DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System

Muskogee, Oklahoma

CHIP REPORT | REPORT #18-06510-222 | SEPTEMBER 24, 2019

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Figure 1. *Eastern Oklahoma VA Health Care System, Muskogee, OK (Source: https://vaww.va.gov/directory/guide/, accessed on April 16, 2019)*

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FPPE	focused professional practice evaluation
FY	fiscal year
LIP	licensed independent practitioner
MST	military sexual trauma
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UCC	urgent care center
UM	utilization management
VHA	Veterans Health Administration
VISN	veterans integrated service network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Eastern Oklahoma VA Health Care System (the facility). The inspection covers key clinical and administrative processes that are associated with promoting quality care.

CHIP inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus each year.

The OIG team looks at leadership and organizational risks as well as areas affecting quality patient care. At the time of the review, the clinical areas of focus were

1. Quality, safety, and value;
2. Medical staff privileging;
3. Environment of care;
4. Medication management (specifically the controlled substances inspection program);
5. Mental health (focusing on military sexual trauma follow-up and staff training);
6. Geriatric care (spotlighting antidepressant use for elderly veterans);
7. Women's health (particularly abnormal cervical pathology result notification and follow-up); and
8. High-risk processes (specifically the emergency department and urgent care center operations and management).

This unannounced visit was conducted during the week of December 10, 2018. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the director, chief of staff, associate director for Patient Care Services (ADPCS), and associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure, with the Executive Governing Board having oversight for several working groups. The director is the chair of the Quality Safety Value Committee, which was responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes.

The director and associate director were permanently assigned June 12, 2016, and December 25, 2005, respectively. The chief of staff was the acting chief of staff from June 24, 2018, until permanently assigned November 25, 2018. The ADPCS has served in an acting capacity since October 31, 2018.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders have opportunities to improve employee satisfaction and provide a safe workplace environment where employees feel comfortable with bringing forth issues or ethical concerns. The leaders verbalized ongoing efforts to improve the culture of the organization. The selected patient experience survey scores were generally better than the VHA average, and facility leaders reported implementation of processes and plans to maintain positive patient experiences.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[1] disclosures of adverse patient events, and patient safety indicator data and identified organizational risk factors that may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored. Further, at the time of the on-site visit, the OIG found that one OIG hotline inspection report recommendation had not been closed but noted the facility's progress toward closing the recommendation based on evidence provided by the chief of the Quality, Safety and Value Service.

The OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom

[1] The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

performers" within VHA.[2] Although the leadership team members were knowledgeable within their areas of responsibility about selected SAIL metrics, the leaders should continue to take actions to sustain and improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "2-star" rating.[3]

The OIG noted deficiencies in five of the eight clinical areas reviewed and issued 11 recommendations that are attributable to the director, chief of staff, and associate director. These are briefly described below.

Medical Staff Privileging

The OIG found there was general compliance with requirements for privileging. However, the OIG found evidence that solo practitioners were not evaluated by providers with similar training. Also, the OIG found that time limits were not delineated in the FPPE process and providers were not notified of FPPEs for cause.[4]

Environment of Care

Generally, the facility met cleanliness and safety requirements. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified an infection prevention concern related to the storage of clean and sterile supplies that warranted a recommendation for improvement.

[2] VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star rating" system to designate a facility's performance in individual measures, domains, and overall quality. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 6, 2019, but is not accessible by the public.)

[3] Based on fiscal year 2018, quarter 3 ratings at the time of the site visit.

[4] The definitions of ongoing professional practice evaluation and focused professional practice evaluations can be found within Office of Safety and Risk Awareness, Office of Quality and Performance, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, July 2016 (Revision 2). An ongoing professional practice evaluation is "the ongoing monitoring of privileged providers to confirm the quality of care delivered and ensures patient safety." A focused professional practice evaluation is "a time-limited process whereby the clinical leadership evaluates the privilege-specific competence of a provider who does not yet have documented evidence of competently performing the requested privilege(s) at the facility." A focused professional practice evaluation for cause is "a time-limited period during which the medical staff leadership assesses the provider's professional performance to determine if any action should be taken on the provider's privileges."

Mental Health

Generally, the OIG found compliance with many of the performance indicators, including the designation of an MST coordinator and documentation of MST referrals. However, the OIG noted concerns with the lack of communication of MST services and initiatives to local leadership, tracking and monitoring MST-related data, and completion of mandatory training by providers that warranted recommendations for improvement.[5]

Geriatric Care

Generally, the OIG found compliance with documenting justification for initiating the antidepressant medication. However, the OIG found noncompliance with patient/caregiver education specific to the newly prescribed antidepressant and medication reconciliation.

Women's Health

The facility generally complied with many of the performance indicators, including requirements for clinical oversight of the women's health program. However, the OIG identified concerns within the Women Veteran Health Committee membership and reporting requirements to the Medical Executive Committee that warranted recommendations for improvement.

Summary

In reviewing key healthcare processes, the OIG issued 11 recommendations for improvement directed to the facility director, chief of staff, and associate director. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

[5] VHA Directive 1115.01.

Comments

The Veterans Integrated Service Network director and facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 64–65, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to provide oversight of healthcare services to veterans. This focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Eastern Oklahoma VA Health Care System (the facility) is accomplished by examining a broad overview of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions can be made on improving care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.[6] Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.[7] Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following nine areas of clinical and administrative operations that support quality care at the facility:

1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff privileging
4. Environment of care
5. Medication management (specifically the controlled substances inspection program)
6. Mental health (focusing on military sexual trauma follow-up and staff training)
7. Geriatric care (spotlighting antidepressant use for elderly veterans)
8. Women's health (particularly abnormal cervical pathology results notification and follow-up)

[6] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (The website was accessed on January 24, 2019.)

[7] Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen. (The website was accessed on January 24, 2019.)

9. High-risk processes (specifically the emergency department and urgent care center operations and management).[8]

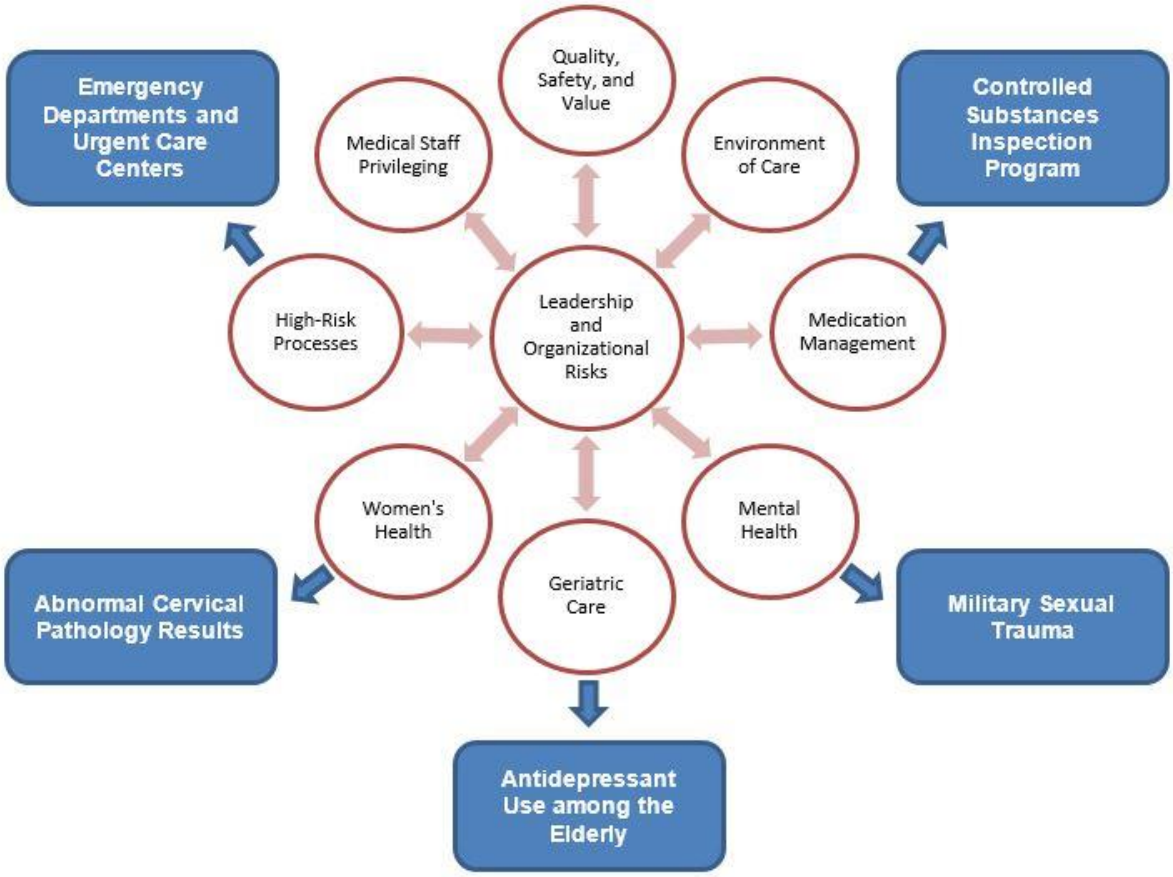

Figure 2. *Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services*
Source: VA OIG

[8] See Figure 2. CHIP inspections address these processes during FY 2019 (October 1, 2018, through September 30, 2019); they may differ from prior years' focus areas.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;[9] physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from January 30, 2016, through December 14, 2018, the last day of the unannounced week-long site visit.[10] While on site, the OIG did not receive any complaints beyond the scope of the CHIP review.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the facility completes corrective actions. The facility director's comments submitted in response to the report recommendations appear within each topic area.

The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reports and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

[9] The OIG did not review VHA's internal survey results, instead focusing on OIG inspections and external surveys that affect facility accreditation status.

[10] The range represents the time period from the last Clinical Assessment Program review, which was performed prior to the comprehensive healthcare inspection, to the completion of the unannounced week-long CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.[11] To assess the facility's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation and/or for-cause surveys and oversight inspections
5. Factors related to possible lapses in care
6. VHA performance data

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of the director, chief of staff, associate director for Patient Care Services (ADPCS), and associate director (primarily nonclinical). The chief of staff and ADPCS oversee patient care, which requires managing service directors and program chiefs.

[11] L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on February 2, 2017.)

