Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04573-378

Healthcare Inspection

Quality of Care and Access to Care Concerns Jack C. Montgomery VA Medical Center Muskogee, Oklahoma

June 16, 2015

Washington, DC 20420

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Executive Summary

At the request of Senator James Inhofe, the Office of Inspector General Office of Healthcare Inspections conducted an evaluation in response to several allegations concerning quality of care and access to care at the Jack C. Montgomery VA Medical Center (facility), located in Muskogee, Oklahoma.

We identified some quality of care deficiencies in the cases we reviewed. We substantiated that a patient did not receive appropriate treatment for his back pain because of a delay in the diagnosis of a malignancy, which may have been the source of his pain. We did not substantiate a failure to provide a patient operative care associated with bleeding gastrointestinal polyps because it is unlikely the patient's low blood count (anemia) resulted from the bleeding polyps but noted that the patient was not evaluated for an alternative diagnosis. We did not substantiate that a failure in VA agreeing to pay for the patient's open heart surgery resulted in a delay in the patient receiving the surgery. We did not substantiate that a provider's failure to address leg swelling or a nose bleed affected the rupture of a patient's "brain aneurysm." We did not substantiate that the VA advised a patient to wait until he tore the remaining two healthy discs in his back and then call 911 to make it a medical emergency. We did not substantiate a delay in scheduling a computed tomography scan and a colonoscopy.

We substantiated that a patient experienced poor access to dental services and was not notified by mail of his scheduled appointment. We also substantiated that another patient experienced poor access to neurosurgical services. We conducted a broad review of the facility's Non-VA Care Coordination maternity care processes in response to allegations concerning delayed and denied consult requests. While we did not substantiate the allegations, we found that the information pregnant patients receive in a document titled "*Jack C. Montgomery Fee Basis Pregnancy Process*" as well as the non-VA maternity care providers' authorization document is ambiguous, at least when applied to select cases.

During the course of the review, we also found systemic issues in the Dental Services, and we determined limited parking at the Ernest Childers VA Outpatient Clinic, located in Tulsa, OK, created an access and safety concern for patients, visitors, and employees. We also determined a VA provider did not document all clinically pertinent telephone communications. We made eight recommendations.

Comments

The Veterans Integrated Service Network and Facility Director concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 18–25 for the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the validity of allegations received from Senator James Inhofe regarding quality of care and access to care at the Jack C. Montgomery Veterans Affairs Medical Center (facility), Muskogee, OK.

Background

The facility serves veterans in 25 counties in the eastern region of Oklahoma and is part of Veterans Integrated Service Network (VISN) 16. It offers a variety of primary and secondary levels of inpatient medical and surgical care (99 inpatient beds). The facility also provides outpatient primary and consultative care in medicine, surgery, and psychiatry and oversees community based outpatient clinics (CBOCs) located in Hartshorne, Tulsa, Muskogee, and Vinita, OK. The facility covers prenatal care, delivery, and postnatal care through Non-VA Care Coordination[1] (NVCC) arrangements with community providers.[2]

Previous OIG reports have identified a number of concerns regarding both quality of care and access to care at the facility. In 2009, the Office of Healthcare Inspections conducted an inspection that found deficiencies in access to mammograms, colonoscopies, and cardiology services. Also in 2009, a Combined Assessment Program review identified deficiencies in peer review processes and the re-privileging of providers, among other concerns, and made six recommendations. The facility provided acceptable action plans to resolve issues identified in both reports, and OIG closed the recommendations.

In 2010, OIG inspected the Tulsa CBOC. We identified one provider who did not have a background check completed. No other credentialing and privileging concerns were identified. The facility provided an acceptable plan for ensuring all employees received background checks in accordance with VA policy.

In 2012, a complainant alleged deficiencies in the way the facility managed patient airways outside of the operating rooms. We did not substantiate the allegations. In 2013, we conducted another Combined Assessment Program review, which did not identify deficiencies in credentialing and privileging. The 2013 review did, however, identify weaknesses in notifying providers of abnormal cervical cancer screening results and in documenting tetanus vaccinations.

In August 2014, Senator James Inhofe provided OIG with two large binders containing documentation of VA patient, VA staff, and non-VA care provider complaints. This

[1] Non-VA medical care is care provided to eligible veterans outside of the VA when VA facilities are not feasibly available. http://www.va.gov/PURCHASEDCARE/programs/veterans/nonvacare/index.asp#sthash.4xuDyCe8.dpuf
[2] Under 38 United States Code §§1703, 1725, 1728, 8111, and 8153, VA has the authority to obtain services from non-VA providers when a VA medical center is unable to provide specialty services.

report focuses on the complaints contained in the binders that were related to health care, specifically, quality of care and access to care, including NVCC for maternity care.

Most of the complaints contained in the binders concerned the facility, but some concerned care provided at other Veterans Health Administration (VHA) facilities. Our reviews of the complaints related to other VHA facilities are not included in this report. Additionally, this report does not address complaints related to compensation and pension claims or adjudications, travel pay reimbursement, and retaliation against whistleblowers. We also received an allegation that a NVCC provider was not paid for services rendered. However, at the time of this review the provider had been paid, and we did not address this allegation within the body of this report.

From the patient-specific information we received from Senator Inhofe, we reviewed the quality of care provided to six patients (Patients A–F). Because one of the cases involved a tort claim (Patient F), it was not further reviewed. We also reviewed specific complaints regarding access to care at the facility for two patients (Patients G–H) and conducted a broad review of the facility's NVCC maternity care consult processes to address a complaint of delayed and denied NVCC maternity care consult requests. The allegations are summarized below.

Quality of Care:

- The facility failed to provide operative care of bleeding gastrointestinal polyps, potentially resulting in Patient A's death.
- The facility failed to provide appropriate treatment for Patient B's, Patient D's, and Patient E's back pain.
- A patient (Patient C) died because the facility refused to pay for coronary artery bypass grafting surgery in the community.

Access to Care:

- Patient G experienced a delay in receiving dental services.
- Patient H experienced delays when trying to schedule an appointment.
- NVCC maternity care consult requests were delayed and denied.

Scope and Methodology

The period of our review was August 6, 2014 to February 23, 2015. We conducted a site visit August 25–28, 2014. We interviewed patients, the facility Director and Chief of Staff (COS), the Acting Chief of Primary Care, and the Chiefs of Dental and Business services. We also interviewed the Woman Veterans Program manager, business office staff, primary care providers (PCPs), a medical support assistant, a patient advocate, mid-level managers, clinicians, and front-line employees.

