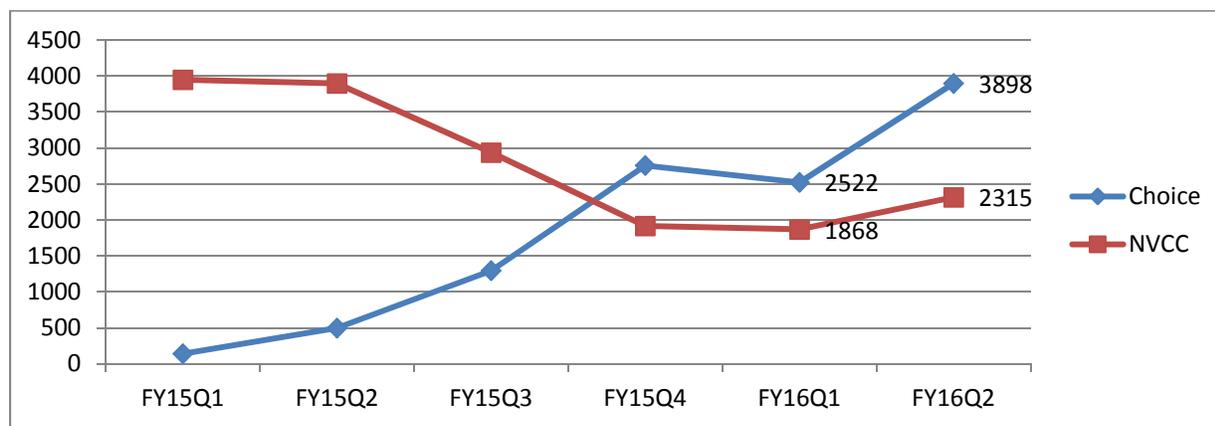
If the patient chooses to use Veterans Choice, the Choice consult, authorization, and supporting documentation are uploaded to the TriWest portal⁷⁷ for further action. Per the contract, TriWest schedules appointments, obtains the clinical results documentation, and communicates with the patient and VA. CIC staff track the date and location of scheduled appointments, attach the date of the appointment to the consult request, respond to requests for additional authorizations, and obtain and upload clinical results from the TriWest portal to the patient’s EHR.

If the patient declines Veterans Choice, NVCC may be used. CIC staff send the NVCC consult, authorization, and supporting documents to a community provider or a medical practice and obtain the date, time, and location of the patient’s appointment. CIC staff communicate with the patient and coordinate all care and services. CIC staff also track the completion of the consultation or evaluation, obtain the clinical documentation from the community provider, and ensure it is uploaded to the EHR.

CIC Volume and Staffing.

System leaders reported that, after implementation of the Veterans Choice Program, the System was not prepared for the new requirements and changing demand for non-VA care. Figure 2 illustrates the volume of Veterans Choice and NVCC consults between Q1 FY 2015 and Q2 FY 2016.

Figure 2. System’s Veterans Choice and NVCC Consult Volume Q1 FY 2015 Through Q2 FY 2016



Source: VHA Support Service Center (VSSC), Community Care Consult Cube V2

In Q1 FY 2016, CIC received nearly 4,400 Veterans Choice and NVCC consults combined. In Q2 FY 2016, incoming Veterans Choice and NVCC consults exceeded 6,200.

⁷⁷ As noted above, TriWest is the VA-contracted third-party administrator in the System’s region that coordinates patient care and maintains a “network” of providers to meet patient care needs. The TriWest portal is a secure network which enables providers and staff to access patient referrals, check authorization status, print the authorizations, and attach medical documentation and required forms.

The System hired a nurse manager in March 2015, and staff worked overtime to address the increased number of consults. However, by September 2015, System leaders determined that the organization of the CIC department was “not effective” and lacked dedicated and properly trained staff to manage the consult volume. In early December 2015, the acting COS responsible for the CIC presented a proposal to System leadership to reorganize the department, which included increasing the number of staff, updating procedures, and identifying an interim chief. Despite staff volunteering to “help the program get up and running,” the acting COS described to us that the System was “in over [its] head” and in need of VISN assistance.

At the request of System leaders, a VISN 19 team evaluated the CIC in late January 2016 and made recommendations to improve processes in the following areas:

- Consult authorization and approval authority
- Consult processing
- Program leadership
- Staff training
- Appointment scheduling and follow up

As of May 20, 2016, the System had not fully implemented all of the VISN 19 team’s recommendations. The System hired additional nursing and administrative staff and identified an interim chief; however, five administrative positions remained vacant. Because the restructured CIC had only been operational for 1 month, we were unable to determine whether changes will ensure timely processing of CIC consults.

Availability of Community-Based Providers

The System is located in a rural part of Oklahoma, which impacts the System’s ability to recruit in-house providers. (See Issue 4, *Staffing*.) As a result, the System relies on non-VA options to meet patient care needs. For example, the System lost its only full-time urologist. Due to the inability to recruit a replacement, the CIC was managing all urology consults. The acting COS told us “This is a small community, and there are only so many specialists available.” He further stated that TriWest used the same pool of community providers, and if the patient wanted to stay in the local area, the availability was “pretty limited.” While TriWest had contracts with providers in neighboring states, some patients chose not to travel those distances.

System managers reported particular challenges in arranging for orthopedics, neurosurgery, GI, and interventional cardiology services. The System’s approach to meeting the demand for specialty services included continuous recruitment, use of telemedicine, contracting with provider groups, and the implementation of a psychiatry residency program.

Impact of CIC Challenges: EHR Review Results

CIC Consult Processing. To determine whether staff followed VHA operating procedures and System policy, we reviewed a non-generalizable sample of 88 EHRs of patients with CIC consults requested from January 2015 through February 2016.^{78,79} We found that:

- Nine consults did not contain documentation of administrative eligibility review;⁸⁰
- Eighteen consults did not contain documented evidence of COS approval within 24–48 hours; and⁸¹
- Forty consults did not contain documentation that the authorization for services was uploaded or faxed within 5 days.⁸²

We did not find evidence that the System denied requests for CIC services for the cases reviewed.

Appointment Scheduling and Document Linking. To determine if CIC staff followed VHA and System appointment scheduling guidelines,⁸³ we evaluated the 88 consultation requests described above against specified policy.⁸⁴ We excluded 15 of the requests from further review because they were either cancelled before scheduling or declined by the patient.⁸⁵ Table 6 on the next page summarizes our findings.

⁷⁸ Department of Veterans Affairs, Veterans Health Administration, Chief Business Office, *Non-VA Medical Care Coordination Process Guide*, December 2013, page 3.

⁷⁹ Eastern Oklahoma VA Health Care System Standard Operating Procedure 161-72-8, *Managing Non VA Care (NVCC) Consults*, January 21, 2015.

⁸⁰ Department of Veterans Affairs, Veterans Health Administration, Chief Business Office, *Non-VA Medical Care Coordination Process Guide*, December 2013, page 3.

⁸¹ Eastern Oklahoma VA Health Care System Standard Operating Procedure 161-72-8, *Managing Non VA Care (NVCC) Consults*, January 21, 2015.

⁸² Ibid.

⁸³ Department of Veterans Affairs, Veterans Health Administration. *Non-VA Medical Care Coordination (NVCC) Process Guide, Appointment and Clinical Documentation Management*, December 2013

⁸⁴ Eastern Oklahoma VA Health Care System Standard Operating Procedure 161-72-8, *Managing Non VA Care (NVCC) Consults*, January 21, 2015.

