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 in Muskogee

CHIP REPORT | REPORT #21-00251-212 | SEPTEMBER 2, 2021

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Figure 1. *Eastern Oklahoma VA Health Care System in Muskogee.*
Source: https://vaww.va.gov/directory/guide/ (*accessed January 6, 2021*).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
COVID-19	coronavirus disease
FDA	Food and Drug Administration
FY	fiscal year
OIG	Office of Inspector General
QSV	quality, safety, and value
RN	registered nurse
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Eastern Oklahoma VA Health Care System in Muskogee, which operates the Jack C. Montgomery VA Medical Center and multiple outpatient clinics in Oklahoma. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high quality and timely VA healthcare services. The inspections 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, and at the time of the inspection, focused on the following additional seven areas:

1. COVID-19 pandemic readiness and response[1]
2. Quality, safety, and value
3. Registered nurse credentialing
4. Medication management (targeting remdesivir use)
5. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
6. Care coordination (spotlighting inter-facility transfers)
7. High-risk processes (examining the management of disruptive and violent behavior)

The OIG conducted an unannounced virtual review of the Eastern Oklahoma VA Health Care System during the week of December 7, 2020. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of 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 the healthcare system's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this healthcare system and other Veterans Health

[1] "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It," World Health Organization, accessed August 25, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 (coronavirus disease) is an infectious disease caused by the "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)."

Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued nine recommendations to the Director and Chief of Staff. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual review, the healthcare system's leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care Services, and Associate Director. Organizational communications and accountability were managed through a committee reporting structure; the Executive Governing Board oversaw several working groups. Leaders monitored patient safety and care through the Quality Safety and Value Committee, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the healthcare system's leaders had worked together for over a year, following the permanent assignment of the Associate Director for Patient Care Services in July 2019. The Director, who was permanently assigned in June 2016, was the most tenured leader. The Chief of Staff and Associate Director had served in their positions since January 2018 and April 2017, respectively.

The Director described the positive effect of the 21.5 percent increase in the system's fiscal year 2020 budget compared to the previous year, which allowed leaders to address needs associated with the COVID-19 pandemic, increase staffing, and improve access to care. The Chief of Staff and Associate Director for Patient Care Services also discussed actions taken to alleviate provider shortages.

The OIG reviewed employee survey results and concluded that opportunities exist for the Chief of Staff and Associate Director for Patient Care Services to improve perceptions of leadership, the Chief of Staff to address staff's fear of retaliation, and the Director and Associate Director for Patient Care Services to reduce feelings of moral distress at work.[2] However, leaders generally appeared to maintain an environment where employees felt respected and discrimination was not tolerated. Patient experience survey data implied overall satisfaction with

[2] "2020 VA All Employee Survey (AES): Questions by Organizational Health Framework," VA Workforce Surveys Portal, VHA Support Service Center, accessed July 29, 2021, http://aes.vssc.med.va.gov/SurveyInstruments/_layouts/15/DocIdRedir.aspx?ID=QQVSJ65U5ZMQ-229890423-174. (This is an internal website not publicly accessible.) The All Employee Survey defines moral distress as being "unsure about the right thing to do or could not carry out what you believed to be the right thing."

the care provided, but leaders have an opportunity to improve female veterans' patient-centered medical home experiences.

The inspection team also reviewed accreditation survey findings and did not identify any substantial organizational risk factors. Although the Director was able to speak knowledgeably about improvements in the root cause analysis process, the OIG identified concerns with conducting institutional disclosures for adverse events identified as sentinel events.[3]

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite 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.[4]

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific SAIL measures and were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences.

COVID-19 Pandemic Readiness and Response

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[5]

Quality, Safety, and Value

The healthcare system complied with requirements for a quality, safety, and value oversight committee and protected peer reviews. However, the OIG identified weaknesses with a designated systems redesign and improvement coordinator and the Surgical Work Group.

Medication Management

The healthcare system addressed many of the indicators of expected performance, including the availability of staff to receive remdesivir shipments, proper naming of medication orders,

[3] 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."

[4] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center, accessed March 6, 2020, https://vssc.med.va.gov. (This is an internal website not publicly accessible.)

[5] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19*, Report No. 21-01699-175, July 7, 2021.

satisfaction of patient criteria prior to medication administration, and completion of required testing. However, the OIG found a deficiency with patient and caregiver education.

Care Coordination

Generally, the healthcare system met expectations for an inter-facility transfer policy, monitoring and evaluation of inter-facility transfers, and nurse-to-nurse communication. However, the OIG identified deficiencies with the completion of the VA *Inter-Facility Transfer Form* and transmission of medical records to the receiving facility.[6]

High-Risk Processes

The healthcare system met many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with Disruptive Behavior Committee meeting attendance, patient notification of behavior restriction orders, and staff training.

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued nine recommendations for improvement to the System Director and Chief of Staff. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for system leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues and other less-critical findings that may eventually interfere with the delivery of quality health care.