We reviewed relevant VA and VHA directives and handbooks, facility policies and procedures, and administrative documents. We reviewed the VA electronic health

records (EHRs) of the patients identified in the allegations, non-VA records available in the patients' EHRs, and NVCC maternity care-related medical records as germane to this complaint. We reviewed the EHRs of all facility patients (20) who received NVCC approval for maternity care April 2013 through January 2014. We also reviewed Patient Advocate Tracking System documents and relevant VHA and facility NVCC authorization policies and procedures.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Quality of Care

We reviewed alleged examples of poor care for five patients (Patients A–E), and identified quality of care concerns for three (Patients A, B, and E) of the five cases. Our findings and the care these patients received at the facility are reviewed below.

Patient A: The complainant alleged that the patient did not receive operative care for bleeding gastrointestinal polyps, which resulted in his death. We did not substantiate this allegation because it is unlikely the patient's low blood count (anemia) resulted from the bleeding polyps. However, we found that providers missed an opportunity to evaluate the patient for another diagnosis, which may have been responsible for the patient's low blood count.

The patient was a male in his 70s with a long history of mild anemia (low red blood cell count), which worsened in summer 2012. At that time, when the patient saw his PCP, his hemoglobin was significantly lower than normal. The PCP noted that the patient had lost weight. The patient had a recent history of surgery, and the provider initially suspected that blood loss from the surgery had caused the anemia.[3] However, approximately 2 months later, the patient's anemia had worsened. The patient's laboratory results suggested that most of his red blood cells were large, without a significant variation in size, which is not generally consistent with the kind of anemia seen following surgery.[4] The patient was subsequently transfused and then underwent an esophagogastroduodenoscopy (EGD)[5] and colonoscopy shortly thereafter for further evaluation of anemia and weight loss. Initial studies performed prior to transfusion detected the presence of a cold antibody.[6] The patient's B12, folate level, and thyroid studies were normal, and his ferritin level was slightly low (14.9 mcg/l; 24 mcg/l is the lower limit of normal).[7] The gastroenterologist discovered no abnormalities on EGD and found only diverticulosis and internal hemorrhoids on colonoscopy. The gastroenterologist did not identify these findings as the source of the patient's bleeding. Instead, the gastroenterologist recommended a consult to hematology, the branch of medicine that specializes in diseases affecting blood cell counts, like anemia.

Over the course of the next 2 years, the patient intermittently experienced declines in his hemoglobin and hematocrit, requiring blood transfusions. He had further weight loss and complained of shortness of breath and weakness. EHR notes attributed his

[3] Blood loss from surgery can cause a deficiency in iron. This is not unusual. Because the body cannot make red blood cells without iron, this can cause a low red blood cell count, or anemia.
[4] The patient had an MCV (mean cell volume) of 100.9 and an RDW (red cell distribution width) that was only slightly increased, suggesting that most of the patient's red blood cells were larger. Iron deficiency anemia resulting from surgery typically results in smaller red blood cells.
[5] This is a procedure in which a gastroenterologist puts a flexible scope down the throat into the stomach to visualize the esophagus, stomach, and first part of the intestine.
[6] A cold antibody is a type of antibody that can suggest an autoimmune cause for anemia—where the body makes antibodies that attack its own cells.
[7] These tests would exclude other common reasons for anemia, but not an autoimmune cause.

shortness of breath to the anemia and chronic lung disease. However, blood bank reports documented the continued presence of a cold antibody. In winter 2013, the patient's PCP again consulted the gastroenterology service. The gastroenterologist again recommended consultation with hematology. About 2 months later, another consultation with the gastroenterology service resulted in the performance of a second EGD, which demonstrated only mild, non-bleeding angiodysplasia.[8]

The presence of a cold antibody can signal the onset of cold agglutinin disease.[9] This type of anemia can occur by itself or in association with an underlying malignancy, which should especially be considered in a patient with a history of weight loss. The associated anemia may be mild to very severe, such as that which this patient experienced. However, it does not appear that the PCP evaluated the patient for cold agglutinin disease or consulted a hematologist. To determine definitively whether the patient had a hemolytic anemia resulting from cold agglutinin disease, the patient needed additional blood tests and potentially a bone marrow biopsy. The patient's EHR does not contain evidence that he received these tests.

Instead, the patient received repeated endoscopies, which did not identify a source of bleeding that would account for the patient's anemia. Because a source of bleeding was not identified, operative intervention for bleeding polyps was not recommended or indicated by the patient's condition as described in his EHR. The patient expired in spring 2014 at an outside hospital following a cardiac arrest. Non-VA notes describe the cause of death as respiratory failure.

We concluded this patient received poor quality of care because his PCP did not evaluate him for causes of anemia other than gastrointestinal bleeding, such as cold agglutinin disease, or refer him to a hematologist, as recommended by the gastroenterologist. We did not substantiate that the patient should have received operative intervention for bleeding polyps because the EHR does not contain evidence that this was the source of his anemia.

Patient B: The complainant alleged that Patient B had severe back pain that was not appropriately treated. We substantiated that the patient did not receive appropriate treatment for his back pain because of a delay in the diagnosis of a tumor, which may have been the source of this patient's pain.

At the time of our review, the patient was in his 70s and had established care at the Tulsa CBOC in fall 2011. About that time, the patient first complained of low back pain. The patient's PCP considered the diagnosis of shingles, although the patient had no abnormal skin findings, and treated the patient with pain medications. The patient returned the following week with complaints of continued pain without relief from narcotic pain medications. His PCP sent him to the Emergency Department for tests to rule out kidney stones. The Emergency Department physician ordered a computed

[8] Angiodysplasia is a proliferation of blood vessels.
[9] Cold agglutinin disease is a form of autoimmune hemolytic anemia wherein antibodies bind to the red blood cell membrane leading to premature red blood cell destruction.

tomography[10] (CT) scan of the abdomen and pelvis. The CT scan included imaging of the lower lung fields. No acute abnormalities were identified. An anti-inflammatory drug relieved the patient's pain, and he was discharged home.

Three weeks later, the PCP again saw the patient, who continued to complain of low back pain. The PCP ordered x-rays of the spine, which revealed some bone loss and degenerative changes, physical therapy, and continued pain medications. The physical therapist documented pain in the flank area radiating to the lower abdomen. The patient continued to complain of this pain to his PCP for the next several months. The PCP's working diagnosis was post herpetic neuralgia, a type of chronic pain that can occur after shingles.