⁸⁵ We reviewed cases from January 2015 to February 2016 to coincide with System policy. We excluded 14 Veterans Choice requests.

**Table 6. System’s Compliance with Appointment Scheduling Requirements
January 2015 through February 2016**

	Veterans Choice Compliance	NVCC Compliance
Schedulers contacted the patient to get input on the date and time of the appointment ⁸⁶	51/52 (98%)	3/21 (14%)
Schedulers linked the scheduled appointment to the consultation request ⁸⁷	31/31 (100%)	12/13 (92%)
For consultation requests with scheduled appointments, clinical documentation from non-VA providers was obtained, scanned, and attached to the request in the patient’s EHR ⁸⁸	25/31 (81%)	8/13 (62%)
For appointments with scheduled dates, appointment was scheduled within 30 days of the provider’s request or clinically indicated date ⁸⁹	11/31 (35%)	8/13 (62%)

Source: OIG analysis of patient EHR reviews.

Consult Completion Timeliness. Per VHA guidelines, CIC consults meet timeliness metrics when appointments are completed and results are uploaded and linked within 90 days of the request date.⁹⁰ The System has been making steady progress as reflected in Table 7.

Table 7. VSSC Report – Average Days to Complete System CIC Consultation Requests

	Average number of days to complete consultation requests		
	Q2 FY 2015	Q4 FY 2015	Q2 FY 2016
Veterans Choice	286	124	53
NVCC ⁹¹	96	48	28

Source: VSSC-Community Care Consults Measures cube

⁸⁶ Eastern Oklahoma VA Health Care System Medical Center Memorandum 11-61, *Scheduling Patients for Appointments*, September 2015.

⁸⁷ Ibid.

⁸⁸ VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This VHA Directive was in effect at the time of the events discussed in the report; it was rescinded and replaced by VHA Directive 1232, *VHA Consult Processes and Procedures*, August 24, 2016, amended September 23 2016; the two Directives contain the same or similar language regarding the scanning of NVCC supporting documentation.

⁸⁹ Eastern Oklahoma VA Health Care System Medical Center Memorandum 11-61, *Scheduling Patients for Appointments*, September 2015.

⁹⁰ United States Government Accountability Office Testimony before the Committee on Veterans’ Affairs. *VA Health Care Ongoing and Past Work Identified Access Problems That May Delay Needed Medical Care for Veterans*, April 2014.

⁹¹ The NVCC Geriatric and Extended Care program provides residential and community-based programs and services to patients who may have difficulty with self-care due to chronic diseases or injuries. This data does not include consults for this program.

As part of our quality of care review (see Issue 7), we independently evaluated the timeliness of consult completion, including CIC consultation requests. While our review results reflected similar average CIC consultation completion times, nearly half of the Veterans Choice and NVCC consultation requests reviewed were in an active⁹² status greater than 90 days. Of the 55 active CIC consultation requests open greater than 90 days, 21 (38 percent) were for urology and colonoscopy services.

Table 8. CIC Consultations Ordered March 6–12, 2016

	Completed < 90 days	Open < 90 days	Open > 90 days	Discontinued / Cancelled	Total Count
Veterans Choice	23 (average 55 days)	16	39	7	85
NVCC	5 (average 30 days)	3	16	13	37

Source: OIG analysis of patient medical record reviews.

The CIC Coordinator told us that on May 17, 2016, the System had 6,013 active CIC consultation requests greater than 90 days old. As of July 6, that number increased to 7,368.

System leaders acknowledged that patients experienced delays receiving CIC services but denied knowledge of any cases of clinically significant negative outcomes related to the delays.^{93,94}

To validate this assertion, we reviewed patient complaints, the EHRs of patients hospitalized for conditions associated with the reason for the consult, and cases the System self-identified as concerning.⁹⁵ Eighteen cases were relevant to our review. We found that 9 of the 18 consultation appointments were in excess of 30 days from the clinically indicated date and 2 of the 9 patients required hospitalization for a condition associated with the reason for the non-VA care request. Although two hospitalized patients experienced waits in excess of 30 days for the initial consult appointment, we determined that the delays did not contribute to or significantly impact the reason for their hospitalization.

At the time of our review in May 2016, System managers had begun implementation of the VISN recommendations.

⁹² In this context, “active” refers to consults still being tracked through appointment completion and consult closure.

⁹³ For the purposes of this review, we defined clinically significant negative outcomes as any patient hospitalized for a diagnosis associated with the delayed consult.

⁹⁴ A delay in care or treatment is defined as the patient not receiving the care that has been ordered in the time frame in which it was supposed to be delivered. This includes not getting an initial appointment or follow-up appointment in a timely manner.

⁹⁵ Concerning CIC consults included appointments scheduled in excess of 30 days, patient advocate complaints, or delay- or care-related concerns.

Recommendation 14. We recommended the Veterans Integrated Service Network Director charter a team to conduct a follow-up site visit to ensure the System Director's corrective actions taken in response to previous non-VA care-related recommendations were effective.

Issue 7: Quality of Clinical Care

Outpatient care in the areas of abnormal lab result notification and interventions, consultation completion timeliness, and mental health staffing needs improvement.

PC is the foundation of VHA health care; it is in this outpatient setting that many enrolled patients have their first contact with a VA clinical provider.⁹⁶ According to VHA policy, providers must maintain complete, accurate, timely, clinically pertinent, and readily accessible EHRs, which contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses, warrant treatment, and measure outcomes.⁹⁷

To determine if PACT teams were providing and documenting specified care and follow-up, we identified 567 System patients who completed PC appointments⁹⁸ March 6–12, 2016, with an associated primary or secondary diagnosis of hypertension, diabetes mellitus, or congestive heart failure.⁹⁹

We evaluated:

- Clinical care and medication reconciliation documentation during the PC appointments
- Compliance with abnormal lab result notifications and interventions
- Consultation completions
- Medical advice line call responses

We also evaluated outpatient MH care quality by examining the System's SAIL metrics.

⁹⁶ VHA Directive 2012-011, *Primary Care Standards*, April 11, 2012. This Directive was rescinded and replaced by VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, and contains the same or similar language (see p. 1).

⁹⁷ VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2015.

⁹⁸ Completed appointments were identified using stop codes within VHA's primary care clinic group, including 322, 323, and 350.

⁹⁹ We chose to focus our review on these chronic conditions because of their high prevalence within the veteran population and because of the availability of nationally recognized guidelines for treating these conditions. Primary or secondary diagnoses were identified using selected International Classification of Diseases, Tenth Edition (ICD-10) codes that went into effect October 1, 2015.

Clinical Care Documentation.

The EHR is a tool for communication and continuity of care for the health care team.¹⁰⁰ EHR documentation allows providers and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor the patient's health over time. In the outpatient setting, the health care provider must document a pertinent progress note at the time of each outpatient care visit.¹⁰¹

We reviewed EHRs to determine if required components of care¹⁰² were documented. We found high compliance in the following areas:

- Presenting problem(s) – 99.3 percent
- History and objective data relevant to presenting problem(s) – 99.1 percent
- Assessment of problem(s) – 99.8 percent
- Treatment plan for problem(s) – 99.6 percent
- Diagnosis(es) treated or that required further treatment – 99.1 percent

Medication Reconciliation.

Medication reconciliation is the process by which clinicians maintain and communicate accurate patient medication information through identifying, addressing, and documenting medication discrepancies found in the EHR as compared to the medication information given by the patient.¹⁰³ We found that PACT team members performed and documented medication reconciliation in 559 of the 567 (98.6 percent) EHRs reviewed.