[6] VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017. A completed VA *Inter-Facility Transfer Form* or an equivalent note communicates critical information to facilitate and ensure safe, appropriate, and timely transfer. Critical elements include documentation of patients' informed consent, medical and/or behavioral stability, mode of transportation and appropriate level of care required, identification of transferring and receiving physicians, and proposed level of care after transfer.

Comments

The Veterans Integrated Service Network Director and System Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes F and G, pages 56–57, 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.

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Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Eastern Oklahoma VA Health Care System examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so that informed decisions can be made to improve care.[1]

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[2] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[3] Figure 2 illustrates the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual review, paused physical inspection steps (especially those involved in the environment of care-focused review topic), and initiated a COVID-19 pandemic readiness and response evaluation.

As such, to examine risks to patients and the organization, the OIG focused on core processes in the following eight areas of administrative and clinical operations (see figure 2):[4]

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response[5]
3. Quality, safety, and value (QSV)
4. Registered nurse credentialing

[1] VA administers healthcare services through a network of 18 regional offices nationwide referred to as the Veterans Integrated Service Network.

[2] Anam Parand et al., "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014), https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae Sfantou et al., "Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4 (December 2017): 73, https://doi.org/10.3390/healthcare5040073.

[4] Virtual CHIP site visits address these processes during fiscal year 2021 (October 1, 2020, through September 30, 2021); they may differ from prior years' focus areas.

[5] "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It," World Health Organization, accessed August 25, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 (coronavirus disease) is an infectious disease caused by the "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)."

5. Medication management (targeting remdesivir use)
6. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
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8. High-risk processes (examining the management of disruptive and violent behavior)

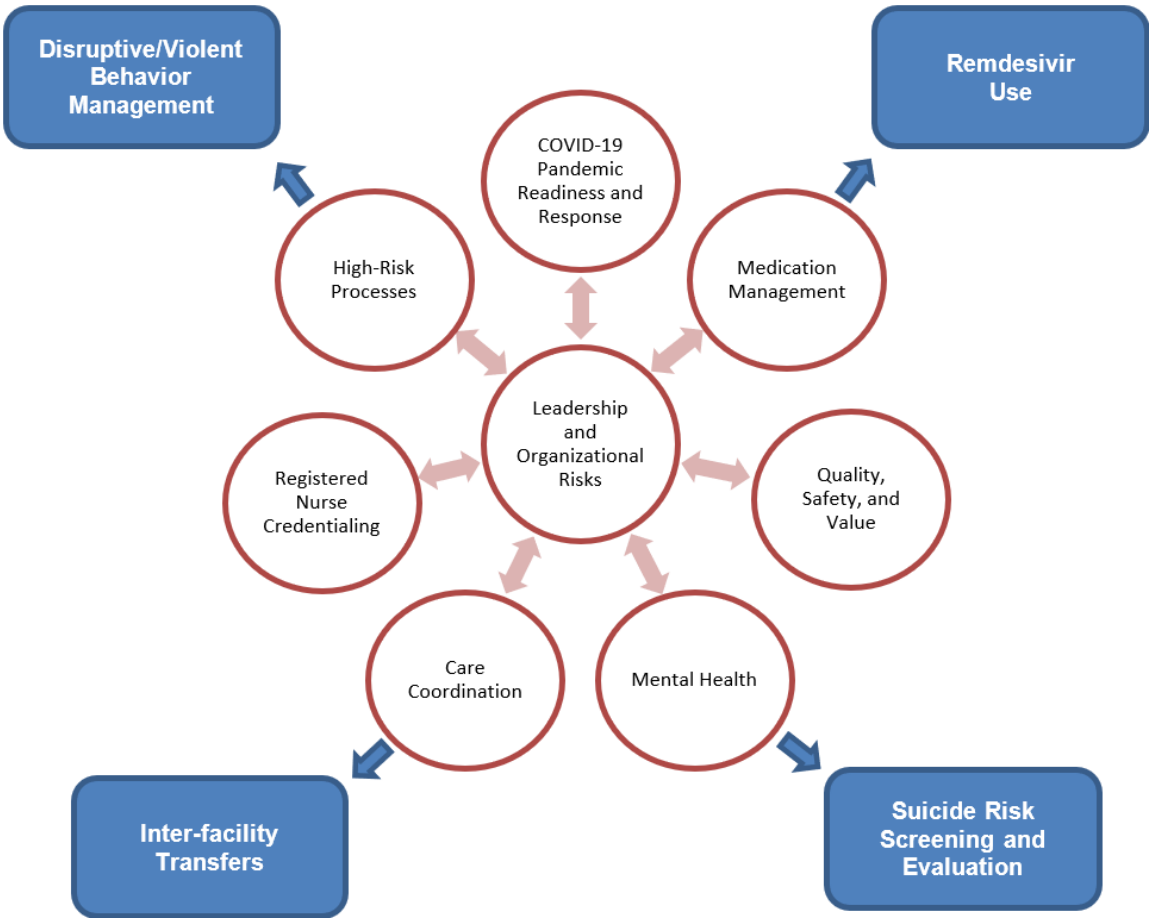

Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services. Source: VA OIG.*

Methodology

The Eastern Oklahoma VA Health Care System includes the Jack C. Montgomery VA Medical Center and multiple outpatient clinics in Oklahoma. Additional details about the types of care provided by the healthcare system can be found in appendixes B and C.