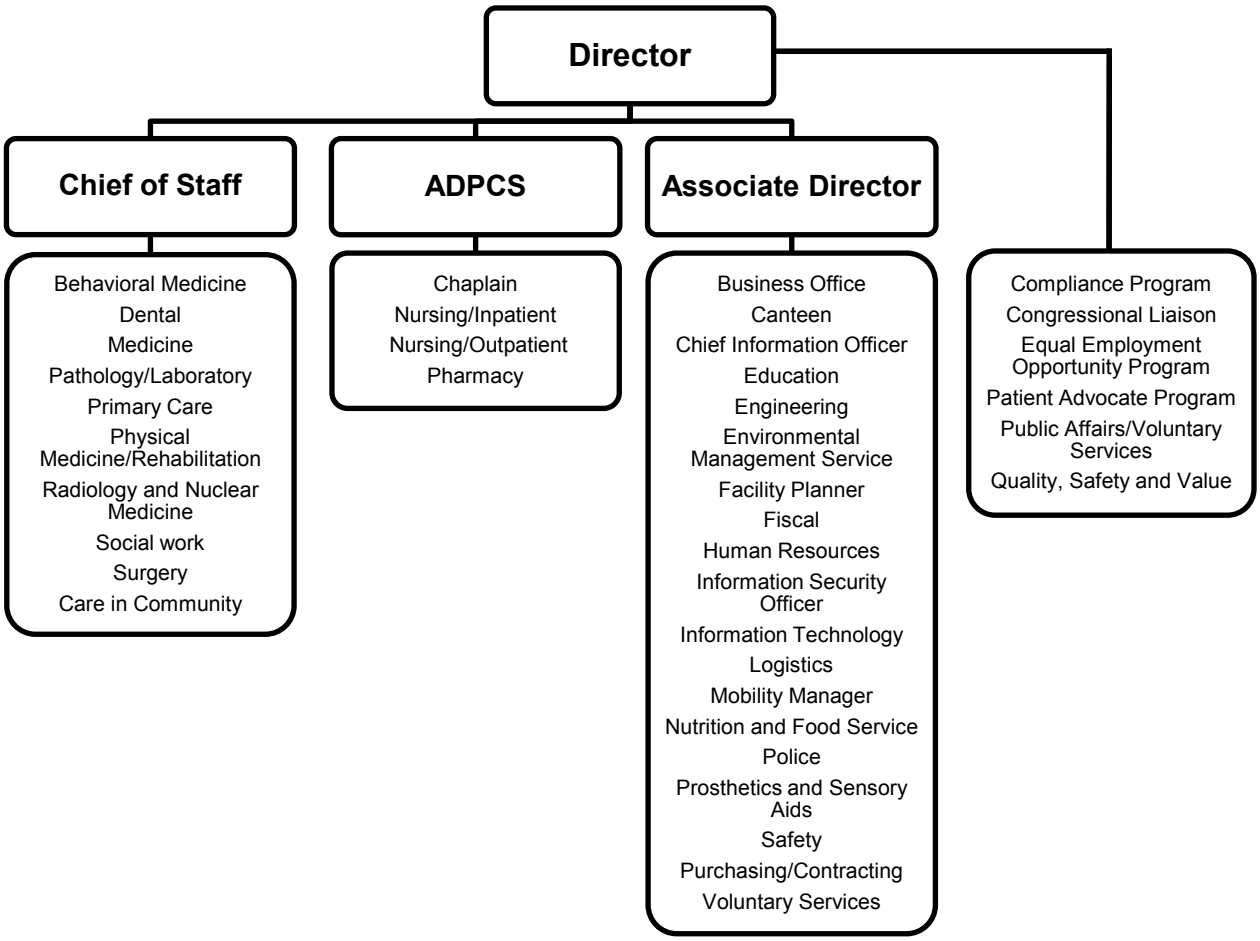

Figure 3. *Facility Organizational Chart*[12]
Source: Eastern Oklahoma VA Health Care System (received December 10, 2018)

Two of the executive team members had been in their positions over a year, but at the time of the OIG site visit, the leadership team had only been working together for one month (see Table 1).

[12] At this facility, the director is responsible for the Compliance Program; Congressional Liaison; Equal Employment Opportunity Program; Patient Advocate Program; Public Affairs/Voluntary Services; and Quality, Safety and Value.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	June 12, 2016
Chief of staff	June 24, 2018 (acting) and November 25, 2018 (permanently)
Associate director for Patient Care Services	October 21, 2018 (acting)
Associate director	April 30, 2017

Source: Eastern Oklahoma VA Health Care System human resources officer (received December 10, 2018)

To help assess facility executive leaders' engagement, the OIG interviewed the director, chief of staff, ADPCS, and associate director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders were generally knowledgeable within their scope of responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed in greater detail below.

The director serves as the chairperson of the Executive Governing Board, with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Governing Board also oversees various working groups, such as the Organizational Health Committee, Medical Executive Committee, and Administrative Executive Board.

The leaders are also engaged in monitoring patient safety and care through the Quality Safety Value Committee, for which the director services as the chairperson. The Quality Safety Value Committee is responsible for tracking, trending, and monitoring quality of care and patient outcomes and reports to the Executive Governing Board. See Figure 4.

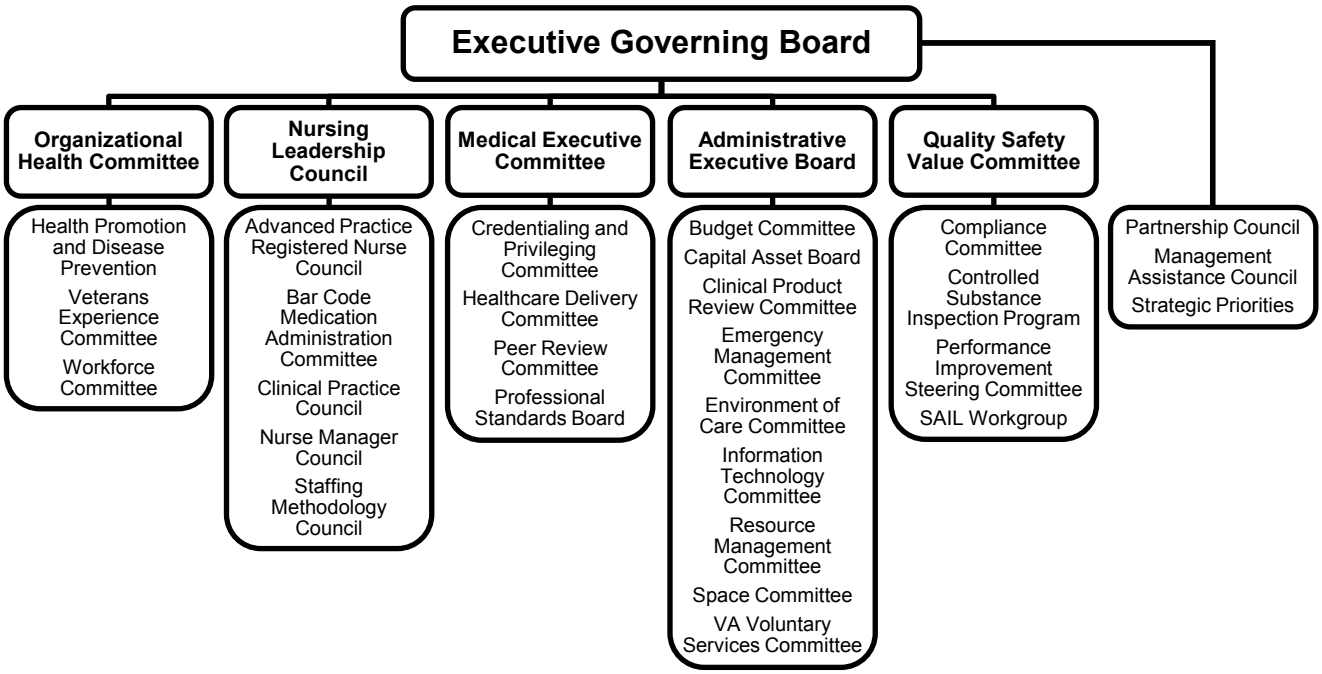

Figure 4. *Facility Committee Reporting Structure*[13]
Source: Eastern Oklahoma VA Health Care System (December 10, 2018)

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on facility leadership.

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2017, through September 30, 2018.[14] Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA's All Employee Survey. The OIG found the facility average for selected survey questions was below the VHA average.[15] Specifically, the director and associate director scores were consistently

[13] The Executive Governing Board directly oversees the Partnership Council, Management Assistance Council, and Strategic Priorities.

[14] Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPCS, and associate director.

[15] The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

above the VHA average while those for the chief of staff were consistently lower than the facility and VHA averages. These scores were likely reflective of the previous chief of staff.

Table 2. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*[16]	0–100 where HIGHER scores are more favorable	71.7	70.4	76.0	45.0	89.5	77.7
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.2	3.7	2.7	3.3	4.0
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.3	3.7	3.2	3.0	4.1
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.3	3.7	2.6	3.0	4.0

Source: VA All Employee Survey (accessed November 9, 2018)

[16] According to the 2018 VA All Employee Survey Questions by Organizational Health Framework, Servant Leader Index "is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others' contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others' needs before their own."

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the facility averages for the selected survey questions were generally similar to the VHA average. Results for the chief of staff were consistently worse than the VHA averages. Further, except for the associate director, the leaders' averages were worse than the VHA and facility averages related to employees experiencing moral distress at work. Opportunities appear to exist for the leaders to provide a safe workplace environment where employees feel comfortable with bringing forth issues or ethical concerns, and the leaders verbalized ongoing efforts to improve the culture of the organization.

Table 3. Survey Results on Employee Attitudes toward the Workplace (October 1, 2017, through September 30, 2018)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.6	3.9	3.4	4.8	4.2
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.7	4.2	3.3	4.2	4.1

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never) – 6 (Every Day)	1.5	1.5	1.7	1.9	2.1	1.2

Source: VA All Employee Survey (accessed November 9, 2018)

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through July 31, 2018. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.[17]

VHA also collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients' attitudes toward facility leaders (see Table 4). For this facility, three of four patient survey results reflected higher care ratings than the VHA average. Patients appear generally satisfied with the leadership and care provided, and facility leaders appeared to be actively engaged with patients.

[17] Ratings are based on responses by patients who received care at this facility.