Abnormal Lab Result Notification.

In the delivery of high quality patient-centered care, all VA medical facilities are expected to have appropriate systems and processes in place to ensure timely communication and follow-up of test results. To do this, VHA requires that all test results requiring action be communicated to patients no later than 7 calendar days from the date on which the results are available.¹⁰⁴

We reviewed EHRs for evidence of patient notification of, and interventions taken for, abnormal lab results that were clinically significant.¹⁰⁵ For our selected patient population with the diagnosis(es) of hypertension, diabetes mellitus, and/or heart failure,

¹⁰⁰ VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2015.

¹⁰¹ Ibid.

¹⁰² Ibid.

¹⁰³ VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011, p. 1. This Directive expired March 31, 2016, and has not been updated.

¹⁰⁴ VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

¹⁰⁵ Clinically significant lab results are those that required action (interventions) by the ordering providers.

we evaluated selected diagnostically-relevant lab results associated with each patient's March 2016 encounter.¹⁰⁶

Patient Notification of Abnormal Lab Results. PACT team members notified patients of 748 of the 839 (89.2 percent) abnormal results of the selected lab tests within 7 days of the availability of the results. PACT team members used a variety of ways to notify patients, including face-to-face visits, letters, and phone calls. (See Table 9 for details.) Notification count percentages in Table 9 may not sum to the totals due to rounding.

Table 9: Patient Notification of Selected Abnormal Lab Results, by System Location for Patients With Completed Appointments March 6–March 12, 2016.

Clinical Site	Patient Notification				Total Count	Total Percent
	YES		NO			
	Count	Percent	Count	Percent		
JCM VAMC	439	52.3	1	0.1	440	52.4
Ernest Childers VAOPC	276	32.9	76	9.1	352	42.0
Hartshorne VA Clinic	29	3.5	6	0.7	35	4.2
Vinita VA Clinic	4	0.5	8	1.0	12	1.4
Total	748	89.2	91	10.8	839	100.0

Source: OIG EHR review

Interventions Taken for Abnormal Results. PACT providers took actions to address 698 of the 762 (91.6 percent) clinically significant abnormal lab results. See Table 10 for details. Intervention count percentages in Table 10 may not sum to the totals due to rounding.

¹⁰⁶ Diagnostically-relevant lab tests included Creatinine, Hemoglobin A1c, Low Density Lipoprotein, Cholesterol, Urine Microalbumin, Potassium, Triglyceride, Urine Glucose, Urine Ketones, Urine Protein, and Urine Protein Random (quantitative).

Table 10: Follow-Up Actions Taken for Clinically Significant Abnormal Lab Results, by System Location for Patients With Completed Appointments March 6–March 12, 2016.

Clinical Site	Follow-Up Actions Taken				Total Count	Total Percent
	YES		NO			
	Count	Percent	Count	Percent		
JCM VAMC	384	50.4	3	0.4	387	50.8
Ernest Childers VAOPC	278	36.5	57	7.5	335	44.0
Hartshorne VA Clinic	31	4.1	0	0.0	31	4.1
Vinita VA Clinic	5	0.7	4	0.5	9	1.2
Total	698	91.6	64	8.4	762	100.0

Source: OIG EHR review

Consult Completions

In the provision of comprehensive care, clinical consultations for SC are sometimes required to meet the needs of outpatients. The requesting provider coordinates his/her patients' care and communicates with VHA and private-sector specialists.¹⁰⁷ SC appointments are considered complete after consultation results are entered in the patient's EHR.¹⁰⁸

We reviewed 447 VA (in-house) consult requests for patients who had a PC visit from March 6, 2016, through March 12, 2016. Nine of these consults were subsequently discontinued or cancelled. We found that 426 of the 438 (97 percent) clinical consults¹⁰⁹ had a completed status by June 9, 2016.¹¹⁰ The remaining 12 (3 percent) open VA consults either had a scheduled appointment that was for a future date beyond June 9, 2016, or lacked EHR documentation by the PC and/or SC provider (or Service) to indicate care had been tendered.

We also identified five consult categories that exceeded 35 days¹¹¹ for completion and affected more than one patient. See Table 11 for details.

¹⁰⁷ VHA Directive 2012-011, *Primary Care Standards*, April 11, 2012. This Directive was rescinded and replaced by VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, and contains the same or similar language (see p. 1).

¹⁰⁸ MCM 11-16, *Consultation Policy*, May 14, 2015.

¹⁰⁹ We excluded inpatient consults as well as prosthetic and home oxygen consults because these involved the procurement of equipment.

¹¹⁰ We validated all completed, discontinued, and cancelled consults, we then re-reviewed all consult requests with a "pending" status after June 9 to determine if consults were completed during our review period.

¹¹¹ We selected the 35-days timeframe to allow for potential patient-delay circumstances.

Table 11. Completed VA Consults by Title, Average Timeliness, and System Location for Patients With Completed Appointments March 6–March 12, 2016.

Completed VA Consults by Title	Average Days to Completion	Number of Patients Involved
CP [clinical procedure) ECHO [echocardiogram] ADULT	45	13
SUR[surgical] ORTHOPEDIC OUTPT [outpatient]	40	16
NUTRITION/MUSK [Muskogee] OUTPT	41	2
MED [medical] PULMONARY OUTPT	40	4
REHAB [rehabilitation] PODIATRY TUL [Tulsa] OUTPT	37	16

Source: OIG EHR review

Medical Advice Line Call Responses

To promote accessibility and timeliness, patients must be able to obtain medical advice when they seek it, whether for urgent, minor, or chronic conditions.¹¹² The System encourages patients to contact its telephone care line if they need medical advice, have a question about their medication, or need to schedule a non-urgent appointment.¹¹³ The System requires PACT team members to respond to calls within 2 hours for acute symptoms that have occurred within 24 to 48 hours and 2 business days for chronic symptoms that have occurred greater than 48 hours.¹¹⁴ In our review of the March 6–March 12, 2016 EHRs described above, we found that generally, PACT clinicians responded to patients' calls in a timely manner.

MH Outpatient Care

In SAIL metrics, the MH Domain includes composites of Population Coverage, Continuity of Care, and Experience of Care. In general, the Population Coverage composite includes the percentages of certain patients receiving MH care and of patients with certain MH diagnoses receiving specified care. The Continuity of Care composite generally includes the percentage of patients receiving follow-up care after discharge from an inpatient or residential treatment setting and the percentage of patients receiving diagnosis-specific treatment and therapies. The Experience of Care composite includes the survey results of both patients and MH providers regarding their perceptions of, and satisfaction with, MH care.

We noted that the System's ranking in the MH Domain measure declined (in comparison to 5-star facilities) from the second highest quintile in Q1 FY 2015 to the

¹¹² VHA Directive 2012-011, *Primary Care Standards*, April 11, 2012 (pages 2 and 3). This Directive was rescinded and replaced by VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, and contains the same or similar language (see p. 18).

¹¹³ System Internet Contact Page. Retrieved June 22, 2016, from <http://www.muskogee.va.gov/contact/>.