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality and clinical functions, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports.[6] The team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection examined operations from December 15, 2018, through December 11, 2020, the last day of the unannounced multiday evaluation.[7] During the virtual review, the OIG did not receive any complaints beyond the scope of the inspection.

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[8]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[9] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the healthcare system completes corrective actions. The System Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that the system leaders developed based on the reasons for noncompliance.

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

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

[7] The range represents the time period from the prior CHIP site visit to the completion of the unannounced, multiday virtual CHIP visit in December 2020.

[8] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19*, Report No. 21-01699-175, July 7, 2021.

[9] Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare system. Leadership and organizational risks can affect a healthcare system's ability to provide care in the clinical focus areas.[10] To assess this healthcare system's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Staffing
4. Employee satisfaction
5. Patient experience
6. Accreditation surveys and oversight inspections
7. Identified factors related to possible lapses in care and the healthcare system response
8. VHA performance data (healthcare system)

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 healthcare system's reported organizational structure. The healthcare system had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. The Chief of Staff and ADPCS oversaw patient care, which required managing service directors and chiefs of programs and practices.

[10] Laura Botwinick, Maureen Bisognano, and Carol Haraden, *Leadership Guide to Patient Safety*, Institute for Healthcare Improvement, Innovation Series White Paper, 2006.

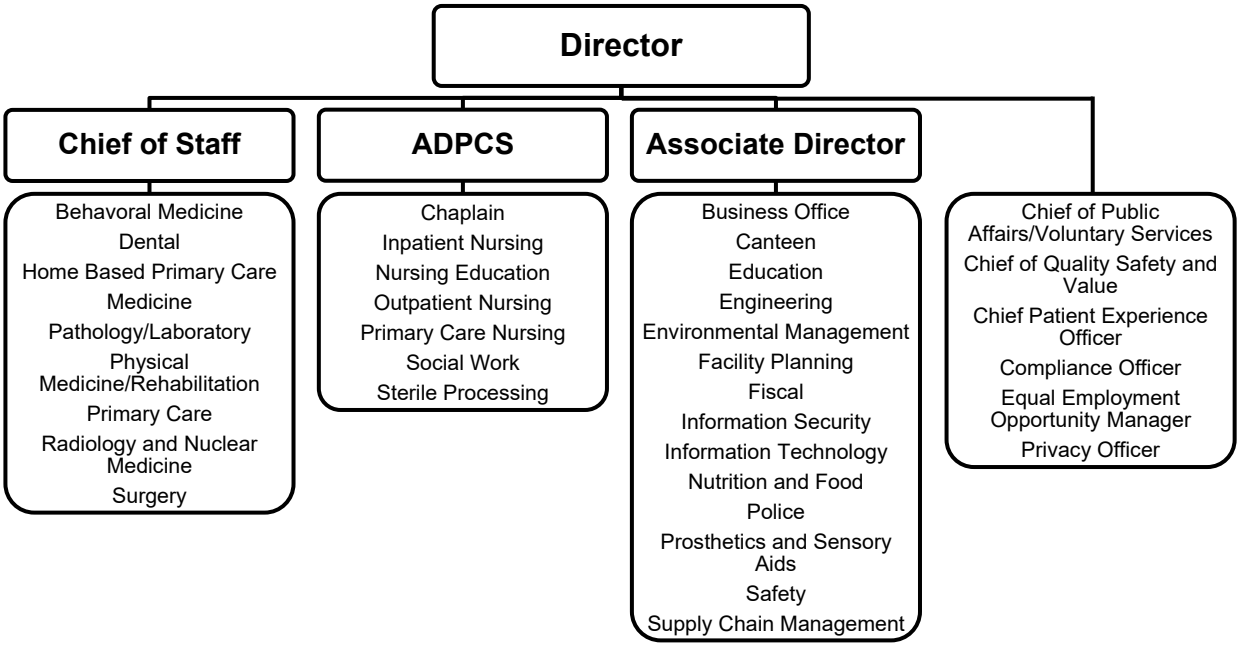

Figure 3. *Healthcare system organizational chart.*
Source: Eastern Oklahoma VA Health Care System (received December 7, 2020).

At the time of the OIG inspection, the executive team had worked together for more than a year, following the permanent assignment of the ADPCS in July 2019. The Director was the most tenured leader and had served in the role since 2016 (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
System Director	June 12, 2016
Chief of Staff	January 7, 2018
Associate Director for Patient Care Services	July 7, 2019
Associate Director	April 30, 2017

Source: Eastern Oklahoma VA Health Care System Acting Strategic Business Partner (received December 7, 2020).