Table 4. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2017, through July 31, 2018)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.9	68.2
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	84.2	84.4
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.1	76.3
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	76.3	75.2

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 9, 2018)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.[18] Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).[19] During the on-site review, the OIG noted that the most recent OIG

[18] The Joint Commission (TJC) conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.

[19] According to VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017, TJC provides an "internationally accepted external validation that an organization has systems and processes in place to provide safe and quality-oriented health care." TJC "has been accrediting VA medical facilities for over 35 years." Compliance with TJC standards "facilitates risk reduction and performance improvement."

Healthcare Inspection report had one open recommendation.[20] The chief of Quality, Safety and Value (QSV) Service has been monitoring the facility's progress and demonstrated that steps are being taken toward closing the recommendation.

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and College of American Pathologists.[21]

Table 5. Office of Inspector General Inspections/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma, Report No. 16-00102-253, April 13, 2016*)	January 2016	10	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma, Report No. 16-00011-259, April 14, 2016*)	January 2016	14	0
OIG (*Healthcare Inspection – Clinical Activities, Staffing, and Administrative Practices, Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma, Report No. 16-02676-297, July 10, 2017*)	May 2016	19	1
TJC Hospital Accreditation TJC Behavioral Health Care Accreditation TJC Home Care Accreditation TJC Follow Up (Hospital Accreditation)	March 2017 June 2017	31 0 2 2	0 0 0 0

[20] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

[21] According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs; According to the College of American Pathologists, for 70 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." College of American Pathologists. https://www.cap.org/about-the-cap. (The website was accessed on February 20, 2019.); In accordance with VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

Sources: OIG and TJC (Inspection/survey results verified with the quality manager on December 13, 2018)

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from January 30, 2016 (the prior comprehensive OIG inspection), through December 14, 2018.[22]

Table 6. Summary of Selected Organizational Risk Factors (January 30, 2016, through December 14, 2018)

Factor	Number of Occurrences
Sentinel Events[23]	10
Institutional Disclosures[24]	10
Large-Scale Disclosures[25]	0

Source: Eastern Oklahoma VA Health Care System's patient safety manager (received December 13, 2018)

The OIG also reviewed patient safety indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and

[22] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Eastern Oklahoma VA Health Care System is a mid-high complexity (1c) affiliated facility as described in Appendix B.)

[23] The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

[24] According to VHA Directive 1004.08, *Disclosure of Adverse Events To Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or [his or her] personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."

[25] According to VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

procedures.[26] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 7 summarizes patient safety indicator data from July 1, 2016, through June 30, 2018.

Table 7. Patient Safety Indicator Data (July 1, 2016, through June 30, 2018)

Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 19	Facility
Pressure ulcer	0.76	0.63	1.08
Death among surgical inpatients with serious treatable conditions	114.89	90.91	166.67
Iatrogenic pneumothorax[27]	0.15	0.14	0.00
Central venous catheter-related bloodstream infection	0.16	0.04	0.00
In-hospital fall with hip fracture	0.09	0.12	0.00
Perioperative hemorrhage or hematoma	2.59	3.63	3.64
Postoperative acute kidney injury requiring dialysis	0.96	1.22	0.00
Postoperative respiratory failure	4.88	6.09	11.11
Perioperative pulmonary embolism or deep vein thrombosis	3.05	2.16	3.48
Postoperative sepsis	3.70	4.85	0.00
Postoperative wound dehiscence (rupture along incision)	0.93	0.47	0.00
Unrecognized abdominopelvic accidental puncture or laceration	1.07	2.05	0.00

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.

The patient safety indicator measure for pressure ulcer, death among surgical inpatients with serious treatable conditions, perioperative hemorrhage or hematoma, postoperative respiratory failure, and perioperative pulmonary embolism or deep vein thrombosis (DVT) show a higher reported rate than VISN 19 and VHA.

Three patients developed pressure ulcers. Facility managers met with the staff caring for the veterans to provide wound care education as each occurrence was identified. During the review

[26] Agency for Healthcare Research and Quality. https://www.qualityindicators.ahrq.gov/. (The website was accessed on December 11, 2017.)

[27] According to Northwestern Memorial Hospital, "A Pneumothorax is a type of lung injury that allows air to leak into the area between the lungs and the chest wall, which causes mild to severe chest pain and shortness of breath. An Iatrogenic Pneumothorax is one which was caused by medical treatment, often as an incidental event during a procedure such as a pacemaker insertion." Northwestern Medicine. http://www.nmh.org/nm/quality-lung-injury-due-to-medical-care. (The website was accessed on March 6, 2019.)

of the patients' care, managers also found that clinicians' documentation of wound care was inconsistent and discharge summaries had inaccurate information. The Wound Care Team discussed each item with nurse managers, clinical staff, and providers. Additionally, the performance measures coordinator initiated a weekly complications workgroup to track the indicator.

A single patient experienced death among surgical inpatients with a serious treatable condition. Facility managers noted that the patient's care was discussed in the Facility Surgical Workgroup, and the VA Surgical Quality Improvement Program coordinator tracked data for discussion. No improvement actions were identified related to the patient's care.

A single patient experienced perioperative hemorrhage or hematoma. Facility managers noted that the patient's care was discussed in the Facility Surgical Workgroup and the VA Surgical Quality Improvement Program coordinator tracked data for discussion. No improvement actions were identified related to the patient's care.

A single patient was identified with postoperative respiratory failure. Facility managers noted that the patient's care was reviewed. No improvement actions were identified.

A single patient was identified with a postoperative pulmonary embolism or DVT. Facility managers noted that the patient's care was discussed care in the Facility Surgical Workgroup and the VA Surgical Quality Improvement Program coordinator tracked data for discussion. The review of the patient's care found that appropriate preventative care had been administered.

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes "measures on healthcare quality, employee satisfaction, access to care, and efficiency." It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to "understand the similarities and differences between the top and bottom performers" within VHA.[28]

VA also uses a star-rating system where facilities with a "5-star" rating are performing within the top 10 percent of facilities and "1-star" facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.[29] As of June 30, 2018, the facility was rated as "2-star" for overall quality.

[28] VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model, http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

[29] According to the methods established by the SAIL Model, this is based on normal distribution ranking of the quality domain for 130 VA Medical Centers.

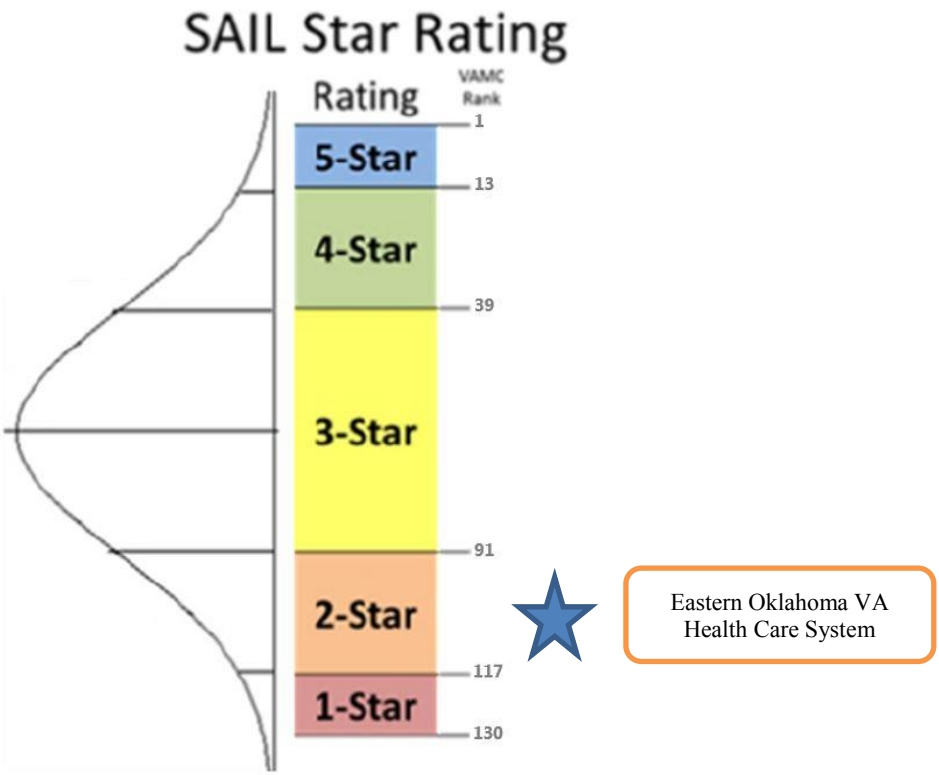

Figure 5. *Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)*
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed November 9, 2018)

Figure 6 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of June 30, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of admit reviews met, capacity, and healthcare (HC) associated (Assoc) infections).[30] Metrics that need improvement are denoted in orange and red (for example, care transition, best place to work, complications, and call responsiveness).

[30] For data definitions of acronyms in the SAIL metrics, please see Appendix D.

