Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00102-253

Combined Assessment Program Review of the Eastern Oklahoma VA Health Care System Muskogee, Oklahoma

April 13, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

AD	advance directive
CAP	Combined Assessment Program
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	Eastern Oklahoma VA Health Care System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OR	operating room
QSV	quality, safety, and value
VHA	Veterans Health Administration

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of January 25, 2016.

Review Results: The review covered seven activities. We made no recommendations in the following activity:

- Advance Directives

The facility's reported accomplishment was the implementation of the patient-centered call center to increase the speed to response time, decrease the call abandonment rate, and improve patient satisfaction.

Recommendations: We made recommendations in the following six activities:

Quality, Safety, and Value: Consistently implement individual improvement actions recommended by the Peer Review Committee. Ensure Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database.

Environment of Care: Ensure ventilation system outlets are clean.

Medication Management: Monitor temperature in the compounding buffer areas. Perform and document monthly cleaning of ceilings, walls, lights, and storage shelving in all compounding areas.

Coordination of Care: Consistently document discharge progress notes or instructions that include patient diagnoses, and provide discharge instructions to patients and/or caregivers.

Computed Tomography Radiation Monitoring: Ensure radiologists document the radiation dose in the Computerized Patient Record System. Require all computed tomography technologists to have documented annual radiation safety training.

Suicide Prevention Program: Ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan.

Comments

The Veterans Integrated Service Network Director and Interim Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 24–28, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Additionally, we are continuing work to evaluate the facility's quality management program, analyze data from VA's Strategic Analytics for Improvement and Learning (SAIL) Value Model report, and follow up on the results of an Employee Assessment Review survey. Our results from these reviews will be addressed in a future Office of Inspector General report.

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

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly. We are continuing work to evaluate the facility's quality management program, analyze data from VA's Strategic Analytics for Improvement and Learning (SAIL) Value Model report, and follow up on the results of an Employee Assessment Review survey. Our results from these reviews will be addressed in a future OIG report.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2015 and FY 2016 through January 28, 2016, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma,* Report No. 13-01670-269, August 7, 2013).

During this review, we presented crime awareness briefings for 92 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. We distributed an electronic survey to all facility employees and received 425 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishment

Patient-Centered Call Center

Due to the large volume of incoming calls to the clinics, employees caring for patients were unable to answer phone calls in a timely manner. This resulted in patients hanging up prior to receiving the care they were seeking. The facility set up goals to improve patient satisfaction with the phone system by having calls answered in less than 30 seconds and to decrease the call abandonment rate to less than 5 percent. In April 2014, phone system data showed the call volume at approximately 13,000, the speed to response time at 105 seconds, and the call abandonment rate at 8.6 percent. In May 2014, leadership approved a proposal to implement a call center at the parent facility. In July 2014, the call center opened with six medical support staff plus one lead. In January 2016, data showed the call volume at 12,323, the speed to response time at 22 seconds, and the call abandonment rate at 3.8 percent. There was no additional cost involved in setting up the call center, and the facility used current employees and existing space and equipment. The call center was acknowledged in the VA Office of Patient Centered Care and Cultural Transformation annual summary for FY 2015.

Results and Recommendations

QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a]

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 20 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		
	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. • The facility followed its policy when employees' licenses expired.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.	• In nine cases, there was no evidence that clinical managers implemented individual improvement actions recommended by the Peer Review Committee.	**1.** We recommended that facility clinical managers consistently implement individual improvement actions recommended by the Peer Review Committee and that facility managers monitor compliance.
X	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • The facility had designated an interdisciplinary group to review utilization management data.	• For 24 of the 195 cases (12 percent) referred to Physician Utilization Management Advisors November 1–December 31, 2015, there was no evidence that advisors documented their decisions in the National Utilization Management Integration database.	**2.** We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.
	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in the dental clinic and the OR.[b]