To help assess the healthcare system 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.

The executive leaders were generally knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific Strategic Analytics for Improvement and Learning (SAIL) measures. In individual interviews, the

executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, or patient experiences. These are discussed in greater detail below.

The Director served as the chairperson of the Executive Governing Board, which has the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Governing Board oversees various working groups such as the Nursing Leadership Council and Medical Executive Committee. These leaders monitored patient safety and care through the Quality Safety and Value Committee, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Governing Board (see figure 4).

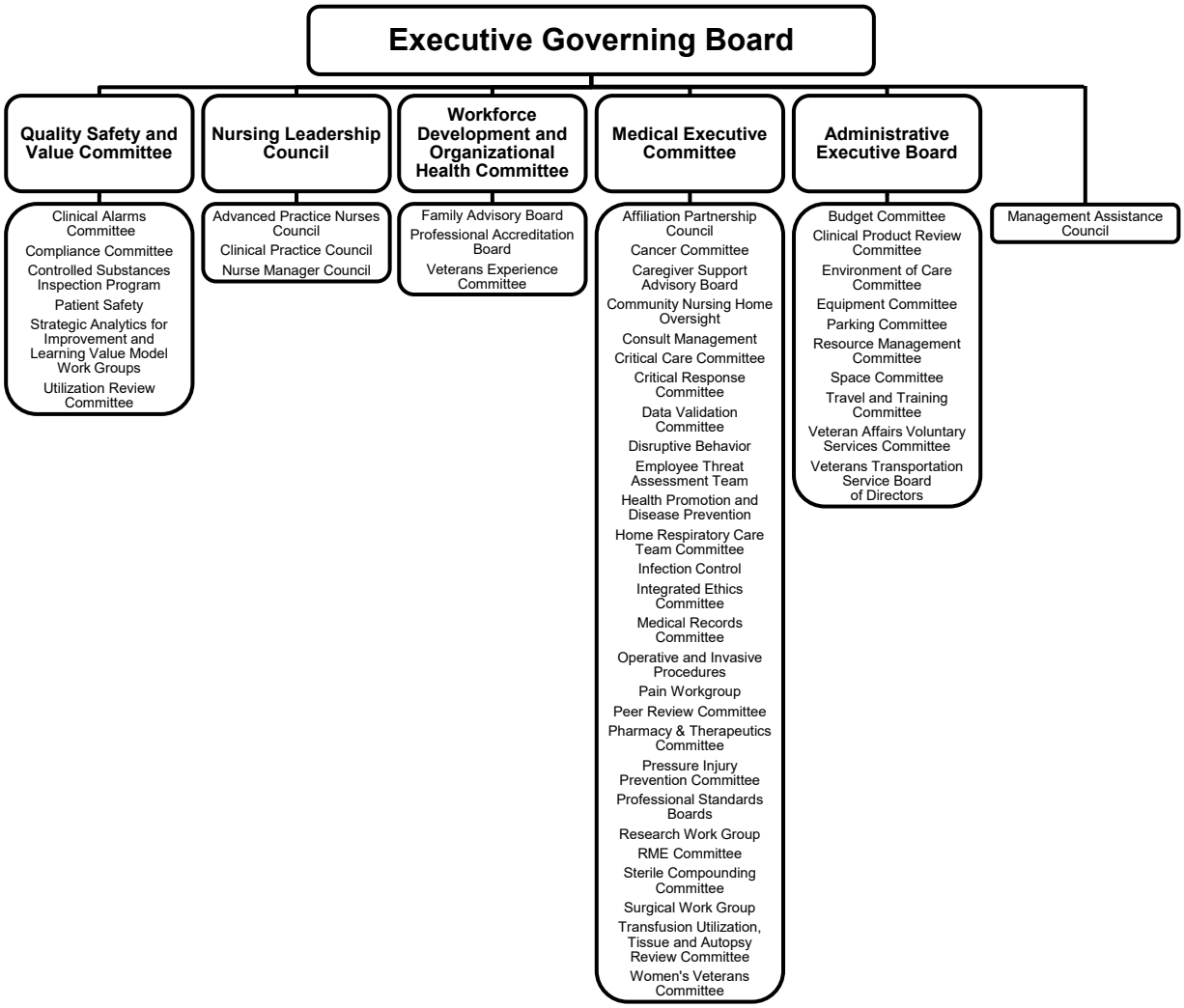

Figure 4. *Healthcare system committee reporting structure.*

Source: Eastern Oklahoma VA Health Care System (received December 7, 2020).

RME = Reusable Medical Equipment.

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of $479,449,801 increased approximately 21.5 percent compared to the previous year's budget of $394,476,762.[11] When asked about the effect of this change on the healthcare system's operations, the Director indicated that the funds helped meet top priority demands caused by the COVID-19 pandemic, allowed for increases in facility staff, and improved veterans' access to care.