In summer 2012, the patient returned to the Emergency Department with complaints of worsening lower abdominal and flank pain. A CT scan performed approximately 9 months after the initial CT of the abdomen and pelvis identified a "malignant-appearing" mass. The radiologist who interpreted the exam identified the mass in a location near the psoas muscle. The CT report also mentioned the presence of a small amount of fluid around the left lung (known as a pleural effusion).

Subsequent notes describe two percutaneous biopsy attempts made at a non-VA hospital. EHR notes by VA providers refer to these biopsy results as either negative for malignancy or inconclusive. The patient's PCP consulted a general surgeon, who recommended a follow-up CT scan. The patient had another CT scan of the abdomen and pelvis in fall 2012. The retroperitoneal tumor appeared to be stable in size, but the lower lung fields demonstrated interval development of bilateral infiltrates, as well as a continued small pleural effusion in the left lung. The general surgeon believed the mass could be related to an old penetrating injury in that area and recommended another CT scan in 6 months. EHR notes by VA providers also stated that the patient had recently been treated at a non-VA hospital for "pneumonia."

The PCP ordered a chest x-ray 2 months later, which was negative for any infiltrates. The patient continued to complain of pain in his left side, which was managed symptomatically. In winter 2013, the patient received a follow-up CT scan of the abdomen and pelvis. This CT demonstrated enlargement of the previous mass and the presence of a new left-sided lower chest mass with erosion into the sixth and seventh rib. The radiologist recommended a chest CT to better visualize the lower chest.

The chest CT was performed approximately 1 month later. The chest CT demonstrated multiple masses in the left lung and multiple areas of lymphadenopathy. Needle biopsy of a left lung mass demonstrated non-small cell carcinoma. The patient's case was referred for evaluation to the tumor board,[11] which recommended palliative chemotherapy. The patient died 9 months later.

[10] Computed tomography (CT) is a combination of X-ray and computer technology that shows detailed images of the body.
[11] Tumor board is a meeting of medical specialists to discuss complicated or difficult to treat cases of cancer.

We identified multiple quality of care concerns in this case. We requested an independent review of the fall 2011 CT abdomen and pelvis, which confirmed that the tumor was present on the images but not diagnosed in the fall 2011 report. Further, the tumor had increased in size on the summer 2012 CT scan as compared to the images from the fall 2011 CT scan. Relying on the negative results of the fall scan, the PCP did not order additional imaging or evaluations despite the patient's ongoing pain in the left flank. When the mass was identified on the summer 2012 CT scan, it measured more than 2 cm in all dimensions, a size which would support biopsying the mass. Interventional radiology at an outside hospital performed two needle biopsies, which were reported as negative. The general surgeon, not realizing that the tumor had increased in size since fall 2011, did not recommend open biopsy.

New lung infiltrates identified on a CT abdomen and pelvis in fall 2012 did not prompt the ordering physician to order a CT scan of the chest or otherwise evaluate these findings. Not until winter 2013, more than 18 months after the initial CT of the abdomen and pelvis, did the provider order a chest CT. The patient died 9 months later.

In the absence of a comprehensive initial evaluation, we cannot determine whether the original mass was related to the patient's subsequent diagnosis of non-small cell lung cancer. However, we note that the scientific literature contains multiple reports of metastasis of non-small cell lung cancer to the psoas muscle.[12] In consideration of the poor life expectancy associated with metastatic non-small cell carcinoma of the lung, we do not know whether, even if the tumor had been identified as metastatic non-small cell lung cancer, an earlier diagnosis would have made a difference in the patient's longevity or life expectancy. But, because of the patient's continued complaints of pain in this area, which were not relieved with narcotics, further evaluation of this mass may have led to an earlier diagnosis and improved his quality of life if the patient could have been treated with other pain-relieving modalities, such as localized radiation.

We concluded that this patient received poor quality of care because of a missed diagnosis of a tumor on the fall 2011 CT scan, contributing to the decision to not perform an open biopsy. We further noted no documentation in the EHR that providers discussed the option of an open biopsy of the tumor with the patient.

Patient C: The complainant alleged that the VA refused to pay for open heart surgery at a non-VA hospital, which resulted in the patient's death. We did not substantiate this allegation. Notes in the EHR document that the patient was considered for coronary artery bypass grafting, but neither the VA nor the non-VA hospital determined this patient to be a good candidate for the procedure.

The patient was in his 80s in spring 2014 with valvular heart disease when he presented and was admitted to an outside hospital following a heart attack. The patient was minimally ambulatory at baseline and had been dependent on a walker for at least the past 4 years. During his hospitalization, he was found to have an abnormality of a heart

[12] Strauss et al., *Psoas Muscle Metastasis in NSCLC*, Journal of Thoracic Diseases. 2012 Feb 4(1): 83–87. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3256543/

valve and diffuse coronary artery disease. A bed became available at the Houston VA Medical Center (VAMC), and the patient was subsequently transferred there for further evaluation of a possible coronary artery bypass graft. This transfer occurred per VA policy and was consistent with providing care within the VA system when it is available.

Upon his arrival at the Houston VAMC, the cardiothoracic surgeon did not consider him an operative candidate, noting that his severe frailty and other health conditions had not been disclosed by the private hospital providers prior to his transfer. Houston VAMC staff also noted that he had poor overall heart function and further added that he was a very poor operative risk. A cardiologist also gave the opinion that cardiac stenting was not an option in this case, and the patient subsequently received medical management for his coronary artery disease and valvular disease.

Following his discharge from the Houston VAMC, the patient presented again to the same non-VA hospital with continued complaints of shortness of breath and chest pain. This facility evaluated him and also did not consider him a candidate for either coronary artery bypass graft surgery or valve replacement. Non-VA records reflect that cardiac stenting was also not an option for this patient. Because surgery would be considered high risk in a patient with his functional status, he and his physicians agreed to treat the condition medically. The patient was subsequently discharged to hospice care.

There is no evidence in the record that whether or not VA agreed to pay for any of these procedures at a non-VA facility was a factor in determining which treatment option was best for this patient. Rather, the patient's EHR documents that he was determined to be a poor operative candidate, with few viable treatment options, and that he desired medical management of his condition. In addition, the patient was evaluated for care through the Houston VAMC.