We inspected the medical, surgical, medical intensive care, and locked MH inpatient units. We also inspected the Emergency Department, OR, and dental and primary care outpatient (Blue Team) clinics. Additionally, we reviewed relevant documents and 10 employee training records, and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
X	The facility met environmental safety requirements.	• Ventilation system outlets were dirty/dusty in three of six areas inspected.	**3.** We recommended that facility managers ensure ventilation system outlets are clean and monitor compliance.
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Dental Clinic		
	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		
	Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets.		
NA	Designated dental clinic employees received laser safety training in accordance with local policy.		
	The facility tested dental water lines in accordance with local policy.		
X	The facility met environmental safety and infection prevention requirements in the dental clinic.	• The ventilation system outlet in the patient bathroom was dirty/dusty.	See recommendation 3.
NA	The facility met laser safety requirements in the dental clinic.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for the OR	Findings	Recommendations
	The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.		
	The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination.		
NA	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.		
	The facility monitored OR temperature, humidity, and positive pressure.		
	The facility met fire safety requirements in the OR.		
	The facility met environmental safety requirements in the OR.		
	The facility met infection prevention requirements in the OR.		
	The facility met medication safety and security requirements in the OR.		
	The facility met laser safety requirements in the OR.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for the safe preparation of CSPs.[c]

We reviewed relevant documents and the competency assessment/testing records of 10 pharmacy technicians. Additionally, we inspected the area where sterile products are compounded. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy on preparation of CSPs that included required components: • Pharmacist CSP preparation or supervision of preparation except in urgent situations • Hazardous CSP preparation in an area separate from routine CSP preparation or in a compounding aseptic containment isolator • Environmental quality and control of ante and buffer areas • Hood certification initially and every 6 months thereafter • Cleaning procedures for all surfaces in the ante and buffer areas		
	The facility established competency assessment requirements for employees who prepare CSPs that included required elements, and facility managers assessed employee competency at the required frequency based on the facility's risk level.		

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	If the facility used an outsourcing facility for CSPs, it had a policy/guidelines/a plan that included required components for the outsourcing facility: • Food and Drug Administration registration • Current Drug Enforcement Agency registration if compounding controlled substances		
	The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.		
	All International Organization for Standardization classified areas had documented evidence of periodic surface sampling, and the facility completed required actions when it identified positive cultures.		
	The facility had a process to track and report CSP medication errors, including near misses.		
X	The facility met design and environmental safety controls in compounding areas.	• There was no evidence of temperature monitoring for the buffer areas.	**4.** We recommended that the facility monitor temperature in the compounding buffer areas and that facility managers monitor compliance.
	The facility used a laminar airflow hood or compounding aseptic isolator for preparing non-hazardous intravenous admixtures and any sterile products.		
	The facility used a biological safety cabinet in a physically separated negative pressure area or a compounding aseptic containment isolator for hazardous medication compounding and had sterile chemotherapy type gloves available for compounding these medications.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	If the facility prepared hazardous CSPs, a drug spill kit was available in the compounding area and during transport of the medication to patient care areas.		
	Hazardous CSPs were physically separated or placed in specially identified segregated containers from other inventory to prevent contamination or personnel exposure.		
	An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing.		
X	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.	• There was no documented evidence of monthly cleaning of ceilings, walls, lights, and storage shelving in the compounding areas as required by local standard operating procedures.	**5.** We recommended that facility managers ensure employees perform and document monthly cleaning of ceilings, walls, lights, and storage shelving in all compounding areas and monitor compliance.
	During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months.		
	Prepared CSPs had labels with required information prior to delivery to the patient care areas: • Patient identifier • Date prepared • Admixture components • Preparer and checker identifiers • Beyond use date		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Coordination of Care