The acting Chief of Human Resources reported that the new Tulsa Health Care Center is expected to open in 2021.[12] The new health care center will consolidate services that are currently provided in several different locations in a single building. Additional services will be provided at the new health care center, including eye and mammography services, an enhanced specialty clinic, and other services. The acting Chief of Human Resources also reported that the new health care center is one of two approved system facilities developed under the Communities Helping Invest through Property and Improvements Needed for Veterans Act of 2016.[13] The second project, a new hospital, received budgetary approval for fiscal year 2021.

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[14] Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[15] In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.[16]

Table 2 provides the top facility-reported clinical and nonclinical facility occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[17] The executive leaders confirmed that occupations listed in table 2

[11] VHA Support Service Center.

[12] Department of Veterans Affairs, "Eastern Oklahoma VA Health Care System," accessed June 2, 2021, https://www.muskogee.va.gov/locations/Tulsa.asp. The Ernest Childers VA Health Care Center will open on July 19, 2021.

[13] Communities Helping Invest through Property and Improvements Needed for Veterans Act of 2016, Pub. L. No. 114-294 (2016).

[14] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

[15] VA Choice and Quality Employment Act of 2017, Pub. L. No. 115-46 (2017); VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*, Report No. 20-01249-259, September 23, 2020.

[16] VA OIG, *Critical Deficiencies at the Washington DC VA Medical Center*, Report No. 17-02644-130, March 7, 2018.

[17] VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.

remained the top clinical and nonclinical shortages at the time of the OIG inspection. The Chief of Staff described strategies to alleviate provider shortages, such as using incentives to hire two inpatient psychiatrists and a part-time cardiologist from one of the affiliate hospitals to provide care at the Tulsa location. In addition, the Chief of Staff informed the OIG about a discussion with an academic affiliate to alleviate the healthcare system's orthopedic physician shortage. The ADPCS reported that advanced practice registered nurses support physician-provided cardiology services through case management of congestive heart failure patients. Healthcare system leaders also indicated that the current number of hospitalist positions, supplemented with community providers, was sufficient to meet patient care needs.

Table 2. Top Facility-Reported Clinical and Nonclinical Staffing Shortages

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Orthopedic Surgery	1. General Engineering
2. Psychiatry	2. Custodial Worker
3. Cardiology Non-Invasive	3. Police
4. Neurology	4. Food Service Worker
5. Hospitalist	5. Medical Support Assistance

Source: VA OIG.

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.[18] 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 healthcare system leaders.

To assess employee attitudes toward healthcare system leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2018, through September 30, 2019.[19] Table 3 provides relevant survey results for VHA, the healthcare system, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the healthcare system average for the selected

[18] "AES Survey History," VA Workforce Surveys Portal, VHA Support Service Center, accessed May 3, 2021, http://aes.vssc.med.va.gov/Documents/04_AES_History_Concepts.pdf. (This is an internal website not publicly accessible.)

[19] Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, and Associate Director.

survey leadership questions was lower than the VHA average.[20] The Associate Director's scores were consistently higher than those for VHA and the healthcare system. The Director's scores were generally similar to the VHA averages. However, there are opportunities for the Chief of Staff and ADPCS to improve their employees' perceptions of senior leaders.

Table 3. Survey Results on Employee Attitudes toward Healthcare System Leaders (October 1, 2018, through September 30, 2019)

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	72.6	70.0	72.8	66.5	65.0	85.0
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.4	3.2	3.6	2.7	3.0	4.3
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.6	3.2	3.4	2.8	3.1	4.5
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	2.7	3.1	4.5

Source: VA All Employee Survey (accessed November 4, 2020).

**The Servant Leader Index is a summary measure based on respondents' assessments of their supervisors' listening, respect, trust, favoritism, and response to concerns.*

[20] 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.

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[21] The healthcare system average for the selected survey questions was generally similar to the VHA average. Scores for the Associate Director were consistently better than those for VHA and the healthcare system. However, opportunities exist for the Chief of Staff to reduce fear of retaliation (I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal), and for the Director and ADPCS to reduce employee feelings of moral distress at work (uncertainty about the right thing to do or inability to carry out what you believed to be the right thing).

Table 4. Survey Results on Employee Attitudes toward the Workplace (October 1, 2018, through September 30, 2019)

Questions/Survey Items	Scoring	VHA Average	Health-care System 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	3.3	3.7	4.6
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	3.5	3.6	4.1	4.5

[21] Ratings are based on responses by employees who report to or are aligned under the Director, Chief of Staff, ADPCS, and Associate Director.

Questions/Survey Items	Scoring	VHA Average	Health-care System 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)	1.4	1.5	2.1	1.5	1.9	0.9

Source: VA All Employee Survey (accessed November 4, 2020).