We concluded that the patient did not receive poor quality of care because VA did not pay for coronary artery bypass grafting at a non-VA hospital. Instead, both VA and non-VA providers determined that he was not a good candidate for this procedure.

Patient D: The complainant alleged that the patient's provider did not treat the patient's swollen legs and nose bleed, resulting in the rupture of the patient's "brain aneurysm." We did not substantiate this allegation.

In spring 2014, the patient saw his PCP. The patient's wife accompanied him and provided the history that the patient had fallen often recently and was no longer able to walk without assistance. The patient had multiple ongoing health problems, including diabetes, high blood pressure, and peripheral neuropathy, which could cause falls. The wife requested a wheelchair. The EHR note does not describe swelling in the legs or a serious nose bleed. Five days after his visit to his PCP, the wife called the clinic again, upset because they had not received a wheelchair and also because the patient was not eating. The next day, the patient's spouse reported that she could not awaken the patient and called an ambulance. The patient was transported to a non-VA hospital and was discovered to have a "brain aneurysm." He underwent evacuation of a blood clot in

the brain and was noted to have residual right sided weakness. The patient improved and followed up with neurology approximately 4 months later.

The note from the patient's PCP did not document complaints of swollen legs or a nose bleed. In addition, these symptoms would not have indicated the presence of a brain aneurysm, even if they were present at the time of the patient's evaluation. We did not substantiate that the provider's failure to address leg swelling or a nose bleed affected the rupture of the patient's "brain aneurysm."

Patient E: The complainant alleged that the VA advised Patient E to wait until he tore the remaining two healthy discs in his back and then call 911 to make surgical repair of his back a medical emergency. We did not substantiate this allegation. However, we noted that the patient's EHR does not fully reflect consideration of operative intervention for the patient's low back pain.

In spring 2010, the patient was in his 50s when he presented to an outside spine clinic with complaints of chronic low back pain and buttock pain. After initial discograms and other imaging studies demonstrated significant disc space disease, the non-VA physician recommended back surgery. At the time of our review, these records were available in the patient's VA EHR.

The patient presented on several occasions to the facility with complaints of chronic low back pain. He received epidurals for pain control and referral to a rehabilitation specialist for further care. In summer 2014, a magnetic resonance imaging (MRI) demonstrated lumbar spondylosis and some disc space disease, but no findings that would explain a right lower extremity radiculopathy. However, the EHR does not document that the VA physicians knew of the outside recommendation for surgery and had considered that recommendation.

The patient's MRI and examinations did not reveal an urgent need for surgery. The patient did not have any impingement of the spinal cord or nerve roots, there was no instability of the lumbar spine, and the patient had not experienced any change in bowel or bladder habits attributable to his lumbar spine condition. These conditions would have required urgent surgery.

We concluded that the patient received poor quality of care because VA physicians should have documented consideration of the non-VA provider's recommendation to perform surgery in light of the patient's ongoing pain. However, we also note that the EHR contains no indication of an urgent need for surgery.

In winter 2014, the patient was undergoing another discogram for further evaluation of his symptoms and had a pending neurosurgical consultation.

Issue 2: Access to Care

The allegations regarding poor access to care involved specialty care services including dental services (Patient G), diagnostic imaging and gastroenterology services (Patient H), and NVCC maternity care consult processes (general issues in the ability to access non-VA maternity services). The allegations encompassed both services

available at the facility (dental services, diagnostic imaging, and gastroenterology) as well as access to non-VA care (maternity services). For purposes of this review, we defined poor access to care, whether it involved services available at the facility or purchased in the community, as (1) a frequency of follow-up that did not comply with nationally recognized clinical guidelines, (2) a frequency of follow-up that did not coincide with the provider's recommendations, or (3) follow-up that did not comply with VHA policy regarding access to specialty services.

Patient G: The complainant alleged that Patient G experienced a delay in receiving dental services. We substantiated that Patient G received poor access to care because scheduling procedures did not comply with VHA policy.

VHA Directive 2010-027 requires that providers "explain rationale and timeframes for return appointments."[13] When scheduling a return appointment, the scheduling clerk must enter the desired date for the appointment. The difference between desired appointment dates and actual appointment dates is used by the facility to determine whether patients are receiving timely access to care. VHA Directive 2010-027 also requires facilities to strive to make follow-up appointments "on the spot" if patients are returning within 3 to 4 months, rather than calling them back.[14]

Patient G obtained dental services in fall 2013. The provider did not indicate in the EHR when the patient was to be seen for a follow-up visit. Dental service at the time did not use the VA electronic recall scheduling package. The facility used slips of paper where the dentist would indicate the type of follow-up appointment, length of the appointment, and when the patient should be scheduled to be seen. The slip of paper was given to the scheduling clerk to schedule the patient. In this case, there was a delay in the scheduling clerk using the individual slips of paper to schedule the appointment. In November, the scheduling clerk scheduled the patient's second appointment for January, but the facility cancelled that appointment. The scheduling clerk rescheduled the cancelled January appointment for a week later; the patient did not come and did not cancel the rescheduled appointment. The patient was not notified by mail, and we received conflicting information on whether or not the patient received phone notification of the rescheduled appointment. However, the scheduling clerk listed the date of the rescheduled appointment as the patient's desired date for an appointment. After missing the rescheduled appointment, the patient was rescheduled again for March.

The patient received a dental procedure in March 2014 with a follow-up procedure approximately one month later. This dental treatment took over 7 months to complete.

We concluded that this patient received poor access to care because scheduling procedures did not comply with VHA policy, resulting in the patient's dental treatment taking more than 7 months to complete. Specifically, the provider did not document in the EHR when the patient should return to clinic, the scheduling clerk used a paper slip process to call the patient 2 months later to schedule a follow-up visit rather than

[13] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010, p. 5.
[14] VHA Directive 2010-027, p. 6.

making the appointment at the time of the visit, and the patient was not notified appropriately of the rescheduled appointment. The Chief of Dental Services, appointed to the position in August, agreed that poor access to care for this procedure was a significant problem. We were informed that the Dental Service now uses both the VA electronic wait list and the individual slips of paper provided to the scheduling clerk.

The Chief further acknowledged systematic concerns that included scheduling problems, utilization of NVCC,[15] and lack of treatment space and staffing. In January 2015, we learned the Chief had completed an analysis to identify gaps between the service's current access and quality of care and the desired Dental Service access and quality of care. The Chief also submitted a newly proposed Dental Service business plan and presented the plan to facility leadership.