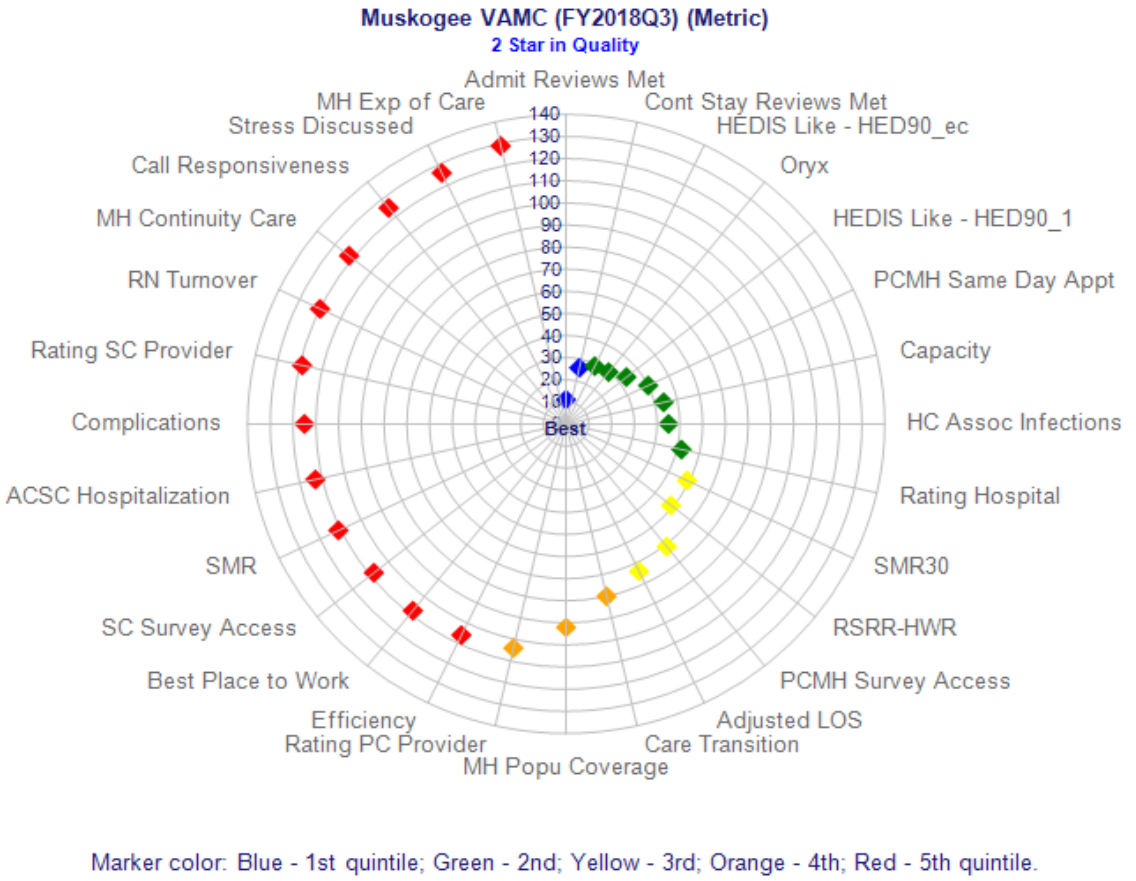

Figure 6. *Facility Quality of Care and Efficiency Metric Rankings (as of June 30, 2018)*
Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

Leadership and Organizational Risks Conclusion

The OIG noted that the facility's executive leadership team had only worked together for one month at the time of the site visit and that the ADPCS position was not permanently assigned. Selected survey scores related to employee satisfaction and trust in the facility's executive leaders highlighted opportunities related to the leaders, and especially, the chief of staff, to provide a safe workplace environment where employees feel comfortable with bringing forth issues or ethical concerns. In review of patient experience survey data, patients appear generally satisfied with the leadership and care provided. Facility leaders were actively working to improve employee and patient engagement and satisfaction. Organizational leaders need to focus on and support efforts related to patient safety, quality care, and other positive outcomes. The presence of organizational risk factors, as evidenced by sentinel events, disclosures, and patient safety indicator data, may contribute to future issues of noncompliance and/or lapses in patient

safety unless corrective processes are implemented and continuously monitored. The leadership team was knowledgeable within their scope of responsibility about selected SAIL metrics but should take actions to improve care and performance of selected metrics that are likely contributing to the SAIL "2-star" quality rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.[31] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[32] VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.[33]

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's Enterprise Framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,[34] utilization management (UM) reviews,[35] patient safety incident reporting with related root cause analyses,[36] and cardiopulmonary resuscitation (CPR) episode reviews.[37]

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and

[31] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 and has not been recertified.)

[32] Department of Veterans Affairs, Veterans Health Administration Blueprint for Excellence, September 2014.

[33] VHA Directive 1026.

[34] The definition of a peer review can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a critical review of care, performed by a peer, to evaluate care provided by a clinician for a specific episode of care, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements.

[35] According to VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria." This directive was in effect at the time of the review but was replaced by VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019). This directive expired on July 31, 2019.

[36] The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA Handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

[37] VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.[38]

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.[39]

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.[40]

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR Committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.[41]

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[42]

- Protected peer reviews
    - Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
    - Implementation of improvement actions recommended by the Peer Review Committee
    - Completion of final reviews within 120 calendar days

[38] VHA Directive 1190.

[39] VHA Directive 1117(2).

[40] VHA Handbook 1050.01.

[41] VHA Directive 1177; VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, January 11, 2017.

[42] For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

  - Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee
  - Peer review of all applicable deaths within 24 hours of admission to the hospital
  - Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[43]
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Annual completion of a minimum of eight root cause analyses[44]
  - Inclusion of required content in root cause analyses (generally)
  - Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report to facility leaders
- Resuscitation episode review
  - Evidence of a committee responsible for reviewing resuscitation episodes
  - Confirmation of actions taken during resuscitative events being consistent with patients' wishes
  - Evidence of basic or advanced cardiac life support certification for code team responders
  - Evaluation of each resuscitation episode by the CPR Committee or equivalent

[43] VHA Directive 1190.

[44] According to VHA Handbook 1050.01, "the requirement for a total of eight [root cause analyses] and Aggregated Reviews is a minimum number, as the total number of [root cause analyses] is driven by the events that occur and the [Safety Assessment Code] SAC score assigned to them. At least four analysis per fiscal year must be individual [root cause analyses], with the balance being Aggregated Reviews or additional individual [root cause analyses]."

Quality, Safety, Value Conclusion

Generally, the facility met requirements with the above performance indicators. The OIG made no recommendations.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of all healthcare professionals who are permitted by law and the facility to practice independently—"without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges." These healthcare professionals are also referred to as licensed independent practitioners (LIPs).[45]

Clinical privileges need to be specific, based on the individual's clinical competence. They are recommended by service chiefs and the Medical Staff Executive Committee and approved by the director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to their expiration.[46]

VHA defines the focused professional practice evaluation (FPPE) as "a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance. The FPPE typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges." "The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation[s] (OPPE), [are] essential to confirm the quality of care delivered."[47]

According to TJC, the "FPPE for Cause" should be used when a question arises regarding a privileged provider's ability to deliver safe, high-quality patient care. The "FPPE for Cause" is limited to a particular time frame and customized to the specific provider and related clinical concerns.[48] Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.[49]

To determine whether the facility complied with requirements for privileging, the OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members:

[45] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This VHA Handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

[46] VHA Handbook 1100.19.

[47] VHA Handbook 1100.19.

[48] Office of Safety and Risk Awareness, Office of Quality and Performance, Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance, July 2016 (Revision 2).

[49] VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009. (This VHA Handbook was scheduled for recertification on or before the last working date of December 2014 and has not been recertified.)

- Three solo few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months[50]
- Ten LIPs hired within 18 months before the site visit
- Twenty LIPs re-privileged within 12 months before the visit
- Three providers who underwent a FPPE for Cause within 12 months prior to the visit

The OIG evaluated the following performance indicators:

- Privileging
  - Privileges requested by the provider
    - Facility-specific
    - Service-specific
    - Provider-specific[51]
  - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
  - Criteria defined in advance
  - Use of required criteria in FPPEs for selected specialty LIPs
  - Results and time frames clearly documented
  - Evaluation by another provider with similar training and privileges
  - Medical Staff Executive Committee consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
  - Criteria specific to the service or section
  - Use of required criteria in OPPEs for selected specialty LIPs

[50] The 18-month period was from June 10, 2017, through December 10, 2018. The 12-month review period covered December 10, 2017, through December 10, 2018; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers "few practitioners" as being fewer than three providers in the facility that are privileged in a particular specialty.

[51] According to VHA Handbook 1100.19, facility-specific means that privileges are granted only for procedures and types of services performed at the facility; service-specific refers to privileges being granted in a specific clinical service, such as neurology; and provider-specific means that the privileges should be granted to the individual provider based on their clinical competence and capabilities.

  - Service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities
  - Evaluation by another provider with similar training and privileges
  - Medical Staff Executive Committee's decision to recommend continuing privileges based on OPPE results
- Focused professional practice evaluations for cause
  - Clearly defined expectations/outcomes
  - Time-limited
  - Provider's ability to practice independently not limited for more than 30 days
  - Shared with the provider in advance
- Reporting of privileging actions to National Practitioner Data Bank

Medical Staff Privileging Conclusion

The OIG found general compliance with requirements for privileging. However, the OIG found evidence that solo practitioners were not evaluated by providers with similar training. Also, the OIG found that time limits were not delineated in FPPEs and providers were not notified of FPPEs for cause.

Specifically, VHA requires ongoing monitoring of privileged practitioners. Activities such as periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients can be included into the ongoing monitoring process. Data must be service and practitioner specific, reliable, easily retrievable, timely, justifiable, comparable, and risk adjusted where appropriate.[52] This OPPE process is essential to confirm the quality of care delivered.

VHA also requires another provider with similar training and privileges to evaluate the privilege-specific competence of the practitioner and document evidence of competently performing the requested privileges of the facility.[53]

The OIG reviewed three solo practitioners' OPPE profiles and found that two (an ophthalmologist and otolaryngologist) were reviewed by a provider who did not have similar training. This resulted in LIPs providing care without a thorough evaluation of their competency, which could potentially impact the quality of care and patient safety. The chief of staff reported that clinical managers had been educated about the requirement for providers with similar training to conduct privilege-specific competence evaluations for solo practitioners and was

[52] VHA Handbook 1100.19.

[53] VHA Memorandum, Requirements for Peer Review of Solo Practitioners, August 29, 2016.

unaware the solo practitioners were not reviewed by providers with similar training. During the OIG site visit, the chief of staff contacted the VISN for guidance to develop a corrective action plan.

Recommendation 1

1. The chief of staff makes certain that ongoing professional practice evaluations are completed by providers with similar training and privileges and monitors compliance.

Facility concurred.

Target date for completion: December 2019

Facility response: The Chief of Staff makes certain that Ongoing Professional Practice Evaluations are completed by providers with similar training. August 2019, Memorandums of Understanding were completed to ensure a provider with similar training and privileges evaluates privilege specific competence requirements for Ongoing professional Practice Evaluations. Requirement will be audited for six months for 90% compliance and reported quarterly to the Medical Executive Committee. Status: Implementation of this recommendation remains in progress.

VHA requires that all LIPs new to the facility have FPPEs completed and "documented in the practitioner's provider profile and reported to an appropriate committee of the Medical Staff."[54] The process involves the evaluation of privilege-specific competence of the practitioner who has not had "documented evidence of competently performing the requested privileges." FPPEs may include "periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients."[55] VHA also requires that FPPEs be time-limited. Time limitations help to ensure an efficient process by preventing undefined or indefinite evaluation of providers.[56]

For 4 of 10 profiles reviewed, the OIG found that FPPE time frames were not clearly defined. This is potentially inefficient and leaves the LIPs unclear about the time frame for the evaluation period. Clinical managers were unaware that FPPEs' are required to have time limitations. During the OIG site visit, the chief of staff reported that clearly defined time frames will be established, and FPPE forms will be modified to reflect this change in practice.