VHA leaders have articulated that the agency "is committed to a harassment-free healthcare environment." To this end, leaders initiated the "End Harassment" and "Stand Up to Stop Harassment Now!" campaigns to help create a culture of safety where staff and patients feel secure and respected.[22]

The Director reported that prior to the beginning of the "Stand Up to Stop Harassment Now!" campaign, the healthcare system had already implemented strategies to support a harassment-free environment.[23] The strategies reportedly included holding public meetings regarding a harassment-free environment and addressing the concerns of female veterans.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The healthcare system and executive leaders' averages for the selected survey questions were generally similar to or better than the VHA average, and leaders appeared to maintain an environment where employees felt respected and discrimination was not tolerated. However, the Chief of Staff's averages for workgroup respect and ability to bring up problems and tough issues were lower than VHA and the healthcare system. The Chief of Staff appeared to have opportunities to improve employees' attitudes toward workgroup relationships.

[22] "Stand Up to Stop Harassment Now!" Department of Veterans Affairs, accessed December 8, 2020, https://vaww.insider.va.gov/stand-up-to-stop-harassment-now/. Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*, October 23, 2019.

[23] Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*.

Table 5. Survey Results on Employee Attitudes toward Workgroup Relationships (October 1, 2018, through September 30, 2019)

Questions/Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	4.2	3.6	3.7	4.3
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree) –5 (Strongly Agree)	4.0	3.9	4.1	4.1	4.1	4.6
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.7	3.8	3.5	4.3	4.4

Source: VA All Employee Survey (accessed November 4, 2020).

Patient Experience

To assess patient experiences with the healthcare system, which directly reflect on its leaders, the OIG team reviewed survey results from October 1, 2019, through July 30, 2020. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients 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 support benchmarking its performance against the private sector.

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home, and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the healthcare system.[24] For this healthcare system, the overall patient satisfaction survey results generally reflected similar care ratings compared to the VHA average. Patients appeared satisfied with the care provided.

[24] Ratings are based on responses by patients who received care at this healthcare system.

Table 6. Survey Results on Patient Experience (October 1, 2019, through July 31, 2020)

Questions	Scoring	VHA Average	Muskogee Healthcare System 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.	69.6	72.3
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.8	82.0
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	84.9	84.3

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 4, 2020).

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[25] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender, including those for Inpatient, Patient-Centered Medical Home, and Specialty Care surveys (see tables 7–9). The results for male respondents were generally similar to or less favorable than the corresponding VHA averages. Inpatient and specialty care results for female respondents were generally similar to or more positive than female VHA patients nationally, with the exception of being treated with courtesy and respect by nurses in the inpatient setting. Leaders also have opportunities to engage with women veterans to improve the patient-centered medical home experience. System leaders are reportedly actively engaged with

[25] "Veteran Population," Table 1L: VetPop2018 Living Veterans by Age Group, Gender, 2018-2048, National Center for Veterans Analysis and Statistics, accessed November 30, 2020, https://www.va.gov/vetdata/Veteran_Population.asp.

male and female patients; for example, meeting with veterans and their families during executive rounds to discuss any concerns.

Table 7. Inpatient Survey Results on Experiences by Gender (October 1, 2019, through July 31, 2020)

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.9	72.1	79.1
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	85.5	83.8	94.9
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	82.9	83.3	63.9

Source: VHA Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 4, 2020).

**The VHA averages are based on 40,127–40,617 male and 1,938–1,962 female respondents, depending on the question.*

†*The healthcare system averages are based on 333–339 male and 15 female respondents, depending on the question.*

Table 8. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2019, through July 31, 2020)

Questions	Scoring	VHA*		Healthcare System†	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.6	44.7	51.1	15.4
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	60.0	53.2	62.1	39.0
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.1	69.6	71.0	57.1

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 4, 2020).

**The VHA averages are based on 62,558–187,954 male and 5,096–11,416 female respondents, depending on the question.*

†*The healthcare system averages are based on 403–976 male and 32–62 female respondents, depending on the question.*

Table 9. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2019, through July 31, 2020)

Questions	Scoring	VHA*		Healthcare System †	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.8	46.2	44.5	85.4
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.7	54.0	51.3	94.4
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.1	76.2	90.2

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed November 4, 2020).

**The VHA averages are based on 52,852–156,236 male and 3,104–8,711 female respondents, depending on the question.*

†*The healthcare system averages are based on 334–840 male and 15–35 female respondents, depending on the question.*

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 responded to identified problems.[26] Table 10 summarizes the relevant system inspections most recently performed by the OIG and The Joint

[26] "Profile Definitions and Methodology: Joint Commission Accreditation," American Hospital Directory, accessed December 12, 2020, https://www.ahd.com/definitions/prof_accred.html. "The Joint Commission 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."

Commission (TJC).[27] At the time of the OIG virtual review, the system had closed all but three recommendations for improvement issued since the previous CHIP site visit in December 2018.[28] The Chief of QSV reported actively collaborating with the OIG's follow-up team and stated that the system would submit evidence to support closure of the open recommendations by February 17, 2021.