Patient H: The complainant alleged that patient H experienced a delay in scheduling appointments. We did not substantiate a delay in scheduling a CT scan of the abdomen and pelvis and a colonoscopy.[16] We substantiated a neurosurgery appointment scheduling delay.

The patient was a male in his 70s who presented in winter 2014 to his VA provider with complaints of mid abdominal pain, bloating, straining to defecate, and lower back pain for 2 months. The same day, the provider requested a CT scan of the abdomen and pelvis and a colonoscopy to be scheduled within the VA. However, approximately 2 weeks later (before the VA performed the requested CT), the patient presented to a non-VA Emergency Department where a CT scan of the abdomen and pelvis was performed. Ten days later, the patient's provider noted that a CT scan of the abdomen and pelvis was performed at a non-VA facility and a colonoscopy was pending to be performed by a non-VA provider.

In summer, the patient was seen by his VA provider for continued lower back pain progressive over the prior 6 months. The VA provider ordered a routine non-VA Neurosurgery consult, which was approved 4 days later. Over the next 2 months, the facility NVCC staff contacted four community neurosurgeons in an attempt to schedule a neurosurgery appointment. The first neurosurgery appointment was scheduled a month later. The scheduling delay occurred because of difficulty in identifying a neurosurgeon in the community willing to see the patient. However, it did result in poor access to care for the patient in that the patient did not receive an appointment with the neurosurgeon within 30 days of referral as required by VHA policy.

We determined that this patient received poor access to care because the delay in obtaining a neurosurgery appointment violated VHA policy regarding the timeliness of consults. But the reason for this delay was difficulty in finding a non-VA neurosurgeon willing to see a VA patient rather than a failure by VA to act on the consult request.

[15] Non-VA medical care is care provided to eligible veterans outside of the VA when VA facilities are not feasibly available. http://www.va.gov/PURCHASEDCARE/programs/veterans/nonvacare/index.asp#sthash.4xuDyCe8.dpuf
[16] Colonoscopy is performed using a flexible thin tube that allows the provider to see the inner lining of the rectum and colon in real time, take biopsies if needed, and take pictures.

VHA Consult Requirements: VHA policy requires that patients be scheduled for an appointment with a specialist within 30 days of referral[17] and that facilities track and process consults that are not acted upon within 7 days of the request.[18]

NVCC Maternity Care Consult Process: We conducted a broad review of the facility's NVCC maternity care consult process in response to an allegation that NVCC maternity care consult requests were delayed and denied. While we did not substantiate the allegation and found the facility adhered to NVCC consult request requirements, we determined that the information patients receive in a document titled "*Jack C. Montgomery Fee Basis[19] Pregnancy Process,*" as well as the NVCC maternity care providers' authorization document, is ambiguous at least when applied to select cases, and could cause care delays.

The facility covers prenatal care, delivery, and postnatal care through NVCC arrangements with community providers.[20, 21]

NVCC Maternity Care Consult Request Process at the Facility:

- PCPs submit a NVCC maternity care consult request after a patient requests maternity care and pregnancy is confirmed. Depending on the patient's medical history, the PCP can submit a NVCC consult request for standard maternity care or a maternal-fetal specialist if the patient's pregnancy has been identified as high-risk.

- The facility Director has authorized the Chief of Staff to review and approve or deny NVCC maternity care consult requests after NVCC staff verify the patient's eligibility.

- After the patient's eligibility is verified and the consult is approved, an NVCC staff advises the patient that she is to inform NVCC staff the name of her selected maternity care provider. The NVCC staff also gives the patient an information sheet titled "*Jack C. Montgomery Fee Basis Pregnancy Process."*

    - The information sheet states, in part, that the VA will cover all routine obstetric care; all procedures not relating to pregnancy require pre-approval and the patient is to notify the facility immediately to coordinate care that deviates from the approved obstetric care.

- After the patient informs the NVCC staff the clinician she has selected, the staff sends the selected obstetrician (OB) provider an "Authorization Remarks" document.

[17] VHA Directive 2006-041, *Veterans Health Care Service Standards*, June 27, 2006. This Directive expired June 30, 2011 and has not yet been updated.
[18] VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This Directive has expired and has not yet been updated.
[19] Non-VA Care Coordination was formerly known as "Fee Basis."
[20] Under 38 United States Code §§1703, 1725, 1728, 8111, and 8153, VA has the authority to obtain services from non-VA providers when a VA medical center is unable to provide specialty services.
[21] VHA Directive 1601, *Non-VA Medical Care Program*, January 23, 2013.

- The document includes the services the NVCC OB is authorized to provide and states, in part, that patients should be referred to the facility as soon as possible for high risk patients with unforeseen complications; additional services must be, where practical, pre-approved; and, if procedures or diagnostics are to be referred to a secondary agency, prior authorization should be obtained.

To determine the facility's responsiveness to initial NVCC maternity care requests and maternity care providers' specialty consult requests, we reviewed the VA EHRs of 20 patients who requested NVCC maternity care benefits April 2013 through February 2014. Of these, 16 were standard maternity consult requests and 4 were requests for a maternal-fetal specialist due to an identified high-risk pregnancy.

NVCC Maternity Care Eligibility and Approval Timeliness: We determined initial NVCC maternity care consult requests were all approved as required. As displayed in Table 1 below, all PCP requests for patients' NVCC maternity care were approved within standard time frames, and the majority of requests were approved within 2 days. Of the five approvals that occurred 3 or more days after the initial request, four had an intervening 2 or 3 day weekend. All four maternal-fetal NVCC consult requests (high-risk pregnancy) were approved the day of or the day after the consult request was submitted.

Table 1: Days Between PCP Request for NVCC Maternity Care to Approval of 20 Patients Who Requested NVCC Maternity Care Benefits April 2013 Through February 2014

Days	0	1	2	3	4
Patients	7/20	5/20	3/20	3/20	2/20

Source: Jack C. Montgomery Veterans Affairs Medical Center

NVCC Maternity Care Authorization Timeliness: We determined NVCC staff documented their efforts to identify selected NVCC maternity care providers and sent authorization documents to the NVCC providers as required. Of the 20 records we reviewed, 11 patients informed the NVCC staff of their selection within 7 days. Staff documented calling patients and sending letters to patients who did not notify NVCC staff of their selection soon after the NVCC was approved. NVCC staff faxed the selected NVCC maternity providers' authorization documents the day they learned of the patients' selections 15 times, the day after learning the patients' selections 3 times, and 3 days later 1 time. The remaining patient did not respond to phone calls or a letter but later notified NVCC staff she had a healthy pregnancy and delivery.