[54] VHA Handbook 1100.19.
[55] VHA Handbook 1100.19.
[56] VHA Handbook 1100.19.

Recommendation 2

2. The chief of staff makes certain that all focused professional practice evaluations include clearly defined time limitations and monitors compliance.

Facility concurred.

Target date for completion: December 2019

Facility response: The Focused Professional Practice Evaluation forms were updated to include clearly defined time limitations. Requirement will be audited for six months for 90% compliance and reported quarterly to the Medical Executive Committee. Status: Implementation of this recommendation remains in progress.

VHA requires FPPEs for cause to have clearly defined expectations and outcomes that are accepted by the provider in advance of the evaluation.[57] For two of three completed FPPEs for cause, the OIG found that expectations and outcomes were not shared with the providers in advance. Failure to clearly define expectations and outcomes can hinder the provider's clinical ability for improvement. The chief of staff stated awareness of the requirement but did not monitor clinical managers' documentation to ensure compliance. Also, the chief of staff reported that staff were updating forms at the time of the OIG site visit to allow for monitoring of compliance.

Recommendation 3

3. The chief of staff confirms that clinical managers share in advance the expectations and outcomes for focused professional practice evaluations for cause with providers and monitors clinical managers' compliance.

Facility concurred.

Target date for completion: December 2019

Facility response: The Chief of Staff or designee confirms all clinical managers share, in advance, the expectations and outcome for Focused Professional Practice Evaluations for cause. Requirement will be audited for six months for 90% compliance and reported quarterly to the Medical Executive Committee. Status: Implementation of this recommendation remains in progress.

[57] Office of Quality and Performance, "Provider Competency and Clinical Care Concerns," July 2016 (Revision 2).

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[58]

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.[59]

VHA requires its facilities to have the "capacity for [providing] mental health services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting;" however, for facilities that do not have inpatient mental health services, that "capacity" could mean facilitating care at a nearby VA or non-VA facility.[60]

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities' efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.[61] Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,

[58] VHA Directive 1608, Comprehensive Environment of Care (CEOC Program), February 1, 2016.

[59] Applicable requirements for high-risk areas and emergency management include those detailed in or by various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

[60] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (This VHA Handbook was scheduled for recertification on or before the last working date of September 2018 and has not been recertified.)

[61] VHA Directive 0320.01, Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures, April 6, 2017.

Occupational Safety and Health Administration,[62] and National Fire Protection Association standards.[63] The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.[64]

In all, the OIG team inspected 12 areas—medical/surgical 4E and 4W, rehabilitation 5W, intensive care, mental health, and post-anesthesia care units; emergency department; and women's health, primary care, endoscopy, specialty care (gold) and specialty care (silver) clinics. The team also inspected the McCurtain County VA Clinic and reviewed the emergency management program. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Community based outpatient clinic
  - General safety
  - Environmental cleanliness and infection prevention
  - General privacy
  - Women veterans program
  - Availability of medical equipment and supplies
- Locked inpatient mental health unit
  - Mental health environment of care rounds
  - Nursing station security

[62] The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA's Mission is to assure safe and healthy working conditions "by setting and enforcing standards and by providing training, outreach, education, and assistance." https://www.osha.gov/about.html. (This website was accessed on June 28, 2018.)

[63] The National Fire Protection Association (NFPA) is a global nonprofit organization "devoted to eliminating death, injury, property, and economic loss due to fire, electrical, and related hazards." https://www.nfpa.org/About-NFPA. (This website was accessed on June 28, 2018.)

[64] TJC. Environment of Care standard EC.02.05.07.

- Public area and general unit safety
- Patient room safety
- Infection prevention
- Availability of medical equipment and supplies

- Emergency management
  - Hazard vulnerability analysis (HVA)
  - Emergency operations plan (EOP)
  - Emergency power testing and availability

Environment of Care Conclusion

Generally, the facility met cleanliness and safety requirements associated with the above performance indicators. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified an infection prevention concern related to the storage of clean and sterile supplies that warranted a recommendation for improvement.

Specifically, VHA requires environmental control and inventory management procedures to minimize the risk of cross-contamination when storing clean or sterile supplies. Shipping cartons may harbor microorganisms and are considered contaminated. Clean or sterile packaged items must not be stored in shipping cartons or corrugated boxes and must be removed from these containers before being brought into clean or sterile storage.[65,66] The OIG found corrugated shipping containers shelved with clean and sterile supplies in five patient care units.[67] This could present the potential risk for cross-contamination of patient care supplies. Unit supervisors were unaware that clean and sterile supplies remained in corrugated containers after delivery to patient care units.

Recommendation 4

4. The associate director confirms that unit supervisors remove clean and sterile packaged items from shipping cartons and corrugated boxes prior to stowing in clean or sterile storage areas and monitors unit supervisors' compliance.

[65] VHA Directive 1116(2), *Sterile Processing Services,* March 23, 2016.
[66] VHA Directive 1761(2), *Supply Chain Inventory Management,* October 24, 2016.
[67] Medical/surgical 4E and 4W, rehabilitation 5W, women's health clinic, and specialty care (gold clinic).

Facility concurred.

Target date for completion: December 2019

Facility response: The Associate Director or designee monitors unit supervisor's compliance with removing clean and sterile packaged items from shipping cartons and corrugated boxes prior to stowing in clean or sterile areas. Audits occur weekly during environment of care rounds. Findings of cardboard or shipping containers within clean or sterile storage areas are immediately corrected. The staff within the department of the finding receive Just in Time training. Requirement will be tracked for six months for 90% compliance and reported monthly to the Environment of Care Committee. Status: Implementation of this recommendation remains in progress.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.[68] Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.[69]

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.[70]

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for the prior two completed quarters;[71] and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
  - Monthly summary of findings to the director
  - Quarterly trend reports to the director
  - Quality Management Committee's review of monthly and quarterly trend reports
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Staff restrictions for monthly review of balance adjustments[72]
- Requirements for controlled substances inspectors

[68] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (The website was accessed on March 7, 2019.)

[69] American Society of Health-System Pharmacists, "ASHP Guidelines on Preventing Diversion of Controlled Substances," *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

[70] VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

[71] The two quarters were from April 1, 2018, through September 30, 2018.

[72] Controlled substances balance adjustment reports list transactions in which the pharmacy vault inventory balance was manually adjusted.

  - No conflicts of interest
  - Appointed in writing by the director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required annual competency assessment
- Controlled substances area inspections
  - Completion of monthly inspections
  - Rotations of controlled substances inspectors
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of controlled substances orders
  - Performance of routine controlled substances inspections
- Pharmacy inspections
  - Monthly physical counts of the controlled substances in the pharmacy
  - Completion of inspections on day initiated
  - Security and verification of drugs held for destruction[73]
  - Accountability for all prescription pads in pharmacy
  - Verification of hard copy controlled substances prescriptions
  - Verification of 72-hour inventories of the main vault
  - Quarterly inspections of emergency drugs
  - Monthly checks of locks and verification of lock numbers
- Facility review of override reports[74]

[73] According to VHA Directive 1108.02(1), The Destructions File Holding Report "lists all drugs awaiting local destruction or turn-over to a reverse distributor." Controlled substances inspectors "must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report."

[74] When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists' review of medications ordered by the providers.

Medication Management Conclusion

Generally, the facility met requirements with the above performance indicators. The OIG made no recommendations.

Mental Health: Military Sexual Trauma Follow-Up and Staff Training

The Department of Veterans Affairs uses the term "military sexual trauma" (MST) to refer to a "psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training."[75] MST is an experience, not a diagnosis or a mental health condition. Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.[76]

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.[77] Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.[78]

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system.[79] Those who screen positive must have access to appropriate MST-related care.[80] VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.[81]

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.[82] All mental health and primary care providers must complete MST mandatory

[75]VHA Directive 1115, Military Sexual Trauma (MST) Program, May 8, 2018.

[76]Military Sexual Trauma. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. (The website was accessed on November 17, 2017.)

[77] VHA Directive 1115.

[78] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008 (amended November 16, 2015). (This VHA Handbook was scheduled for recertification on or before the last working date of September 2013 and has not been recertified.)

[79]VHA Directive 1115 states that "MST-related care is not subject to the minimum active duty service requirement set forth in 38 U.S.C. 5303A; Veterans may therefore be able to receive MST-related care even if they are not eligible for VA health care under other treatment authorities."

[80]VHA Directive 1115.

[81] VHA Handbook 1160.01.

[82] VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[83]

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 49 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Designated facility MST coordinator
  - Establishes and monitors MST-related staff training
  - Establishes and monitors informational outreach
  - Communicates MST-related issues, services, and initiatives with local leaders
- Evidence of tracking MST-related data
- Provision of clinical care
  - Referral for MST-related care to patients with positive MST screens
  - Initial evaluation within 24 hours of referral for mental health services
  - Comprehensive diagnostic and treatment planning evaluation within 30 days of referral for mental health services
- Completion of MST mandatory training requirement for mental health and primary care providers

Mental Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including the designation of an MST coordinator and documentation of MST referrals. However, the OIG noted concerns with the lack of (1) communication of MST services and initiatives to facility leadership, (2) tracking and monitoring MST-related data, and (3) completion of training by providers that warranted recommendations for improvement.[84]

[83] VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017; Acting Deputy Under Secretary for Health for Operations and Management Memorandum, Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers, February 2, 2016.

[84] VHA Directive 1115.01.

Specifically, VHA requires that the MST coordinator communicates MST-related issues, services, and initiatives to facility leadership.[85] The OIG reviewed facility processes and documentation, including five months of the MST coordinator minutes, and did not find evidence that MST issues, services, and initiatives were communicated to facility leaders.[86] The lack of communication between the MST coordinator and facility leaders impacts the latter's awareness of the current status of MST-related services and initiatives. Because program information is monitored nationally, the MST coordinator thought that facility efforts met requirements.

Recommendation 5

5. The facility director ensures the military sexual trauma coordinator communicates the status of military sexual trauma-related information to leadership and monitors coordinator's compliance.

Facility concurred.

Target date for completion: October 2019

Facility response: The Facility Director ensures the Military Sexual Trauma Coordinator communicates the status of military sexual trauma-related information to leadership. Requirement will be monitored for six months for 100% compliance and reported quarterly to the Medical Executive Committee. Status: Implementation of this recommendation remains in progress.