The purpose of this review was to evaluate selected aspects of the facility's patient flow process over the inpatient continuum (admission through discharge).[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient discharge and scheduling discharges early in the day.		
	The facility had a policy that addressed temporary bed locations, and it included: • Priority placement for inpatient beds given to patients in temporary bed locations • Upholding the standard of care while patients are in temporary bed locations • Medication administration • Meal provision		
	The Facility Director had appointed a Bed Flow Coordinator with a clinical background.		
	Physicians or acceptable designees completed a history and physical exam within 1 day of the patient's admission or referenced a history and physical exam completed within 30 days prior to admission. • When resident physicians completed the history and physical exams, the attending physicians provided a separate admission note or addendum within 1 day of the admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• When the facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete history and physical exams, they were properly documented.		
	Nurses completed admission assessments within 1 day of the patient's admission.		
	When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer. • When resident physicians wrote the transfer notes, attending physicians documented adequate supervision. • Receiving physicians documented transfers.		
	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.		
X	Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels. • When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision. • When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented.	• For 11 of the 31 applicable EHRs (35 percent), physician documented discharge progress notes or instructions did not include patient diagnoses.	**6.** We recommended that physicians consistently document discharge progress notes or instructions that include patient diagnoses and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians provided discharge instructions to patients and/or caregivers and documented patients and/or caregiver understanding.	• Six of the 31 applicable EHRs (19 percent) did not contain documentation that clinicians provided discharge instructions to patients and/or caregivers.	**7.** We recommended that clinicians provide discharge instructions to patients and/or caregivers.
	The facility complied with any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for eight CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
X	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.	Local radiation safety policy reviewed, which required radiation dose to be documented in the CT report: • Although required by local policy, radiologists did not document the radiation dose in the Computerized Patient Record System for 20 patients (40 percent).	**8.** We recommended that radiologists document the radiation dose in the Computerized Patient Record System and that facility managers monitor compliance.
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
X	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.	• Three CT technologists did not have documented evidence of annual radiation safety training.	**9.** We recommended that the Radiation Safety Officer ensure all computed tomography technologists have documented annual radiation safety training.
NA	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients who had an acute care admission July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.		
	The facility met any additional elements required by VHA or local policy.		

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[g]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 40 patients assessed to be at risk for suicide during the period October 1, 2014–September 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 15 new employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