¹¹⁴ JCMVAMC Primary Care SOP#27, *Communication between Nurse and Medical Support Assistant for Patients Calling Requesting an Appointment*, June 1, 2015.

second lowest quintile in Q1 FY 2016. The acting Chief of MH reported that MH staffing shortages impact the System's ability to meet and exceed some of the measures. The System implemented a psychiatry residency program in July 2016; however, residents will not start their psychiatry rotations until 2017. The System also implemented a "consult hour" for each provider to have open access for 1 hour per day to address urgent consults. Other than these actions, we did not identify, nor were we told about, corrective actions to improve the System's MH performance measure scores.

Recommendation 15. We recommended that the System Director ensure that Patient Aligned Care Team clinicians follow Veterans Health Administration requirements for patient notification and follow-up of abnormal lab results.

Recommendation 16. We recommended that the System Director monitor consult completion timeliness and identify process improvements for those exceeding 30 days.

Recommendation 17. We recommended that the System Director ensure that a Mental Health-related Strategic Analytics for Improvement and Learning workgroup identify priorities, and develop and implement improvement actions accordingly.

Issue 8: ED

The ED is meeting performance targets for timeliness in most measures, but attention is needed to ensure patients not requiring admission are timely discharged from the ED.

The ED has 14 beds including an MH observation room. All patients who present to the ED are checked in and triaged using the 5-level Emergency Severity Index (ESI).¹¹⁵ After triage, a provider assesses the patient, orders laboratory and other tests as needed, enters consults, and determines the patient's disposition (such as admission to a unit or discharge home with PC follow-up). During the workweek, and when staffing allows, the ED uses a Fast Track area that¹¹⁶ provides care and treatment for patients with ESI scores of 4 or 5. ED staff treated approximately 15,000 patients in FY 2015 and 7,500 patients in Q1 and Q2 FY 2016.

We reviewed ED Integrated Software (EDIS) data for timeliness of care for patients seen in the ED in FY 2015 and Q1 and Q2 FY 2016. EDIS reports provide performance data for timeliness of patient care within the ED, and EDIS collects, tracks, and trends the data. ED managers review and monitor the data and information is discussed daily, as needed, in the Director's morning report.

¹¹⁵ ESI levels range from level 1, which requires immediate life-saving interventions, to level 5, no resources needed.

¹¹⁶ The Fast Track area is for patients with less immediate needs. The patients have to be well enough to sit in the ED lobby area.

Timeliness of Care

The three ED timeliness of care metrics we reviewed were triage, patients leaving without being seen, and LOS.

Triage. The System consistently met VHA’s target measure of less than 12 minutes for nursing triage¹¹⁷ timeliness for the 18 months reviewed. In FY 2015, the median patient wait time was 6 minutes for triage, and the median wait time decreased to 5 minutes for Q1 and Q2 FY 2016.

Patients Leaving [the ED] Without Being Seen. The System consistently met VHA’s target measure of less than 2 percent for the 18 months reviewed. In FY 2015, 1 percent of patients left without being seen, and in Q1 and Q2 FY 2016, the number decreased to 0.8 percent.

LOS. LOS is the elapsed time from when the patient checks in to the ED to the time of disposition. The System met the overall timeliness measure for LOS; however, when separated out by admitted and discharged patients, the System did not meet these LOS measures.

The ED Chief reported that prior to a patient’s discharge, providers tended to assess and complete diagnostic tests¹¹⁸ beyond the presenting problem(s). This was done because of the rural location of the JCM VAMC and the long distances that some patients must travel. The ED Chief stated this limited the opportunity for patients to “fall through the cracks.” See Table 12 for EDIS timeliness data.

Table 12. LOS Performance Measures

LOS Measure	Performance Goal	FY 2015	Q1 & Q2 FY 2016
Overall Median Time from Door to Disposition	< 200 minutes	176 minutes	176 minutes
• Median Time from Door to <i>Admission</i>	< 240 minutes	243 minutes	240 minutes
• Median Time from Door to <i>Discharge</i>	< 150 minutes	159 minutes	158 minutes

VHA data obtained through VSSC on May 9, 2016.

Diversion

VHA defines diversion as any situation where patients arriving to the System from another VA or non-VA facility (who would normally be transferred to the receiving System for their particular care need) are not accepted for care, services, or beds because they are not available. Also, adequate staffing or normal operations could be

¹¹⁷ Triage is from check-in until the triage nurse assesses the patient and determines the ESI level.

¹¹⁸ Further work-up includes obtaining ordered labs and completing pending orders. One example provided was to have a scheduled outpatient computed tomography scan completed while the patient was in the ED.

interrupted by a disaster. In these situations, most patients are diverted to another facility for care and treatment.¹¹⁹

The ED attending physician, along with the ED charge nurse and the COS, determine when to go on diversion.¹²⁰ ED leadership and staff stated that when there are too many patients to manage in the ED, a hospital-wide announcement is made for assistance. The ED Chief could recall only four times in the past 12 years when the ED went on diversion. The System was on diversion once during the 18 months covered in FY 2015 and Q1 and Q2 FY 2016.

Patient Satisfaction

The Patient Advocate Tracker System tracks both complaints and compliments the System receives. The patient advocate forwards information regarding ED physicians to the acting Chief of PC and concerns related to nursing staff to the ED nurse manager for follow-up. Leadership is to review, resolve, and respond to the complaint within 7 days. The patient advocate reviews the response to ensure the complaint has been appropriately resolved. If a response is inadequate or not received within 7 days, then the COS is notified. Once resolved, the complaint is closed out of the Patient Advocate Tracker System. For FY 2015 and Q1 and Q2 FY 2016, the ED received a nominal number of complaints (30 total) and 23 compliments.

Recommendation 18. We recommended that the System Director ensure continued efforts to improve lengths of stay for patients being discharged from the Emergency Department.

Issue 9: EOC

Actions are needed to ensure that the System maintains a clean and safe health care environment in accordance with applicable requirements.

VHA requires facilities to maintain a clean and safe health care environment in accordance with applicable requirements.¹²¹ VHA facilities must comply with requirements, standards, and recommendations from VHA, Occupational Safety and Health Administration (OSHA), National Fire Protection Association (NFPA), Centers for Disease Control and Prevention (CDC), and JC to ensure a safe environment, reduce infection risks, and facilitate optimal patient care outcomes. We reviewed System documents and inspected patient care areas focusing on selected elements of medication safety and security, information technology (IT) security, environmental

¹¹⁹ VHA Directive 2009-069, *VHA Medical Facility Emergency Department Diversion Policy*, December 16, 2009, pg. 3. This Directive was in effect at the time of the events discussed in this report; it has been rescinded and replaced by VHA Directive *Emergency Medicine*, September 2, 2016, amended October 23, 2016 contains the same or similar definition of diversion of patients.

¹²⁰ Medical Center Memorandum 11-14, *Medical Center and Emergency Department Diversion Policy*, May 25, 2011, and June 23, 2015.

¹²¹ VHA Directive 1608, *Comprehensive Environment of Care Program*, February 1, 2016.

safety, infection prevention, fire prevention, work place violence, the Women Veterans Program, and privacy. A summary of the review topics can be found in Appendix B.

We inspected five inpatient units,¹²² the ED, and four OPCs¹²³ located at the JCM VAMC. We also inspected the Ernest Childers OPC, JCM-East, Tulsa Behavioral, and Vinita CBOCs.¹²⁴ Additionally, we reviewed EOC and infection control committee (ICC) meeting minutes for FY 2015 and Q1 and Q2 FY 2016.

We found no deficiencies during our Medication Safety and Security or our IT Security reviews. We also found that the System conducted and documented appropriate infection prevention activities.