VHA requires that accurate documentation of MST screening, referral, and treatment be maintained and aggregated by gender.[87] This process includes use of the MST software and the MST clinical reminder to track and monitor the level of compliance with the standard of screening all enrolled veterans.[88] The OIG noted that the facility maintains an MST dashboard, however, data are not monitored. Failure to monitor the level of compliance with the screening of all enrolled veterans may hinder the facility from improving its care for patients with MST. The chief of Behavioral Medicine Service and the MST coordinator believed the facility's efforts to maintain an MST dashboard met the requirement.

[85] VHA Directive 1115.

[86] January, February, March, June, and October 2018.

[87] VHA Handbook 1160.01.

[88] VHA Handbook 1160.01.

Recommendation 6

6. The facility director ensures that the military sexual trauma coordinator tracks and monitors the screening, referral, and treatment services provided to veterans and monitors coordinator's compliance.

Facility concurred.

Target date for completion: October 2019

Facility response: The Facility Director or designee ensures the Military Sexual Trauma Coordinator reports the screening, referral, and treatment services provided to Veterans to the Medical Executive Committee quarterly. Requirement will be monitored for six months for 100% compliance and reported quarterly to the Medical Executive Committee. Status: Implementation of this recommendation remains in progress.

VHA also requires that all primary care and mental health providers complete the MST mandatory training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.[89] The OIG found that for those hired after July 1, 2012, 3 of 16 did not complete training within 90 days of their hire date and 6 of 16 did not complete training at all. This could potentially prevent clinicians from providing a consistent level of counseling, care, and service to veterans who experienced MST. The MST coordinator and chief of QSV reported lack of oversight as a reason for noncompliance.

Recommendation 7

7. The facility director confirms that providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: October 2019

Facility response: The Facility Director or designee confirms that providers complete mandatory Military Sexual Trauma training within the required timeframe. Onboarding processes of all new employees have been revised to incorporate Military Sexual Trauma Training. Requirement will be monitored for six months for 90% compliance and reported quarterly to the Medical Executive Committee. Status: Implementation of this recommendation remains in progress.

[89] VHA Directive 1115.01; Acting Deputy Under Secretary for Health for Operations and Management, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."[90] The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.[91]

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepression drugs, psychotherapy, or a combination of both."[92]

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.[93] The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."[94] In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.[95] Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.[96] The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

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[90] Hans Peterson, "Late Life Depression," *U.S. Department of Veterans Affairs*, Mental Health Featured Article, March 1, 2011. https://www.mentalhealth.va.gov/featureArticle_Mar11LateLife.asp. (The website was accessed on March 8, 2019.)

[91] VA/DoD *Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf. (The website was accessed November 20, 2018.)

[92] Centers for Disease Control and Prevention, "Depression is Not a Normal Part of Growing Older," January 31, 2017. https://www.cdc.gov/aging/mentalhealth/depression.htm. (The website was accessed on March 8, 2019.)

[93] American Geriatrics Society 2015 Beers Criteria Update Expert Panel, "American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." http://www.sigot.org/allegato_docs/1057_Beers-Criteria.pdf. (The website was accessed on March 22, 2018.)

[94] TJC. Provision of Care, Treatment, and Services standard PC.02.03.01.

[95] VHA Directive 1164, Essential Medication Information Standards, June 26, 2015.

[96] TJC. National Patient Safety Goal standard NPSG.03.06.01.

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.[97]

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 41 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.[98] The OIG evaluated the following performance indicators:

- Justification for medication initiation
- Evidence of patient and/or caregiver education specific to the medication prescribed
- Clinician evaluation of patient and/or caregiver understanding of the education provided
- Medication reconciliation

Geriatric Care Conclusion

Generally, the OIG found compliance with many of the performance indicators, including documenting justification for initiating the antidepressant medication. However, the OIG found noncompliance with patient/caregivers' education specific to the newly prescribed antidepressant and medication reconciliation performed relevant to the episode of care, which warranted recommendations for improvement.

Specifically, TJC requires that clinicians educate patients and families about "safe and effective use of medications."[99] The OIG estimated that clinicians provided this education to 7 percent of the patients in the facility, based on electronic health records reviewed.[100] Providing medication education is critical to ensuring that patients or their caregivers have the information they need to manage their own health at home.[101] The chief of Pharmacy was aware of the need for documenting the required medication education elements; however, the chiefs of Primary Care and Home-Based Primary Care along with a QSV representative reported that some prescribing providers were unaware of the elements.

[97] VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.

[98] The seven selected antidepressant medications are Amitriptyline, Clomipramine, Desipramine, Doxepin (>6mg/day), Imipramine, Nortriptyline, and Paroxetine.

[99] TJC. Medication Management standard PC.02.03.01.

[100] The OIG is 95 percent confident that the true compliance rate is somewhere between 0.0 and 16.3 percent, which is statistically significantly below the 90 percent benchmark.

[101] VHA Directive 1164.

Recommendation 8

8. The chief of staff makes certain that clinicians provide education to the patient and/or caregiver about the risks/benefits, potential interactions, and side effects of newly prescribed medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: January 2020

Facility response: The Chief of Staff or designee will ensure clinicians provide education to patient and/or caregiver about the risks/benefits, potential interactions, and side effects of newly prescribed geriatric antidepressant medications. Requirement will be audited for six months for 90% compliance and reported to the Medical Executive Committee. Status: Implementation of this recommendation remains in progress.

According to TJC, "In medication reconciliation, a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolve any discrepancies.[102] VHA requires that clinicians review and reconcile medications relevant to the episode of care.[103] TJC also requires patients' "medical records contain information that reflects the patient's care, treatment, and services."[104]

The OIG estimated that providers performed medication reconciliation for 73 percent of the patients at the facility, based on electronic health records reviewed.[105] Failure to maintain and communicate accurate patient medication information and reconcile medications increases the risk that there may be duplications, omissions, and interactions in the patient's actual drug regimen.[106] The chiefs of Primary Care and Home-Base Primary Care reported the clinicians' inconsistent documentation of medication reconciliation was due to lack of oversight as the reason for noncompliance.

Recommendation 9

9. The chief of staff ensures clinicians maintain and communicate accurate patient medication information in patients' electronic health record and reconcile medications and monitors clinicians' compliance.

[102] TJC. National Patient Safety Goal standard NPSG.03.06.01.

[103] VHA Directive 1164.

[104] TJC. Record of Care, Treatment, and Services standard RC.02.01.01.

[105] The OIG is 95 percent confident that the true compliance rate is somewhere between 58.9 and 86.6 percent, which is statistically significantly below the 90 percent benchmark.

[106] TJC. National Patient Safety Goal standard NPSG.03.06.01.

Facility concurred.

Target date for completion: January 2020

Facility response: The Chief of Staff or designee will ensure clinicians perform a complete and accurate medication reconciliation for newly prescribed geriatric antidepressants. Requirement will be audited for six months for 90% compliance and reported quarterly to the Medical Executive Committee. Status: Implementation of this recommendation remains in progress.

Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.[107] Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.[108] In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.[109] Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.[110]

VA is authorized to provide "gender-specific services, such as Papanicolaou tests (Pap smears)," to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.[111]

VHA requires that each facility have a "full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health care." VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women's health program. Each facility must also have a "Women Veterans Health Committee (WVHC) comprised of appropriate facility leaders and program directors, which develops and implements a Women's Health Program strategic plan." The Women Veterans Health Committee must meet at least quarterly and report to the executive leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.[112]

VHA has established time frames for notifying patients of abnormal cervical pathology results. Abnormal cervical pathology results must be communicated to patients within seven calendar days from the date the results are available to the ordering provider. Communication of the

[107] Centers for Disease Control and Prevention. "Cervical Cancer" *Inside Knowledge* fact sheet, December 2016. https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf. (The website was accessed on February 28, 2018.)
[108] Center for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)
[109] Centers for Disease Control and Prevention. *What Are the Risk Factors for Cervical Cancer?* February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/risk_factors.htm. (The website was accessed on March 8, 2019.)
[110] Center for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)
[111] VHA Directive 1330.01(2), *Health Care Services for Women Veterans,* February 15, 2017 (amended July 24, 2018).
[112] VHA Directive 1330.01(2).

results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.[113]

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The team also reviewed the electronic health records of 10 women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Appointment of a women veterans program manager
- Appointment of a women's health medical director or clinical champion
- Facility Women Veterans Health Committee
  - Core membership
  - Quarterly meetings
  - Reports to clinical executive leaders
- Collection and tracking of cervical cancer screening data
  - Notification of patients due for screening
  - Completed screenings
  - Results reporting
  - Follow-up care
- Communication of abnormal results to patients within required time frame
- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women's Health Conclusion

The facility generally complied with many of the performance indicators, including requirements for clinical oversight of the women's health program and provision of follow-up care.[114] However, the OIG identified concerns within the Women Veteran Health Committee membership and reporting requirements that warranted recommendations for improvement.

Specifically, VHA requires that the core membership of the women veterans health committee includes a women veterans program manager, women's health medical director; "representatives

[113] VHA Directive 1330.01(2).
[114] VHA Directive 1330.01(2).

from primary care, mental health, medical and/ or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, emergency department, radiology, laboratory, quality management, business office/non-VA medical care; and a member from executive leadership."[115] The OIG found that the committee charter lacked representation from pharmacy, emergency department, and laboratory. This resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for quality and equitable care for women veterans.[116] The women veterans program manager and women veterans medical director were unaware of the requirement and plan to update the committee charter.

Recommendation 10

10. The facility director confirms that the Women Veterans Health Committee includes required core members and monitors the committee's compliance.

Facility concurred.

Target date for completion: September 2019

Facility response: The Facility Director or designee ensures the Women Veterans Health Committee includes the required core memberships. The Women Veterans Health Committee Charter has been updated and includes all required memberships. Requirement will be audited for six months for 90% compliance and reported quarterly to the Medical Executive Committee.
Status: Implementation of this recommendation remains in progress.

According to VHA, each facility is to have a Women Veterans Health Committee that meets at least quarterly and reports to executive leadership with signed meeting minutes.[117] The OIG reviewed Medical Executive Committee meeting minutes from April through September 2018 and found the women veterans program manager did not report to executive leadership. Failure to report activities to executive leadership has the potential to impede oversight and support of the women's health program. The women veterans program manager cited that women's health-related information is reported at the Veterans Experience Committee meetings and believed this reporting met the requirement.