During the March 2020 TJC Triennial survey, the system received a recommendation to address the lack of harm prevention strategies in the inpatient mental health unit that required follow-up. In November 2020, a TJC For Cause review was conducted. The system did not receive any recommendations for improvement and was awarded full accreditation. At the time of the virtual review, the OIG team also noted the system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[29]

[27] 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."

[28] VA OIG, *Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma,* Report No. 18-06510-222, September 24, 2019.

[29] 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 CARF [Commission on Accreditation of Rehabilitation Facilities] to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs." "About the College of American Pathologists," College of American Pathologists, accessed February 20, 2019, https://www.cap.org/about-the-cap. According to the College of American Pathologists, for 75 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." Additionally, as stated in 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.

Table 10. Office of Inspector General Inspection/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma,* Report No. 18-06510-222, September 24, 2019*)*	December 2018	11	3*
TJC Hospital Accreditation	March 2020	27	0
TJC Behavioral Health Care Accreditation		6	0
TJC Home Care Accreditation		2	0
TJC For Cause	November 2020	0	–

Source: OIG and TJC (inspection/survey results received from the Compliance Officer on December 7, 2020).

**As of August 2021, two recommendations remained open.*

Identified Factors Related to Possible Lapses in Care and Healthcare System Responses

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 11 lists the reported patient safety events from December 15, 2018 (the prior OIG CHIP site visit), through December 6, 2020.[30]

[30] 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. (The Eastern Oklahoma VA Health Care System is a medium complexity (2) affiliated system as described in appendix B.) According to 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." Additionally, as stated in 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 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." Lastly, in VHA Directive 1004.08, 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."

Table 11. Summary of Selected Organizational Risk Factors (December 15, 2018, through December 6, 2020)

Factor	Number of Occurrences
Sentinel Events	5
Institutional Disclosures	3
Large-Scale Disclosures	0

Source: Eastern Oklahoma VA Health Care System's Patient Safety Manager and Risk Manager (received December 7 and 8, 2020).

The Director spoke knowledgeably about the system's adverse event reporting process and described having daily huddles with leaders and being provided with safety updates by an executive team member during weekends, if needed. The Director also reported that the root cause analysis process was improved to include those who have the needed expertise or knowledge to develop corrective action plans that can be immediately implemented.

The healthcare system's process for serious event follow-up begins with the Patient Safety Manager's review of reported incidents, which includes identifying those that meet sentinel event criteria. The Director reported that institutional disclosures were generally recommended through the Quality Department to the Chief of Staff. The Director also stated that the Chief of QSV was heavily involved in all committee meetings and made executive-level decisions.

The Patient Safety Manager reported five sentinel events from December 15, 2018, through December 6, 2020. However, healthcare system staff did not conduct institutional disclosures for any of the reported events (see Leadership and Organizational Risks Findings and Recommendations).

Veterans Health Administration Performance Data for the Healthcare System

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite 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.[31]

Figure 5 illustrates the healthcare system's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2020. Figure 5 shows the Eastern Oklahoma VA Health Care System's performance in the first through fifth quintiles. Those in the

[31] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center, accessed March 6, 2020, https://vssc.med.va.gov. (This is an internal website not publicly accessible.)

first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of adjusted length of stay (LOS), emergency department (ED) throughput, and rating (of) hospital). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, care transition, rating (of) primary care (PC) provider, mental health (MH) experience (exp) of care, and health care (HC) associated (assoc) infections).[32]