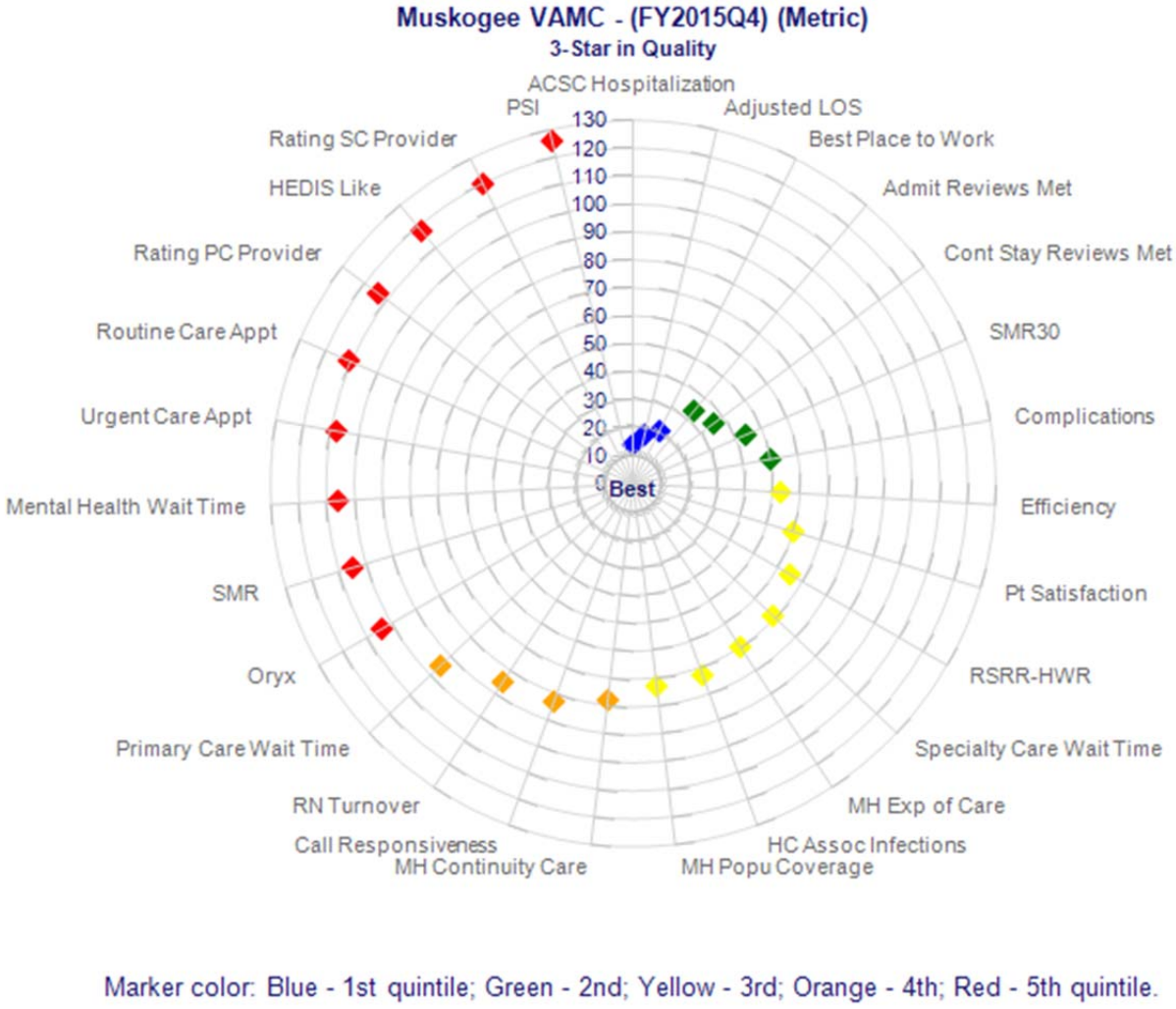
NM	Areas Reviewed	Findings	Recommendations
	The facility had a full-time Suicide Prevention Coordinator.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.		
	The facility had a process to follow up on high-risk patients who missed MH appointments.		
	The facility provided training within required timeframes: • Suicide prevention training to new employees • Suicide risk management training to new clinical employees		
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		
	Clinicians assessed patients for suicide risk at the time of admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.		
	Clinicians documented Suicide Prevention Safety Plans that contained the following required elements: • Identification of warning signs • Identification of internal coping strategies • Identification of contact numbers of family or friends for support • Identification of professional agencies • Assessment of available lethal means and how to keep the environment safe		
X	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.	• For 38 of the 41 applicable EHRs (93 percent), clinicians did not document that they gave patients and/or caregivers a copy of the safety plan.	**10.** We recommended that clinicians ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan and that facility managers monitor compliance.
	The treatment team evaluated patients as follows: • At least four times during the first 30 days after discharge • Every 90 days to review Patient Record Flags		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Muskogee/623) FY 2016 through December 2015	
Type of Organization	Secondary
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$78.75
Number of:	
• **Unique Patients**	26,536
• **Outpatient Visits**	115,440
• **Unique Employees**[1]	1,386
Type and Number of Operating Beds:	
• **Hospital**	99
• **Community Living Center**	NA
• **Domiciliary**	NA
Average Daily Census:	
• **Hospital**	52.8
• **Community Living Center**	NA
• **Domiciliary**	NA
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Tulsa/623BY Hartshorne/623GA Vinita/623GB Muskogee/623QA
Veterans Integrated Service Network Number	19