We found the following deficiencies:

- **Environmental Safety:**
 - EOC Committee meeting minutes (General) - Minutes did not consistently reflect details regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.
 - Cleanliness (4 East, 5 West, ICU, and the Women's Health Clinic) - Areas included one or more of the following conditions: dirty air vents and sprinkler heads; stained ceiling tiles; insects in overhead lights; compromised integrity of bedside rolling drawers (an infection control risk due to inability to properly clean drawers); a dirty hopper in a soiled utility area; and wooden pallets in a clean utility room.
 - Hazardous Chemicals Management (JCM-East, Tulsa Behavioral, and the Vinita CBOCs):
 - Inventory of hazardous materials was not reviewed for accuracy twice within the prior 12 months.
 - Safety data sheets for chemicals were not readily available to staff.
- Infection Prevention (Vinita CBOC) – Expired sterile instrument packages were not consistently discarded.
- Fire Prevention (JCM-East and Tulsa Behavioral) - Fire extinguishers were not consistently visible from the corridors; .
- Workplace Violence Prevention (JCM-East, Tulsa Behavioral, and the Vinita CBOCs) - Managers did not consistently install alarm systems in high-risk areas.
- Women Veterans Program (General) - The System did not consistently ensure provision of feminine hygiene products.

¹²² The inpatient units included the acute MH unit, 5 West, 4 West, 4 East, and the ICU.

¹²³ The OPCs included primary care, women's health, surgery, and audiology.

¹²⁴ We did not review the Hartshorne CBOC because the OIG inspected the Hartshorne CBOC and published a report with 14 recommendations on April 14, 2016. <http://www.va.gov/oig/pubs/VAOIG-16-00011-259.pdf>

- Privacy (JCM VAMC Surgery Clinic; JCM-East and Vinita CBOCs) – Not all exam rooms could be secured by either an electronic or manual door lock.

Recommendation 19. We recommended that the System Director ensure that all patient care areas comply with environment of care requirements and that action plans specifically address deficient areas identified in this report.

Conclusions

During the course of our comprehensive review, we found that the System met many of the selected performance measures reviewed, programs were operated in accordance with guidelines, and employees were knowledgeable and committed to serving Veterans. However, we found multiple deficient program areas and operations needing improvement.

Several of the System's key leadership positions have been in flux for the past year which has contributed to inconsistent oversight and communication in some areas. A new System Director was installed in June 2016; as of February 2017, several Services were still being led by acting chiefs.

The System's current overall quality performance ranking is fair; however, several measures deteriorated in the past year, and corrective action plans have only recently been initiated. At the time of our review, the System was taking action to improve quality measure scores. From 2013–2015, the System performed well in the BPTW measure.

The System's QSV program, as well as other reporting systems, did not provide the necessary monitoring and oversight to ensure that some patient care processes were safe and effective. The minutes of several subordinate committees did not include information needed to evaluate and correct deficient patient care processes. Further, the System did not follow policy regarding provider privileging. Our review of selected providers' FPPE and OPPE revealed that folders did not always include provider-specific data to support continuation of privileges.

SAC scoring of unanticipated events did not consistently comply with VHA requirements, and, unlike other patient safety programs, VHA does not require a secondary review of SAC scores to ensure accuracy.

The PRC did not consistently include appropriate representation insofar as peers that should have been present were not, and peers that should have recused themselves did not. We also found that the System did not follow guidelines regarding the use of outside peer reviewers. Additionally, the PR policy did not include all required elements; the System did not have a reliable process for tracking, trending, or reporting PR outcomes by provider; and the System did not have processes in place to ensure consideration of institutional disclosure in cases involving unanticipated outcomes.

The System has difficulty recruiting and retaining employees in some areas, reportedly due to its rural location and pay disparity with the private sector. In general, Nursing Service was adequately staffed; however, the System lacked a sufficient number of gastroenterologists, urologists, and psychiatrists. The System uses hiring incentives to recruit specialists, and uses tele-medicine and contracted services to meet patient care needs when in-house specialty care is not available timely.

Despite staffing challenges, the System has largely met access metrics for PC and MH. SC access, particularly in the areas of GI endoscopy and urology, needs improvement. Further, while the System has expanded call center services, it was not meeting metrics as of Q2 FY 2016. The System identified opportunities to improve access and began implementing corrective actions.

The System has not consistently met timeliness goals for Veterans Choice and NVCC care. Several factors have affected the System's ability to assure timely non-VA care, notably the changing demands and requirements of Veterans Choice, inefficient processes, and an inadequate number of trained staff to manage the volume of non-VA care consults. A VISN 19 team evaluated the System's CIC program and recommended multiple corrective actions. Staffing has improved recently, and while some administrative processes are still delayed, the average time to complete non-VA care consults met timeliness metrics as of the end of Q2 FY 2016.

We reviewed the EHRs of 567 System patients who completed PC appointments during a week in early March 2016. We found providers consistently documented required elements including relevant history and presenting problems, treatment plans, and follow-up; medication reconciliation; and in-house consult completion. We found that providers needed to improve documentation that patients were notified of abnormal lab tests and that actions were taken to address abnormal lab values, when appropriate.

As of our mid-May 2016 site visit, the ED was meeting performance targets for timeliness in most measures and the System was rarely on diversion.

We found no deficiencies in our medication safety and security, IT security, or infection prevention risk assessment reviews. We identified opportunities to improve the quality of EOC minutes; general cleanliness in selected areas; review of hazardous chemicals inventory and availability of safety sheets; currency of sterile instrument packages; placement of fire extinguisher signage; installation of alarm systems in high-risk areas; availability of feminine hygiene products; and security of exam room doors.

We made 19 recommendations.

Recommendations

1. We recommended that the System Director take action to fill key leadership positions with qualified, permanent personnel.

- 2.** We recommended that the System Director ensure that established workgroups continue efforts to improve Strategic Analytics for Improvement and Learning-related metrics, and that progress be monitored.
- 3.** We recommended the System Director ensure that the Quality, Safety and Value's subordinate committee minutes comply with Veterans Health Administration policy.
- 4.** We recommended that the System Director ensure professional practice evaluations include performance data to support provider privileges and are conducted as outlined in Veterans Health Administration and local policy.
- 5.** We recommended that the System Director ensure that Service-level privilege lists are relevant to the care provided in the Service.
- 6.** We recommended that the System Director ensure use of the correct methodology to determine the severity assessment code for all reported patient safety events.
- 7.** We recommended that the Veterans Integrated Service Network Director consider an inter-rater reliability system or second-level review to ensure the correct application of the severity assessment code criteria.
- 8.** We recommended that the System Director ensure the local peer review policy includes all Veterans Health Administration policy requirements.
- 9.** We recommended that the System Director ensure adherence to all national peer review program requirements, including the use of suitable peers in Peer Review Committee processes, and monitor for compliance.
- 10.** We recommended that the System Director ensure a process is in place to identify and review cases where institutional disclosure may be indicated, and complete as appropriate.
- 11.** We recommended that the System Director continue efforts to recruit and hire for vacancies, and ensure that, until optimal staffing is achieved, alternate methods are consistently available to meet patient care needs.
- 12.** We recommended that the System Director continue efforts to enhance access to care for Specialty Care and Mental Health clinics and monitor outcomes for continued improvement.
- 13.** We recommended that the System Director continue efforts to enhance call center timeliness and monitor outcomes for continued improvement.
- 14.** We recommended the Veteran Integrated Service Network Director charter a team to conduct a follow-up site visit to ensure the System Director's corrective actions taken in response to previous non-VA care-related recommendations were effective.