Recommendation 11

11. The facility director makes certain that the Women Veterans Health Committee reports at least quarterly to the Medical Executive Committee.

[115] VHA Directive 1330.01(2).
[116] VHA Directive 1330.01(2).
[117] VHA Directive 1330.01(2).

Facility concurred.

Target date for completion: October 2019

Facility response: The Facility Director or designee ensures the Women Veterans Health Committee reports to the Medical Executive Committee quarterly. Requirement will be audited for six months for 100% compliance and reported quarterly to the Medical Executive Committee.
Status: Implementation of this recommendation remains in progress.

High-Risk Processes: Operations and Management of Emergency Departments and Urgent Care Centers

VHA defines an emergency department as a "unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations." An urgent care center (UCC) "provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries."[118] A variety of emergency services may exist, dependent on "capability, capacity, and function of the local VA medical facility;" however, emergency care must be uniformly available in all VHA emergency departments and UCCs.[119]

Because the emergency department or UCC is often the first point of contact for patients seeking treatment of unexpected medical issues, a care delivery system with appropriate resources and services must be available to deliver prompt, safe, and appropriate care. VHA requires that each emergency department provide "unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week." VHA UCCs are also required to provide access and timely care during established operational hours. VHA also requires that "evaluation, management, and treatment [are] provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care."[120]

TJC noted that patient flow problems pose a persistent risk to quality and safety and established standards for the management of the flow of patients in the emergency department and the rest of the hospital. Managing the flow of patients prevents overcrowding, which can "undermine the timeliness of care and, ultimately, patient safety." Effective management processes that "support patient flow [in the emergency department or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care."[121]

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement initiative to improve the quality of emergent and urgent care provided through VA emergency departments and UCCs. As part of this initiative, all VA emergency departments and UCCs must use the Emergency Department Integration Software (EDIS) tracking program to document and manage the flow of patients.[122]

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[118] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016 (amended March 7, 2017).

[119] VHA Directive 1101.05(2).

[120] VHA Directive 1101.05(2).

[121] TJC. Leadership standard LD.04.03.11.

[122] VHA Directive 1101.05(2); The Emergency Medicine Management Tool (EMMT) uses data collected from EDIS to generate productivity metrics. The use of EDIS and EMMT are key tools in accomplishing EMI initiative goals.

VA emergency departments and UCCs must also be designed to promote a safe environment of care.[123] Managers must ensure medications are securely stored,[124] a psychiatric intervention room is available,[125] and equipment and supplies are readily accessible to provide gynecologic and resuscitation services. VHA also requires emergency departments to have communication systems available to accept requests by local emergency medical services for transporting unstable patients to VA emergency departments.[126]

The OIG examined the clinical risks of the emergency department/UCC areas by evaluating the staffing; the provision of care, including selected aspects of mental health and women's health; and the reduction of patient safety risks to optimize quality care and outcomes in those areas. In addition to conducting manager and staff interviews, the OIG team reviewed emergency department staffing schedules, committee minutes, and other relevant documents. The OIG evaluated the following performance indicators:

- General
  - Presence of an emergency department or UCC
  - Availability of acute care medical and/or surgical inpatient beds in facilities with emergency departments
  - Emergency department/UCC operating hours
  - Workload capture process
- Staffing for emergency department/UCC
  - Dedicated medical director
  - At least one licensed physician privileged to staff the department at all times
  - Minimum of two registered nurses on duty during all hours of operation
  - Backup call schedules for providers
- Support services for emergency department/UCC
  - Access during regular hours, off hours, weekends, and holidays
  - On-call list for staff required to respond

[123] VHA Directive 1101.05(2).

[124] TJC. Medication Management standard MM.03.01.01.

[125] A psychiatric intervention room is where individuals experiencing a behavioral health crisis, including serious disturbances, agitation, or intoxication may be taken immediately on arrival.

[126] VHA Directive 1101.05(2).

  - Licensed independent mental health provider available as required for the facility's complexity level
  - Telephone message system during non-operational hours
  - Inpatient provider available for patients requiring admission
- Patient flow
  - EDIS tracking program
  - Emergency department patient flow evaluation
  - Diversion policy
  - Designated bed flow coordinator
- General safety
  - Directional signage to after-hours emergency care
  - Fast tracks[127]
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable
- Women veteran services
  - Capability and equipment for gynecologic examinations
- Life support equipment

High-Risk Processes Conclusion

Generally, the facility complied with the above performance indicators. The OIG made no recommendations.

[127] The emergency department fast track is a designated care area within the emergency department domain where lower acuity patients are assessed and treated.

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation and/or for-cause surveys and oversight inspections • Factors related to possible lapses in care • VHA performance data	Eleven OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director, chief of staff, and associate director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review	• None	• None
Medical Staff Privileging	• Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank	• OPPEs are completed by providers with similar training and privileges.	• FPPEs include clearly defined time limitations. • Clinical managers share in advance the expectations and outcomes for FPPEs for cause with providers.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent facility
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	• Community based outpatient clinic
	  ○ General safety
	  ○ Environmental cleanliness and infection prevention
	  ○ General privacy
	  ○ Women veterans program
	  ○ Availability of medical equipment and supplies
	• Locked inpatient mental health unit
	  ○ Mental health environment of care rounds
	  ○ Nursing station security
	  ○ Public area and general unit safety
	  ○ Patient room safety
	  ○ Infection prevention
	  ○ Availability of medical equipment and supplies
	• Emergency management
	  ○ Hazard vulnerability analysis (HVA)
	  ○ Emergency operations plan (EOP)
		• None	• Clean and sterile packaged items are removed from shipping cartons and corrugated boxes prior to stowing in clean or sterile storage areas.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	○ Emergency power testing and availability		
Medication Management: Controlled Substances Inspections	• Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports	• None	• None
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	• Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers	• None	• The MST coordinator communicates the status of MST-related information to leadership. • The MST coordinator tracks and monitors the screening, referral, and treatment services provided to veterans. • Providers complete MST mandatory training within the required time frame.
Geriatric Care: Antidepressant Use among the Elderly	• Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation	• Clinicians provide education to the patient and/or caregiver about the risks/benefits, potential interactions, and side effects of newly prescribed medications. • Clinicians maintain and communicate accurate patient medication information in patients' electronic health record and reconcile medications.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up	• Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data • Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated	• None	• The Women Veterans Health Committee includes required core members. • The Women Veterans Health Committee reports at least quarterly to the Medical Executive Committee.
High-Risk Processes: Operations and Management of Emergency departments and UCCs	• General • Staffing for emergency department/UCC • Support services for emergency department/UCC • Patient flow • General safety • Medication security and labeling • Management of patients with mental health disorders • Emergency department participation in local/regional EMS system • Women veteran services • Life support equipment	• None	• None

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this mid-high complexity (1c) affiliated[128] facility reporting to VISN 19.[129]

Table B.1. Facility Profile for Eastern Oklahoma VA Health Care System (623) (October 1, 2015, through September 30, 2018)

Profile Element	Facility Data FY 2016[130]	Facility Data FY 2017[131]	Facility Data FY 2018[132]
Total medical care budget dollars:	$294,434,948	$321,494,607	$362,716,022
Number of:			
• Unique patients	39,040	38,630	39,617
• Outpatient visits	459,367	452,598	473,176
• Unique employees[133]	1,134	1,183	1,274
Type and number of operating beds:			
• Medicine	50	50	50
• Mental health	14	14	16
• Rehabilitation medicine	15	15	15
• Surgery	10	10	10
Average daily census:			
• Medicine	29	31	30
• Mental health	11	11	12
• Rehabilitation medicine	9	10	9
• Surgery	2	3	3

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.

[128] Associated with a medical residency program.

[129] The VHA medical centers are classified according to a facility complexity model; a designation of "1c" indicates a facility with medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs.

[130] October 1, 2015, through September 30, 2016.

[131] October 1, 2016, through September 30, 2017.

[132] October 1, 2017, through September 30, 2018.

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

VA Outpatient Clinic Profiles[134]

The VA outpatient clinics in communities within the catchment area of the facility provide primary care integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table B.2. provides information relative to each of the clinics.

Table B.2. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2017, through September 30, 2018)[135]

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[136] Provided	Diagnostic Services[137] Provided	Ancillary Services[138] Provided
Hartshorne, OK	623GA	4,211	2,582	Dermatology Endocrinology Poly-trauma	n/a	Pharmacy Weight management Nutrition
Idabel, OK	623GC	3,667	361	Endocrinology	n/a	Pharmacy Social work Weight management Nutrition

[134] Includes all outpatient clinics in the community that were in operation as of August 15, 2018. The OIG omitted Tulsa, OK (623QC) as no workload/encounters or services were reported.

[135] The definition of an "encounter" can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015, and has not been updated.) An encounter is a "professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition."

[136] Specialty care services refer to non-primary care and non-mental health services provided by a physician.