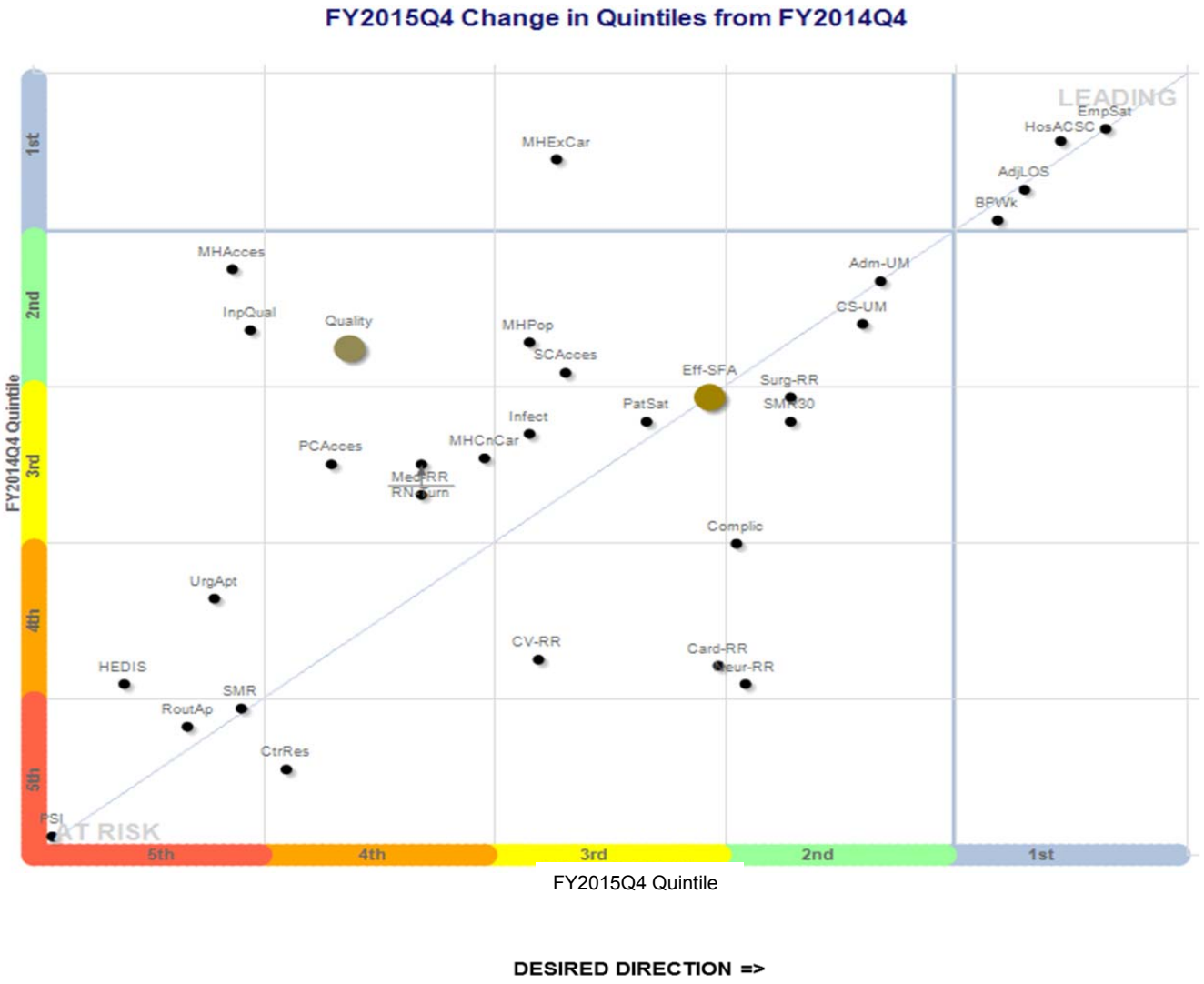
[1] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[2]



[2] Metric definitions follow the graphs.

Scatter Chart



DESIRED DIRECTION =>

NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

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
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	A lower value is better than a higher 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	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH 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
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	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
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-CHF	30-day risk standardized readmission rate for congestive heart failure	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
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 and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: March 22, 2016

From: Director, Rocky Mountain Network (10N19)

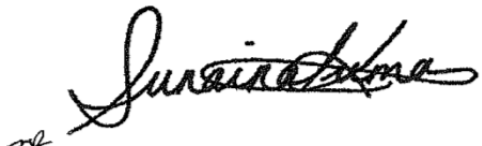
Subject: **CAP Review of the Eastern Oklahoma VA Health Care System, Muskogee, OK**

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

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

1. I have reviewed the response from the Eastern Oklahoma VA Health Care System, Muskogee, OK and concur with the response.

2. If you have any questions or concerns, please contact Susan Curtis, VISN 19, HHS, 303-639-6995.



FOR Ralph T. Gigliotti, FACHE

Director, VA Rocky Mountain Network

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 21, 2016

From: Interim Director, Eastern Oklahoma VA Health Care System (623/00)

Subject: **CAP Review of the Eastern Oklahoma VA Health Care System, Muskogee, OK**

To: Director, Rocky Mountain Network (10N19)

1. We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the quality of health care for America's Veterans.

2. I concur with the findings and recommendations of the OIG CAP Survey Team. The importance of this review is acknowledged as we continually strive to provide the best possible care.