- 15.** We recommended that the System Director ensure that Patient Aligned Care Team clinicians follow Veterans Health Administration requirements for patient notification and follow-up of abnormal lab results.
- 16.** We recommended that the System Director monitor consult completion timeliness and identify process improvements for those exceeding 30 days.
- 17.** We recommended that the System Director ensure that a Mental Health-related Strategic Analytics for Improvement and Learning workgroup identify priorities, and develop and implement improvement actions accordingly.
- 18.** We recommended that the System Director ensure continued efforts to improve lengths of stay for patients being discharged from the Emergency Department.
- 19.** We recommended that the System Director ensure that all patient care areas comply with environment of care requirements and that action plans specifically address deficient areas identified in this report.



Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions



Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
Mental Health Wait Time	Mental health care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	Mental health continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC Provider	Rating of primary care providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care module)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value

Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions
Printed by: VHMASTER\oigatcoatev on 8/18/2016 6:19:38 AM

Environment of Care Review Topics

Review Topic	Requirement Standards	Team Actions
Medication Safety and Security	JC: <ul style="list-style-type: none"> ▪ MM.03.01.01, EP 4, 8 	Verifying that medications were not expired and were secured from unauthorized access.
IT Security	VHA Handbook 6500	Verifying that IT network rooms were locked, restricted to authorized personnel only, and documentation of who accessed the room and when was available.
Environmental Safety	JC: <ul style="list-style-type: none"> ▪ EC.02.06.01, EP 20, 26, ▪ EC.02.02.01, EP 1 <p>VA Directive 0059</p> <p>OSHA: <ul style="list-style-type: none"> ▪ 29 CFR 1910.1200(g)(8) </p>	Ensuring that the facility was clean and well maintained; furnishings were safe and in good repair; EOC inspection rounds occurred and that EOC Committee meeting minutes documented issues and those issues were addressed timely; inventory of hazardous chemicals and wastes were reviewed twice over the past 12 months; and safety data sheets for chemicals were readily available.
Infection Prevention	OSHA: <ul style="list-style-type: none"> ▪ 29 CFR 1910.1030(d)(2)(iii) ▪ 29 CFR 1910.1030(d)(3)(iii) ▪ 29 CFR 1910.1030(d)(4)(iii) ▪ 29 CFR 1910.1030(d)(2) <p>VHA Directive 2011-007</p> <p>International Association of Healthcare Central Services Material Management, Central Service Technical Manual, 7th edition</p> <p>JC: <ul style="list-style-type: none"> ▪ IC.02.01.01, EP 6 </p>	Verifying availability and accessibility of hand hygiene facilities and products, personal protective equipment, and sharps containers; food and drinks were kept separate from blood and other potentially infectious materials; sterile supplies were not expired; and staff minimized the risk when storing or disposing of medical (infectious) waste.
Fire Safety (Life Safety and Emergency Management)	NFPA 101 (2015 edition) <ul style="list-style-type: none"> ▪ 9.6.2.7, Life Safety Code ▪ 7.10.1.2 <p>NFPA 10 (2013 edition) <ul style="list-style-type: none"> ▪ 6.1.3.1 ▪ 6.1.3 ▪ 6.1.3.3.2 ▪ A.6.1.3.3.2 </p> <p>JC: <ul style="list-style-type: none"> ▪ EC.02.03.01, EP 4 </p>	Ensuring accessibility and visibility of fire alarms, pull stations, fire extinguishers, exit signs, and exit routes.

Appendix B

Work Place Violence	<p>JC:</p> <ul style="list-style-type: none"> ▪ EC.02.01.01, EP 7, 8 <p>VA Handbook 6500 VHA Directive 2012-026</p>	Ensuring that all staff wore VA-issued identification badges; was controlled access to areas identified as security sensitive; and alarm systems were installed in high-risk areas.
Women Veterans Program	<p>VHA Handbook 1330.01</p> <p>JC:</p> <ul style="list-style-type: none"> ▪ RI.01.01.01, EP 7 	Ensuring privacy in examination rooms and access to feminine hygiene products both where pelvic examinations occur as well as in women’s public restrooms.
Privacy	<p>HIPAA Privacy Rule</p> <p>JC:</p> <ul style="list-style-type: none"> ▪ RI.01.01.01, EP 7 <p>VHA Handbook 1101.10 VHA Handbook 1907.01 VHA Handbook 6500 VHA Telehealth Services, VHA Clinic Based Telehealth Operations Manual</p>	Ensuring visual and auditory privacy at check-in and in the interview/examination areas; were locks on examination rooms; that privacy signs were posted when Telehealth visits occurred; and protected patient information was secured and not visible to the public.

Legend:

- MM – Medication Management
- EP – Element of Performance
- EC – Environment of Care
- CFR – Code of Federal Regulations
- IC – Infection Prevention and Control
- RI – Rights and Responsibilities of the Individual
- HIPAA – Health Insurance Portability and Accountability Act of 1996

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: March 14, 2017

From: Director, Rocky Mountain Network (10N19)

Subj: Healthcare Inspection—Clinical Activities, Staffing, and Administrative Practices, Eastern Oklahoma VA HCS, Muskogee, Oklahoma

To: Director, Atlanta Office of Healthcare Inspections (54AT)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to review and comment on the draft report, Healthcare Inspection – Clinical Activities, Staffing, and Administrative Practices, Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma. I concur with the findings in the draft report, provide the attached action plan to address recommendations 7 and 14 at the VISN level, and agree with the attached action plan submitted by Eastern Oklahoma VAHCS to address the remaining recommendations.
2. If you have any questions, please contact Ms. Ruth Hammond, VISN 19 Quality Management Specialist at (303) 202-8169

Ralph T. Gigliotti

Ralph T. Gigliotti, FACHE
Director, VA Rocky Mountain Network (10N19)

Comments to OIG Report

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

Recommendation 7. We recommended that the Veterans Integrated Service Network Director consider an inter-rater reliability system or second-level review to ensure the correct application of the severity assessment code criteria.

Concur

Target date for completion: August 1, 2017.

Response: Training on severity assessment code (SAC) scoring of patient safety events will be completed by the VISN Patient Safety Officer (PSO) to the Muskogee Patient Safety Manager (PSM), Risk Manager, and Quality Manager during an on-site visit the week of March 27, 2017. Beginning in April, a random sampling of cases will be reviewed by the VISN PSO and facility on a monthly basis until three consecutive months of 90% compliance is attained.

Recommendation 14. We recommended the Veteran Integrated Service Network Director charter a team to conduct a follow-up site visit to ensure the System Director's corrective actions taken in response to previous non-VA care-related recommendations were effective.

Concur

Target date for completion: Completed

Response: A follow-up site visit was authorized by the VISN 19 Network Director and conducted January 17-20, 2017. The team found that all previous findings had been appropriately addressed with the exception of hiring a permanent Supervisor of Non-VA Care. Currently this position is impacted by the national hiring freeze and is being filled by an interim supervisor.

OIG Update June 2017: We accepted this action as complete based on a review of the Veterans Integrated Service Network 19 site visit report conducted January 17-20, 2017. The Supervisor, Non-VA Care position, was changed to an RN position, and recruitment is in process. The interim Care Coordination RN is serving as the Acting Supervisor.