NVCC Maternity Providers' Specialty Consult Requests: We determined that pregnancy related specialty consult requests initiated by NVCC maternity care providers were timely requested by VA providers and approved by facility staff. NVCC staff attempts to schedule specialty consult requests were documented within required timeframes.

Requests we reviewed included nutrition counseling, tubal ligation, cardiology consultation and testing, and radiology. None of the NVCC maternity care or VA providers documented the requested consults required emergency response. With the exception of an approval for nutrition counseling that took 3 days (which included an intervening weekend), all requests were approved the day of or the day following the NVCC maternity providers' faxed requests. One cardiology request was conducted by VA staff; all other requests were scheduled within 7 days with community NVCC providers.

Although not part of the allegations, we identified two opportunities for improvement.

Maternity Benefits Patient Information and Provider Authorization: We determined that the information patients receive in a document titled "*Jack C. Montgomery Fee Basis Pregnancy Process*" as well as the maternity care providers' NVCC authorization document (both discussed above) is ambiguous at least when applied to select cases.

For example, the patient information sheet lists all routine maternity care as covered, which may imply that non-routine care is not covered. However, the sheet also states that "all procedures not relating to pregnancy require pre-approval," which may imply that routine and non-routine care, as long as pregnancy related, is covered.

The document NVCC maternity care providers receive authorizing maternity services specifies that "patients with unforeseen complications…" should be referred to the facility. It is not clear whether unforeseen complications *of pregnancy* are authorized or also should be referred to the facility.

The document further states that, "additional services must be, where practical, pre-approved by contacting (the facility) and that for procedures or diagnostics referred to a secondary agency, prior authorization should be obtained by contacting the facility.

The phrasing in the authorization document does not offer definitive direction on precisely what is expected of NVCC maternity care providers in, at least, some clinical circumstances.

Medical Record Documentation: Health record documentation is required to record pertinent facts and findings to facilitate communication and continuity of care. Telephone call documentation demonstrates and supports decision making and subsequent actions. During our EHR review, we determined a PCP did not document clinically pertinent telephone communication.[22]

Issue 3: Other Concerns

During the course of our review, we noted the Ernest Childers VA Outpatient Clinic (Tulsa CBOC) parking spaces were not adequate in number to accommodate the staff,

[22] VHA Handbook 1907.01, Health Information Management and Health Records, September 19, 2012. (VHA Handbook 1907.01 dated September 19, 2012 was rescinded and replaced by an updated version on July 22, 2014, after the events giving rise to this complaint.)

visitors, and patients seen daily at the clinic, which affected patient care and the safety of patients, visitors, and employees.

The Tulsa CBOC parking lot has 251 spaces. (See Table 2 below.) On the day of our onsite visit, 196 staff reported to duty by 8 a.m. and there were 110 patient appointments scheduled between 7 and 9 a.m. Additionally, 150 patients walked in for laboratory testing, with the majority arriving before 8 a.m. The total number of patients seen that day was 487.

We observed drivers of cars circling the parking lot and many cars parked on an adjoining field. We learned that patients, visitors, and employees park on the adjoining, non-VA owned property when there are no available parking spaces at the CBOC. The adjoining property is not designated parking for the facility and has a rough uneven terrain. The property is not paved or graveled and is not handicap accessible. There is a fence between the property and the VA parking lot, so patients, visitors, and staff must walk the length of the adjoining property to the street and then walk on the street to get to the CBOC building.

Table 2. VA Ernest Childers VA Outpatient Clinic — Total of 251 Parking Spaces

Type of Parking Space	Number of Parking Spaces
Handicap	24
Patient	112
Employee	108
General Services Administration	5
Shuttle	1
Van Pool	1

Source: Jack C. Montgomery Veterans Affairs Medical Center

We learned facility leadership was aware of the parking shortage, and a workgroup, which is no longer active, was created to explore solutions to address the parking shortage. Operating hours and the days of operations were changed in attempts to relieve the situation. However, on the day of our observation, solutions in place did not adequately manage the parking availability, and we determined the limited parking available that day did not allow for safe access to the CBOC.

Conclusions

We identified some quality of care issues in the cases we reviewed. We substantiated the allegation that a patient did not receive appropriate treatment for his back pain because of a delay in the diagnosis of a tumor which may have been the source of this

patient's pain. We did not substantiate a failure to provide a patient operative care associated with bleeding gastrointestinal polyps because it is unlikely the patient's low blood count (anemia) resulted from the bleeding polyps, but noted that the patient was not evaluated for an alternative diagnosis suggested by information in his EHR. We did not substantiate the allegation that a failure in VA agreeing to pay for a patient's open heart surgery resulted in a delay in the patient receiving the surgery. We did not substantiate that the provider's failure to address leg swelling or a nose bleed affected the rupture of a patient's "brain aneurysm". We did not substantiate that the VA advised a patient to wait until he tore the remaining two healthy discs and then call 911 to make it a medical emergency. We did not substantiate a delay in scheduling a CT of the abdomen and pelvis and a colonoscopy.

Because these patients were seen by different providers and specialties, these findings represent individual errors in medical care. We identified no common themes or patterns in the deficiencies identified. To reduce the chances of such errors occurring, facilities must have robust credentialing, privileging, and peer review processes. The last CAP review conducted by OIG did not identify ongoing systemic deficiencies in these processes. We are scheduled to review the facility again under the CAP program in fiscal year 2016.

We substantiated a patient experienced poor access to dental services and that the patient was not notified by mail of his scheduled appointment. We also substantiated that another patient experienced poor access to neurosurgical services. We did not substantiate the facility delayed and denied NVCC maternity care consult requests. We found that the information patients receive in a document titled "*Jack C. Montgomery Fee Basis Pregnancy Process*" as well as the NVCC maternity care providers' authorization document is ambiguous at least when applied to select cases. In summary, we found the facility's written instructions authorizing NVCC maternity care services to be problematic, especially within the context of a known high-risk pregnancy. However, we did not find the facility uncooperative or to have delayed authorization of NVCC maternity care requests or additionally requested studies for suspected pregnancy complications.

The deficiencies identified in this report had not been previously identified or reviewed by OIG. Previous deficiencies identified by OIG in access to care involved different services, and the facility provided appropriate action plans indicating those issues had been resolved.