3. If you have any questions, please contact Martha Hardesty, Quality, Safety and Value Specialist, at 918-577-3473.

Richard L. Crockett, MBA
Interim Medical Center Director

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 facility clinical managers consistently implement individual improvement actions recommended by the Peer Review Committee and that facility managers monitor compliance.

Concur

Target date for completion: 4/4/2016

Facility response: Action plans created by supervisors of providers with level 2 and level 3 final findings will be documented in the minutes and reported back to the PRC until all actions are completed.

Recommendation 2. We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

Concur

Target date for completion: 4/29/2016

Facility response: Utilization Management Nurse Manager or designee will monitor the PUMA documentation in NUMI on a biweekly basis and report compliance to the PUMA's Service Chief.

Recommendation 3. We recommended that facility managers ensure ventilation system outlets are clean and monitor compliance.

Concur

Target date for completion: 3/14/2016

Facility response: All identified ventilation system outlets have been cleaned. We will continue to monitor through EOC rounds monthly and weekly Environmental Management Service checks.

Recommendation 4. We recommended that the facility monitor temperature in the compounding buffer areas and that facility managers monitor compliance.

Concur

Target date for completion: 3/14/2016

Facility response: The temperature is monitored and documented daily by pharmacy personal. Log is maintained in the pharmacy.

Recommendation 5. We recommended that facility managers ensure employees perform and document monthly cleaning of ceilings, walls, lights, and storage shelving in all compounding areas and monitor compliance.

Concur

Target date for completion: 3/14/2016

Facility response: A monthly log has been put in place to document each time the cleaning is completed. The EMS supervisor will check the log to ensure proper cleaning has been documented.

Recommendation 6. We recommended that physicians consistently document discharge progress notes or instructions that include patient diagnoses and that facility managers monitor compliance.

Concur

Target date for completion: 2/1/2016

Facility response: The Discharge Instructions progress note has been revised to include patient's diagnoses. The diagnosis must be included or the provider cannot continue through the template.

Recommendation 7. We recommended that clinicians provide discharge instructions to patients and/or caregivers.

Concur

Target date for completion: 2/1/2016

Facility response: The Discharge instructions progress note has been revised to include documentation that a copy of the discharge instructions has been given to the patient or care giver at discharge.

Recommendation 8. We recommended that radiologists document the radiation dose in the Computerized Patient Record System and that facility managers monitor compliance.

Concur

Target date for completion: 4/29/2016

Facility response: Staff is being educated on the requirement for documentation of radiation dosage in the dictated report.

Recommendation 9. We recommended that the Radiation Safety Officer ensure all computed tomography technologists have documented annual radiation safety training.

Concur

Target date for completion: 4/29/2016

Facility response: The Radiation Safety Officer has mandated all staff technologists to complete the TMS program "Reducing CT Radiation Dose: Technologist Refresher Training" (VA 23701) annually. This training has been assigned to their annual mandatory training list. Currently all technologist are at 100% compliance for training.

Recommendation 10. We recommended that clinicians ensure patients and/or caregivers receive a copy of the Suicide Prevention Safety Plan and that facility managers monitor compliance.

Concur

Target date for completion: 4/29/2016

Facility response: The safety plan is in revision to include documentation that a copy of the safety plan is given to the patient or caregiver.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Deborah Howard, RN, MS, Team Leader Lindsay Gold, LCSW Judy Montano, MS Jennifer Tinsley, LMSW-C Katrina Young, RN, MSHL Patrick Crockett, Resident Agent in Charge, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Lin Clegg, PhD Marnette Dhooghe, MS Derrick Hudson Larry Ross, Jr., MS Julie Watrous, RN, MS Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Rocky Mountain Network (10N19)
Interim Director, Eastern Oklahoma VA Health Care System (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 at **www.va.gov/oig**.

Endnotes

[a] The references used for this topic were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] The references used for this topic included:
- VHA Directive 2005-037, *Planning for Fire Response,* September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

[c] The references used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of VA Pharmacy Benefits Management Services, The Joint Commission, the United States Pharmacopeial Convention, the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, the Food and Drug Administration, and the American National Standards Institute.

[d] The references used for this topic included:
- VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
- VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[e] The references used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[g] The references used for this topic included:
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected 2/3/11).
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.