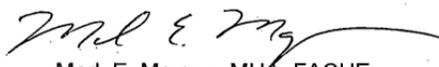
System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 10, 2017
From: Director, Eastern Oklahoma VA HCS (623/00)
Subj: Healthcare Inspection— Clinical Activities, Staffing, and
Administrative Practices, Eastern Oklahoma VA HCS, Muskogee,
Oklahoma
To: Director, Rocky Mountain Network (10N19)

1. In response to the Office of Healthcare Inspection's report, subject as above, Eastern Oklahoma VAHCS concurs with all recommendations. The facility responses detail any outstanding action plans.
2. Thank you for your assistance with our performance improvement efforts. If additional information is needed please contact Martha Hardesty RN, Performance Improvement Specialist for OIG, Quality Safety and Value Service, 918-577-3473.


Mark E. Morgan, MHA, FACHE
Medical Center Director

Comments to OIG 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 System Director take action to fill key leadership positions with qualified, permanent personnel.

Concur

Target date for completion: September 1, 2017.

Facility response: The Eastern Oklahoma VA Health Care System (EOVAHCS) has aggressively pursued filling key leadership positions as evidenced below. The Medical Center Director entered on duty June 12, 2016. The Chief, Quality Safety and Value position was filled December 25, 2016. Interviews for the Associate Director were completed and a selection was sent to Central Office January 23, 2017. This position is impacted by the national hiring freeze and a request for exemption was submitted.

Recommendation 2. We recommended that the System Director ensure that established workgroups continue efforts to improve Strategic Analytics for Improvement and Learning-related metrics, and that progress be monitored.

Concur

Target date for completion: Completed.

Facility response: The established SAIL workgroups remain in place and continue to identify areas of improvement, implement change, and monitor progress. These workgroups are reporting to Quality, Safety and Value (QSV) Committee monthly.

OIG Update June 2017: We accepted this action as complete based on the review of System QSV minutes documenting the analysis of data by the SAIL work group as well as monthly discussion and reporting to the QSV committee.

Recommendation 3. We recommended the System Director ensure that the Quality, Safety and Value's subordinate committee minutes comply with VHA policy.

Concur

Target date for completion: April 1, 2017

Facility response: Medical Center Memorandum 00-64, Councils, Board, and Committees, dated 9/30/2016, was enacted by the System Director. The MCM outlines data collection, analysis, tracking, and reporting responsibilities of all committees.

Quality, Safety and Value Service staff will review QSV subordinate committees' minutes on a monthly basis to ensure compliance with the policy.

OIG Update June 2017: We accepted this action as complete based on a review of the System's revised and approved Medical Center Memorandum 00-64, *Councils, Board, and Committees*, dated September 30, 2016 and QSV committee minutes.

Recommendation 4: We recommended that the System Director ensure professional practice evaluations include performance data to support provider privileges and are conducted as outlined in Veterans Health Administration and local policy.

Concur

Target date for completion: Completed.

Facility response: All general Surgery OPPE's were reviewed and revised by November, 2016. Urology OPPE's were reviewed and revised August 2016. Ophthalmology and Certified Registered Nurse Anesthetists (CRNA) OPPE's were reviewed and revised November 2016.

OIG Update June 2017: We accepted this action as complete based on a review of the revised OPPE forms that include performance data to support provider privileges and a process to ensure OPPEs are conducted in accordance with Veterans Health Administration and local policy.

Recommendation 5. We recommended that the System Director ensure that Service-level privilege lists are relevant to the care provided in the Service.

Concur

Target date for completion: Completed

Facility response: Privilege forms have been reviewed and revised for service-specific and provider-specific (completed November, 2016).

OIG Update June 2017: Based on information received from the System in March 2017, we consider this action completed.

Recommendation 6. We recommended that the System Director ensure use of the correct methodology to determine the severity assessment code for all reported patient safety events.

Concur

Target date for completion: April 1, 2017

Facility response: The Patient Safety Manager (PSM) attended the National Center for Patient Safety's, "Patient Safety 101" program August, 2016 which included Severity

Assessment Code (SAC) matrix training. A new PSM was hired on February 5, 2017 and attended the Patient Safety 101 training March 7-9, 2017. A VISN 19 PSM site visit is scheduled the week of March 27, 2017 where this training will be reinforced.

OIG Update June 2017: We accepted this action as complete based on a review of documentation that the current PSM has completed the assigned training and that a Veterans Integrated Service Network 19 site visit, completed in March 2017, provided guidance on assignment of appropriate severity assessment scores. Additionally, the Veterans Integrated Service Network Patient Safety Officer provided evidence of ongoing monitoring of SAC scoring until the benchmark of 90% reliability was achieved.

Recommendation 8. We recommended that the System Director ensure the local peer review policy includes all Veterans Health Administration policy requirements.

Concur

Target date for completion: Completed.

Facility response: The Medical Center Memorandum 11-13, Peer Review for Performance Improvement, was revised and enacted by the System Director July, 7 2016, to include all elements of VHA policy. The facility policy addresses appropriate membership and representation, as well as the number of voting members required for a quorum.

OIG Update June 2017: Based on information received from the System in March 2017, we consider this action completed.

Recommendation 9. We recommended that the System Director ensure adherence to all national peer review program requirements, including the use of suitable peers in Peer Review Committee processes, and monitor for compliance.

Concur

Target date for completion: March 31, 2017

Facility response: During an on-site visit conducted the week of November 14, 2016, the VISN 19 Risk Manager reviewed the VHA Peer Review (PR) policy and the PR process with the facility Risk Manager (RM) and the PR Committee. The COS will ensure that appropriate peer representation is present during the peer review committee. If there is not appropriate peer representation at the meeting, the case will be postponed until the next meeting when appropriate representation is present. When appropriate representation is not available from within the facility another facility in the VISN is contacted to request an appropriate peer to attend the committee meeting and/or review the case. The committee members who have direct involvement in any of the cases are excused prior to case discussion/review. Outside peer reviewers are sought through VISN 19, as needed, for an appropriate peer review.

OIG Update June 2017: We accepted this action as complete based on a review of Peer Review committee minutes, the current System Peer Review Policy, and evidence that Veterans Integrated Service Network 19 representatives completed a site visit in November 2016.

Recommendation 10. We recommended that the System Director ensure a process is in place to identify and review cases where institutional disclosure may be indicated, and complete as appropriate.

Concur

Target date for completion: Completed.

Facility response: The Patient Safety Manager (PSM) receives events through multiple avenues such as the incident reporting process, the Stop the Line link on the facility homepage, staff calls and e-mails, etcetera. Issues identified are reviewed by the PSM and RM to determine the appropriate course of action including consideration of institutional disclosure. Additionally, the Risk Manager (RM) has weekly meetings with the Acting Chief of Staff to discuss issues. For each peer review completed by the PR committee, a determination is made as to whether institutional disclosure should be done. This is recorded in the PR minutes.

OIG Update June 2017: We accepted this action as complete based on a review of the System Peer Review committee minutes and clear documentation of institutional disclosure discussions.

Recommendation 11. We recommended that the System Director continue efforts to recruit and hire for vacancies, and ensure that, until optimal staffing is achieved, alternate methods are consistently available to meet patient care needs.