During the course of the review, we also found systemic issues in the Dental Services and we found that the Tulsa CBOC's limited parking created an access and safety concern for patients, visitors, and employees.

Recommendations

1. We recommended that the Veterans Integrated Service Network Director ensure that the Facility Director evaluate the care of the cases discussed in this report with Regional Counsel for possible disclosure(s) to the patient(s) and/or surviving family members.

2. We recommended that the Veterans Integrated Service Network Director require the Facility Director to conduct peer reviews of the cases identified in this report and take appropriate action to evaluate clinical competence of the providers involved in these cases based on the results of those reviews and this report.

3. We recommended that the Veterans Integrated Service Network Director send a team to evaluate the facility's Dental Service and oversee the implementation of any recommendations for improvement in scheduling and the general provision of dental care at the facility made by that team.

4. We recommended that the Veterans Integrated Service Network Director ensure that the Facility Director provide appropriate and timely neurosurgical consultation services to patients receiving care at the facility consistent with Veterans Health Administration Directive 2008-056*, VHA Consult Policy*, September 16, 2008.

5. We recommended that the Facility Director ensure that all documents that patients and non-VA providers receive regarding maternity/obstetric care and services are reviewed and revised to eliminate ambiguous language.

6. We recommended that the Facility Director ensure that providers document all clinically pertinent telephone conversations concerning patient care.

7. We recommended that Veterans Integrated Service Network and the Facility Director ensure adequate parking space requirements to strengthen a safe work environment, patient satisfaction, and provide optimal safety to patients, visitors, and staff.

8. We recommended that the Veterans Integrated Service Network and the Facility Director ensure that Ernest Childers VA Outpatient Clinic access and parking is adequate and safe for patients, visitors, and employees.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: April 20, 2015

From Director, Veterans Integrated Service Network 16 (10N16)

Subj: Healthcare Inspection—Quality of Care and Access to Care Concerns, Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma

To: Director, Kansas City Office of Healthcare Inspections (54KC)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. The South Central VA Health Care Network (VISN 16) has reviewed and concur with the findings, recommendations and corrective actions included in the draft report submitted by the Veterans Health Care System of the Ozarks, Fayetteville, AR.

2. If you have questions regarding the information submitted, please contact Reba T. Moore, VISN16 Accreditation Specialist at 601-206-7022.

Fernando Rivera, FACHE
Interim Network Director
South Central VA Health Care Network (10N16)

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Veterans Integrated Service Network Director ensure that the Facility Director evaluate the care of the cases discussed in this report with Regional Counsel for possible disclosure(s) to the patient(s) and/or surviving family members.

Concur

Target date for completion: June 30, 2015

Facility response: All cases in this report will be sent to Regional Counsel for medical-legal opinion as to necessity for disclosure to the patient(s) and/or surviving family members.

Recommendation 2. We recommended that the Veterans Integrated Service Network Director require the Facility Director to conduct peer reviews of the cases identified in this report and take appropriate action to evaluate clinical competence of the providers involved in these cases based on the results of those reviews and this report.

Concur

Target date for completion: August 5, 2015

Facility response: April 8, 2015 all identified cases have been sent off station for external peer reviews. Appropriate actions will be taken based upon the peer review results.

Recommendation 3. We recommended that the Veterans Integrated Service Network Director send a team to evaluate the facility's Dental Service and oversee the implementation of any recommendations for improvement in scheduling and the general provision of dental care at the facility made by that team.

Concur

Target date for completion: April 14, 2015

Facility response: Based on the improvements implemented below we feel that a site visit from the VISN lead dentist will be sufficient. The VISN Lead Dentist completed a site review on April 14, 2015, to verify these improvements and offer suggestions for continual improvement.

The issues pertaining to the dental service in this OIG report are summarized as the following:

1) Delays in receiving dental services.
2) Scheduling problems and compliance with VHA policy.
3) Quality of Care.
4) Utilization of Non-VA Care Coordination.
5) Lack of treatment space and staffing.

These issues have been addressed by the Jack C Montgomery Medical Center's Dental Service in the following ways:

1) Each patient treated is appropriately placed on the facility electronic recall based on the clinically indicated date determined by the treating dentist. Patients are scheduled for ongoing episode of care appointments before leaving the facility when convenient for the patient. When the patient can't make an appointment while at the facility (due to patient reasons) the patient is place on the facility electronic recall system according to the clinically indicated date. The patient transfer form is utilized to communicate clinical indicated dates and next visit information to the Medical Staff Assistant by the clinical team. This prevents communication and scheduling errors while promoting efficiency by allowing the clinical team to return to clinical work without waiting for busy Medical Staff Assistants. The patient transfer forms are not collected and they are shredded daily.
2) When a patient can't be treated within 30 days of the clinically indicated date they are referred to Non-VA Care Coordination as directed by Veterans Access, Choice and Accountability Act.
3) The scheduling of dental services has been further enhanced by the establishment of three new clinics in each provider's schedule. These clinics are priority, lab, and emergency. They allow a provider's schedule to not be overrun with routine dentistry and maintain room for pressing patient needs like surgery, root canals, and prosthesis delivery. By establishing these clinics ongoing complex care is not postponed for three to six months at a time due to a full schedule of routine dentistry. If these clinics are not filled with the established procedures they are opened and filled with routine dentistry.
4) Furthermore, delays in receiving treatment have been enhanced by the increased utilization of Non-VA Care Coordination. Compared to the same time period in Fiscal Year 14, 534 more patients and $637,317.00 more dollars have been spent on dental Non-VA Care Coordination.
5) Dental Service quality monitors related to access (periodic oral evaluation and periodontal preventive) have consistently improved since August 2014. Variation is due to personnel retirement and resignation. Medically compelling is no longer a quality monitor although tracked. The decrease in medically compelling however demonstrates the service's commitment to treating eligible comprehensive care veterans.
6) Quality of care has also improved via personnel decision making. Since August, three dental providers have not been retained due to quality issues. However,

four new high performing dentists have been hired and one new hygienist has been hired. These staff members are maintaining high levels of productivity and quality. Two other dentists have accepted positions and will be on board by July 2015. Announcements have been made for two other staff dentists who will fill the staff dentist position.