[137] Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

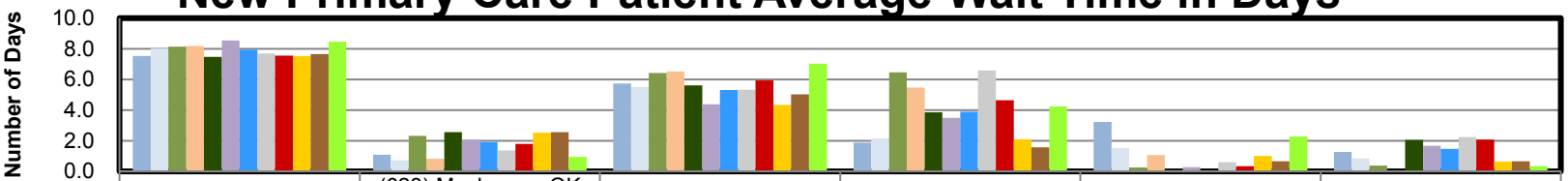
[138] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[136] Provided	Diagnostic Services[137] Provided	Ancillary Services[138] Provided
Muskogee, OK	623QA	n/a	8,112	n/a	n/a	n/a
Tulsa, OK	623BY	45,517	3,181	Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious disease Nephrology Pulmonary/ Respiratory disease Poly-trauma Rehab Physician Spinal Cord Injury Eye General surgery Orthopedics Otolaryngology Podiatry Urology Vascular	EKG Laboratory & pathology Radiology	Nutrition Pharmacy Prosthetics Social work Weight management Dental
Tulsa, OK	623QB	n/a	18,916	n/a	n/a	Pharmacy

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services[136] Provided	Diagnostic Services[137] Provided	Ancillary Services[138] Provided
Vinita, OK	623GB	4,723	3,012	Dermatology Podiatry	EKG	Pharmacy Social work Weight management Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.
n/a = not applicable

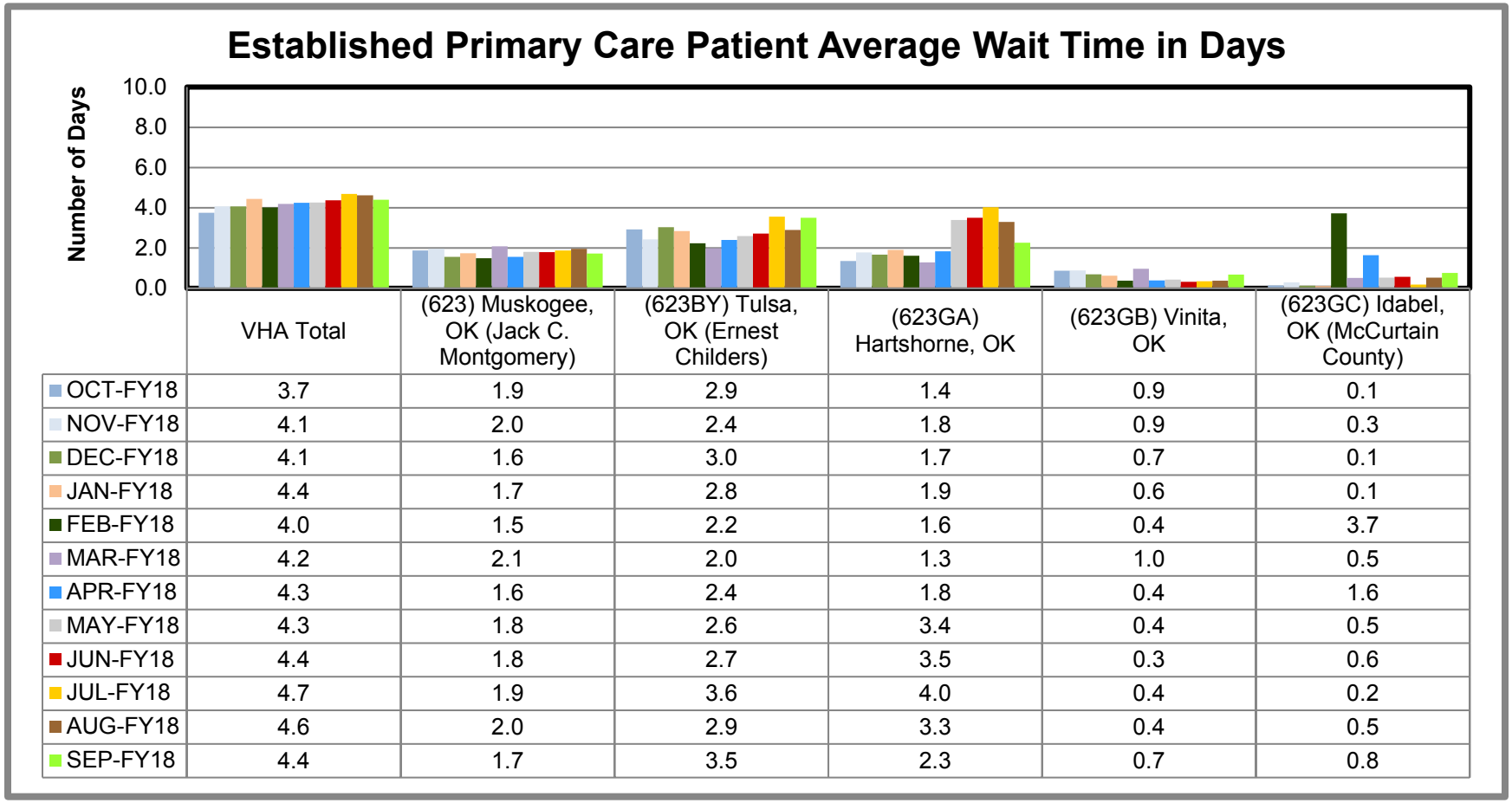
Appendix C: Patient Aligned Care Team Compass Metrics[139]



	VHA Total	(623) Muskogee, OK (Jack C. Montgomery)	(623BY) Tulsa, OK (Ernest Childers)	(623GA) Hartshorne, OK	(623GB) Vinita, OK	(623GC) Idabel, OK (McCurtain County)
OCT-FY18	7.5	1.1	5.7	1.9	3.2	1.3
NOV-FY18	8.0	0.7	5.5	2.2	1.5	0.8
DEC-FY18	8.1	2.3	6.4	6.5	0.3	0.4
JAN-FY18	8.2	0.8	6.5	5.5	1.1	0.0
FEB-FY18	7.5	2.6	5.6	3.9	0.1	2.1
MAR-FY18	8.6	2.1	4.4	3.5	0.3	1.7
APR-FY18	7.9	1.9	5.3	3.9	0.0	1.5
MAY-FY18	7.7	1.4	5.3	6.6	0.6	2.2
JUN-FY18	7.6	1.8	5.9	4.6	0.3	2.1
JUL-FY18	7.5	2.5	4.3	2.1	1.0	0.6
AUG-FY18	7.7	2.6	5.0	1.6	0.7	0.7
SEP-FY18	8.5	1.0	7.0	4.2	2.3	0.3

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Muskogee-Shawnee Road, OK (Jack C. Montgomery) (623QA); Tulsa Eleventh Street, OK (623QB); and Yale Avenue, OK (623QC), as no data were reported.
Data Definition: "The average number of calendar days between a new patient's primary care completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." Note that prior to FY15, this metric was calculated using the earliest possible create date.

[139] Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 13, 2018.



	VHA Total	(623) Muskogee, OK (Jack C. Montgomery)	(623BY) Tulsa, OK (Ernest Childers)	(623GA) Hartshorne, OK	(623GB) Vinita, OK	(623GC) Idabel, OK (McCurtain County)
OCT-FY18	3.7	1.9	2.9	1.4	0.9	0.1
NOV-FY18	4.1	2.0	2.4	1.8	0.9	0.3
DEC-FY18	4.1	1.6	3.0	1.7	0.7	0.1
JAN-FY18	4.4	1.7	2.8	1.9	0.6	0.1
FEB-FY18	4.0	1.5	2.2	1.6	0.4	3.7
MAR-FY18	4.2	2.1	2.0	1.3	1.0	0.5
APR-FY18	4.3	1.6	2.4	1.8	0.4	1.6
MAY-FY18	4.3	1.8	2.6	3.4	0.4	0.5
JUN-FY18	4.4	1.8	2.7	3.5	0.3	0.6
JUL-FY18	4.7	1.9	3.6	4.0	0.4	0.2
AUG-FY18	4.6	2.0	2.9	3.3	0.4	0.5
SEP-FY18	4.4	1.7	3.5	2.3	0.7	0.8

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Muskogee-Shawnee Road, OK (Jack C. Montgomery) (623QA); Tulsa Eleventh Street, OK (623QB); and Yale Avenue, OK (623QC), as no data were reported.
Data Definition: "The average number of calendar days between an established patient's primary care completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[140]

Measure	Definition	Desired Direction
ACSC hospitalization	Ambulatory care sensitive conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit reviews met	Percent acute admission reviews that meet interqual criteria	A higher value is better than a lower value
APP capacity	Advanced practice provider capacity	A lower value is better than a higher value
Best place to work	All employee survey best places to work score	A higher value is better than a lower value
Call responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Care transition	Care transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont stay reviews met	Percent acute continued stay reviews that meet interqual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/capacity	Efficiency and physician capacity	A higher value is better than a lower value
Employee satisfaction	Overall satisfaction with job	A higher value is better than a lower value

[140] VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated December 26, 2018). http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938. (The website was accessed on March 7, 2019, but is not accessible by the public.)

Measure	Definition	Desired Direction
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS like – HED90_1	HEDIS-EPRP based PRV TOB BHS	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS-eOM based DM IHD	A higher value is better than a lower value
MH wait time	Mental health care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	ORYX	A higher value is better than a lower value
PC routine care appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC urgent care appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
Physician capacity	Physician capacity	A lower value is better than a higher value
PC wait time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value

Measure	Definition	Desired Direction
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	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-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value

Measure	Definition	Desired Direction
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC routine care appt	Timeliness in getting a SC routine care appointment (specialty care)	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SC urgent care appt	Timeliness in getting a SC urgent care appointment (specialty care)	A higher value is better than a lower value
Seconds pick up calls	Average speed of call center responded to calls in seconds	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 patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value
Telephone abandonment rate	Telephone abandonment rate	A lower value is better than a higher value

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 19, 2019

From: Director, Rocky Mountain Network (10N19)

Subj: Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System, Muskogee, OK

To: Director, Chicago Office of Healthcare Inspections (54CH02)

Director, GAO/OIG Accountability Liaison (VHA 10EG GOAL Action)

I have reviewed the findings, recommendations, and action plan of the Eastern Oklahoma VA Medical Center, Muskogee, OK. I am in agreeance with the above.

(Original signed by:)

Ralph Gigliotti
Network Director, VISN 19

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 29, 2019

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

Subj: Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System, Muskogee, OK

To: Director, Rocky Mountain Network (10N19)

1. We appreciate The Office of inspector General assisting us with improving the quality of healthcare for our nation's Veterans.

2. Please find attached our response to each recommendation provided in this report.

(Original signed by:)

Mark E. Morgan, MHA, FACHE

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Rose Griggs, MSW. LCSW, Team Leader Sheila Cooley, MSN, GNP Francis Keslof, MHA, EMT Barbara Miller, BSN, RN Jennifer Reed, MSHI, RN
Other Contributors	Judy Brown Shirley Carlile, BA Limin Clegg, PhD Justin Hanlon, BS LaFonda Henry, MSN, RN-BC Gayle Karamanos, MS, PA-C Yoonhee Kim, PharmD Susan Lott, MSA, RN Scott McGrath, BS Larry Ross, Jr., MS Marilyn Stones, BS Erin Stott, MSN, RN Mary Toy, MSN, RN Robert Wallace, ScD, MPH

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