Concur

Target date for completion: October 1, 2017

Facility response: EOVAHCS continues to pursue aggressive recruitment and hiring as demonstrated below. Hiring includes a Gastroenterologist hired September, 2016, a Nephrologist hired December 27, 2016, and two part-time Cardiologists hired May 15, 2016. As of March 3, 2017 we have a fee-basis contract for psychiatric physicians and psychiatric mid-level practitioners. One psychiatrist is currently being credentialed and another is scheduled to enter duty May, 2017. There are two applicants for a Mental Health Nurse Practitioner vacancy and interviews are scheduled for the week of March 20, 2017. We ensure patient care is accomplished by routinely offering Mental Health Choice or other non-VA care as appropriate. Additionally, mental health telehealth has expanded through establishment of a service agreement with the Salt Lake City VA, with appointments initiated March 2, 2017.

Recommendation 12. We recommended that the System Director continue efforts to enhance access to care for Specialty Care and Mental Health clinics and monitor outcomes for continued improvement.

Concur

Target date for completion: October 1, 2017

Facility response: EOVAHCS has open and continuous vacancy postings for Mental Health providers and nurses. The Chief of Behavioral Health assumed duties February 1, 2017 and is implementing a resident supervision program with the initial behavioral health residents scheduled to begin July 1, 2017. The Chief of Behavioral Medicine is now an adjunct faculty at Oklahoma State University and is the site director for the residency program. He is actively networking with the University and other colleagues around the state who refer interested applicants to the VA. A nursing recruitment fair is scheduled for Saturday, April 1, 2017 with Human Resources, Credentialing, and Police Service for PIV/Fingerprinting in attendance to enhance the speed of hiring. The healthcare system will continue to work with VISN 19 HR and VISN 19 physician recruiter in an effort to recruit new providers. Access to care efforts and data are reported and monitored in Quality, Safety, and Value Committee.

Recommendation 13. We recommended that the System Director continue efforts to enhance call center timeliness and monitor outcomes for continued improvement.

Concur

Target date for completion: July 1, 2017

Facility response: We are actively hiring for call center position openings, there are 13 on staff and 6 openings. RN telephone triage was added October 1, 2016. A second Pharmacy tech was hired February, 2017, to assist with pharmacy calls. Telephone response times are monitored by the SAIL Access work group and reported to Quality, Safety, and Value Council. Timeliness has improved as follows: The average speed of call responsiveness was 188.83 in September, 2016 and as of February, 2017 has improved to 71.4. The call abandonment rate in September, 2016 was 15% and as of February, 2017 has improved to 7.4%.

Recommendation 15. We recommended that the System Director ensure that Patient Aligned Care Team clinicians follow Veterans Health Administration requirements for patient notification and follow up of abnormal lab results.

Concur

Target date for completion: Completed.

Facility response: Primary Care Leadership has reviewed Medical Center Memorandum 11-03, Provider Orders/Critical Results, dated March 31, 2016, with all Primary Care providers. This policy outlines reporting timeframes for critical and

non-critical test results and is congruent with VHA policy. Abnormal lab results create a view alert to the ordering provider and the patient is contacted by phone; if the patient is unable to be contacted by phone, a letter is sent informing them of the lab results and providing the PACT phone number for any questions. Primary Care leadership monitors this by conducting monthly random chart reviews, reports the data to the Health Care Delivery Committee (HCDC) and directly discusses any deficiencies found with the provider/PACT involved.

OIG Update June 2017: We accepted this action as complete based on a review of the System's current Medical Center Memorandum 11-03, *Provider Orders/Critical Results*, dated March 31, 2016, oversight committee minutes, and laboratory audit compliance data.

Recommendation 16. We recommended that the System Director monitor consult completion timeliness and identify process improvements for those exceeding 30 days.

Concur

Target date for completion: Completed.

Facility response: A Group Practice Manager (GPM) was hired September, 2016 and now chairs the Consult Management Committee. Committee focuses on current VHA policy to reduce consults in pending status to 7 days (or less) and active status to 30 days (or less). All clinical services report consult data and clinical performance data to the healthcare system Director and senior leaders on a weekly basis and the GPM reports consult status daily to the Director and senior leadership in the Director's morning meeting.

OIG Update June 2017: We will follow up to ensure that the corrective actions have been effective and sustained.

Recommendation 17. We recommended that the System Director ensure that a Mental Health-related Strategic Analytics for Improvement and Learning workgroup identify priorities, and develop and implement improvement actions accordingly.

Concur

Target date for completion: June 30, 2017

Facility response: Behavioral Health has deployed a workgroup targeting the Mental Health-related Strategic Analytics for Improvement and Learning metrics. They are currently working with Behavioral Health experts from VA Central Office to implement change to improve their metric scores and a site visit is scheduled for May, 2017 with a National Technology Assistant Specialist from the Central Office to identify opportunities for improvement. Currently the Behavioral Health workgroup reports progress achieved on their data and actions taken, to central office on a quarterly basis, and beginning

April 2017 they will report their data and actions monthly to the Quality, Safety, and Value Committee.

Recommendation 18. We recommended that the System Director ensure continued efforts to improve lengths of stay for patients being discharged from the Emergency Department.

Concur

Target date for completion: June 30, 2017

Facility response: A workgroup was formed to identify ED delays and implement improvements. The group is comprised of ED staff and is scheduled to begin meeting the week of March 27, 2017. Findings will be reported to HCDC for actions and tracking.

Recommendation 19. We recommended that the System Director ensure that all patient care areas comply with environment of care requirements and that action plans specifically address deficient areas identified in this report.

Concur

Target date for completion: April 30, 2017

Facility response: The EOC minutes format has been changed to reflect the new Medical Center Memorandum 00-64, Councils, Boards, and Committees, dated September 30, 2016. The reports from the EOC rounds are brought to the Environment of Care EOC Committee and the deficiencies are tracked in the minutes until the deficiencies are closed. Beginning April, 2017 the GEMS coordinator will report status of hazardous materials inventories to the EOC committee monthly. The EOC committee will track compliance with the inventory completion and recommend actions for deficiencies. The GEMS coordinator has provided hard copy Safety Data Sheet binders to all services. Vinita CBOC no longer uses reprocessed instruments. All instruments (e.g. suture removal kits) are disposable, one-time use. Fire extinguisher signage has been checked and verified as in proper place. Police Service, Biomed, and IT are installing the Lynx Emergency "hot keys" alarm system on all staff telephones with a projected completion date of April 30, 2017. Feminine hygiene products have been installed in the identified areas. Locks have been installed on clinic doors in Gold Team (Surgery), JCM-East, and Vinita CBOC.

OIG Update June 2017: We accepted this action as complete based on a review of EOC minutes, completed work orders, and documentation that identified deficiencies are completed.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Victoria Coates, LICSW, MBA, Team Leader Toni Woodard, BS, Team Leader Cathleen King, MHA, CRRN ,Team Leader Mary Toy, RN, MSN, Team Leader Gail Bozzelli, RN Craig Byer, MS Myra Conway, MS, RN LaFonda Henry, MSN, RN-BC Julie Kroviak, MD Jennifer Kubiak, BSN, MPH Tishanna McCutchen, DNP, MSPH Lauren Olstad, LCSW Sami O'Neill, MA Anita Pendleton, AAS Jennifer Reed, RN, MSHI Larry Ross, MS Monika Spinks, RN, BSN Emorfia Valkanos, RPh Joanne Wasko, LCSW Robert Yang, MD

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Rocky Mountain Network (10N19)
Director, Eastern Oklahoma VAHCS (623/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: James M. Inhofe, James Lankford
U.S. House of Representatives: Jim Bridenstine, Tom Cole, Frank Lucas,
Markwayne Mullin, Steve Russell

This report is available on our web site at www.va.gov/oig.