7) The quadrad approved a proposal by the dental service to have expanded hours and a compressed work schedule. The service will be open from 7A.M-7PM M-Tr and 7A.M-530P M-F. Staff will work four ten hour days and two different shifts will operate. This expands access to care and more optimally utilizes existing space and resources. Due to shifts and a compressed work schedule, the service will effectively gain one treatment room without cost and renovation to existing space. It will also work as a retention tool for providers due to increased Quality of Life.
8) The quadrad approved a proposal for 8 new dental assistant positions. This will facilitate increased provider productivity, lab productivity, and hygiene productivity, improve the patient experience and help retain quality dentists. A gap still exists in hygiene and lab support.
9) The dental service has monthly staff meetings and morning huddles to discuss elements of quality, customer service and operational efficiency.
10) The space committee has recommended the addition of two new treatment rooms for the Muskogee dental service and discussion has occurred about an off-site dental clinic at Ernest Childers Outpatient Clinic. A gap of 8-12 treatment rooms still exists.

Recommendation 4. We recommended that the Veterans Integrated Service Network Director ensure that the Facility Director provide appropriate and timely neurosurgical consultation services to patients receiving care at the facility consistent with Veterans Health Administration Directive 2008-056*, VHA Consult Policy*, September 16, 2008.

Concur

Target date for completion: N/A

Facility response: The facility has a dual approach plan to assuring appropriate and timely neurosurgical consultations services. The facility will continue to utilize Non-VA Care to support the need for both neurosurgery consults and procedures. The challenge in utilizing Non-VA Care is the limited availability of that specialized resource within the local community. Therefore, the facility is in negotiations to hire a local neurosurgeon on a part time basis to complete neurosurgery consults at the VA medical center. This will diminish the need for Non-VA Care for neurosurgery consultation.

Recommendation 7. We recommended that Veterans Integrated Service Network and the Facility Director ensure adequate parking space requirements to strengthen a safe work environment, patient satisfaction, and provide optimal safety to patients, visitors, and staff.

Concur

Target date for completion: April 6, 2015

Facility response: Engineering is addressing parking:

1) The nursing students from Indian Capital Vo-Tech park at American legion Post #5 since 2011 (Average number of students is 8-12). The students are shuttled to/from the Jack C. Montgomery VA Medical Center.
2) Memorandum of Understanding in place with the City Of Muskogee as of April 6, 2015 through September 30, 2015 for a total of 165 parking spaces at Love-Hatbox Sports Complex near the skateboard ramps along S. 36th Street. A parking shuttle is provided for those parking in that location to/from the Jack C. Montgomery VA Medical Center. If we utilized more than the 165 parking spaces, City of Muskogee is interested in have a lease with VA for their retired airstrip on the west side of Love-Hatbox Sports Complex. This area has a total of at least 500 parking spaces.
3) We are exploring leasing opportunities and conducting market research for parking availability in the vicinity of the medical center.
4) From 2005 through December 31, 2009, VA had a lease contract with the Five Civilized Tribes Museum for a total of 50 parking spaces. The parties weren't able to come to terms for a new or renewing of that parking lease at the time after December 31, 2009.
5) Valet parking began on November 1, 2012, this provided via contract for a total of 34 parking spaces. This is provided for patient parking only if they have an appointment.
6) Jack C. Montgomery VA Medical Center was approved for build parking garage for a total of $6.48 million. Architect/Engineer design was awarded on 8/26/2014. However, due to the extra cost required for site work and structural issues along the access on a small winding road to the south side of the medical center to the front of Parking Lots #10 and #12, it was determined to cancel this project and reapply for a new out-of cycle minor project. Decision was made for this on April 2, 2015. The other site that Engineering Service recommends located the parking garage is parking lot # 4 which is currently a lease. However, the property owner is interested in selling to the VA. VISN 16 and Office Capital Assets Management Engineering Support supports our decision. Timeline would be approximately one year to purchase this property through Real Property, one year for design and one year for construction. On February 2015, due to the Full facility standby generator system project, at total of 37 parking spaces we closed off due to site work for this project. On April 2, 2015 the parking spaces in lots #10 and #12 were closed off due to the settling and cracking of parking lots #10 and #12.
7) Working with VISN 16 for funding and approval for Project 623-15-108 Stabilize Slope and restore parking. Project was submitted on 4/8/2015.

Recommendation 8. We recommended that the Veterans Integrated Service Network and the Facility Director ensure that Ernest Childers VA Outpatient Clinic access and parking is adequate and safe for patients, visitors, and employees.

Concur

Target date for completion: August 1, 2015

Facility response:

1) Approved for parking lease in Tulsa for 60 parking spaces at approximately $100/space a total cost of $72,000 annually (1-14-15). VA is working on this lease. Lease should be in place by 8/1/2015.

2) Had 42 General Services Administration vehicles parked at 11th street Behavioral Medicine Service Clinic beginning July 2012 to free up parking at Ernest Childers VA Outpatient Clinic.

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 9, 2015

From: Director, Jack C. Montgomery VA Medical Center (623/00)

Subj: Healthcare Inspection— Quality of Care and Access to Care Concerns, Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma

To: Director, Veterans Integrated Service Network 16 (10N16)

1. In response to the Office of Healthcare Inspection's report, subject as above, Jack C. Montgomery concurs with all recommendations. See facility responses for action plans.

2. If additional information is required please contact Leslea Jernigan, Acting Chief, Quality Safety and Value, at 918-577-3707.

(original signed by:)
JAMES R. FLOYD, FACHE

Comments to OIG's Report

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

OIG Recommendations

Recommendation 5. We recommended that the Facility Director ensure that all documents that patients and non-VA providers receive regarding maternity/obstetric care and services are reviewed and revised to eliminate ambiguous language.

Concur

Target date for completion: April 8, 2015

Facility response: The information for Non-VA Care Coordination Pregnancy Information and Non VA Obstetrics Care forms have been reviewed and revised to eliminate ambiguous language.

Recommendation 6. We recommended that the Facility Director ensure that providers document all clinically pertinent telephone conversations concerning patient care.

Concur

Target date for completion: April 24, 2015

Facility response: The Chief of Staff will issue a memo to all clinical providers emphasizing the importance of documenting in the medical record all clinical telephone conversations regarding patient care. Each clinical service chief will be required to certify that the memo was received and read by all clinical providers.

Appendix C

OIG Contact and Staff Acknowledgements

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Laura Snow, LCSW, MHCL, Team Leader Andrea C. Buck, MD Stephanie Hensel, RN, JD Thomas Jamieson, MD Cindy Niemack-Brown, LCSW, LMHP

Appendix D

Report Distribution

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Director, South Central VA Health Care Network (10N16)
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