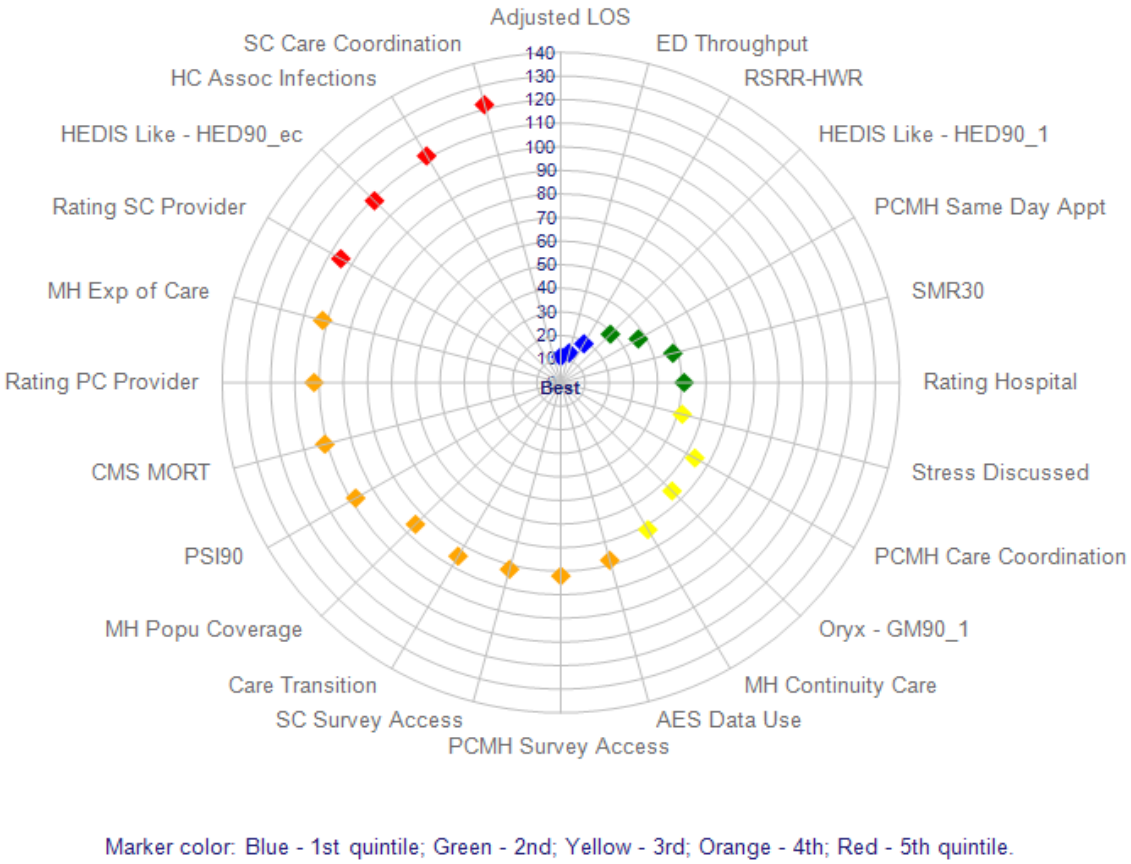

Figure 5. *System quality of care and efficiency metric rankings as of FY 2020 quarter 3 (June 30, 2020).*
Source: VHA Support Service Center.
Note: The OIG did not assess VA's data for accuracy or completeness.

Leadership and Organizational Risks Findings and Recommendations

During this OIG virtual review, all leadership positions were permanently filled following the ADPCS's assignment in July 2019. The leaders were generally knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poorly-performing SAIL measures and were able to speak in depth about actions taken during the previous 12

[32] For information on the acronyms in the SAIL metrics, please see appendix E.

months to maintain or improve organizational performance, employee satisfaction, or patient experiences. The Director described the positive effect of the 21.5 percent increase in the system's fiscal year 2020 budget compared to the previous year, and the Chief of Staff and ADPCS discussed strategies taken to alleviate provider shortages.

Employee satisfaction survey responses demonstrated that opportunities exist for the Chief of Staff and ADPCS to improve perceptions of leadership, the Director and ADPCS to reduce feelings of moral distress at work, and the Chief of Staff to minimize fear of retaliation. However, leaders appeared to maintain an environment where employees felt respected and discrimination was not tolerated. Patient experience survey data implied overall satisfaction with the care provided. However, leaders had an opportunity to address female veteran patient-centered medical home experiences. The OIG's review of the system's accreditation survey findings did not identify any substantial organizational risks.

Although the Director was able to speak knowledgeably about improvements in the root cause analysis process, the OIG identified concerns related to conducting institutional disclosures for adverse events identified as sentinel events.

VHA recognizes that the disclosure of harmful events is "consistent with the VA core values of integrity, commitment, advocacy, respect, and excellence," and therefore, requires system leaders to inform or disclose to a patient or the patient's personal representative when a sentinel event occurs during the course of the patient's care that results in or is expected to result in death or serious injury.[33] The OIG reviewed the system's five reported sentinel events from December 15, 2018, through December 6, 2020, and determined that all events met the TJC definition of a sentinel event. However, the OIG did not find documented evidence that staff conducted an institutional disclosure for any of the five events, as required. The failure to recognize a sentinel event and/or perform an institutional disclosure can erode VA's core values and reduce patients' trust in the organization. When asked why institutional disclosures were not conducted, a quality management staff member cited reasons that included completion of clinical disclosure, performance of a root cause analysis or other type of quality review, or determination that the standard of care had been met.[34]

The OIG previously identified weaknesses with the system's compliance with disclosure of adverse events, completion of clinical disclosures, and determination when large-scale disclosures are warranted.[35]

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[33] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[34] VHA Directive 1004.08. Clinical disclosure is "a process by which the patient's clinician informs the patient or the patient's personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event has occurred during the patient's care."

[35] VA OIG, *Audiology Leaders' Deficiencies Responding to Poor Care and Monitoring Performance at the Eastern Oklahoma VA Health Care System in Muskogee*, Report No. 20-04341-182, July 21, 2021.

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures staff conduct institutional disclosures for all sentinel events.

Healthcare system concurred.

Target date for completion: September 1, 2021

Healthcare system response: The System Director evaluated the deficiency and identified no additional reasons for noncompliance. Beginning January 1, 2021, all sentinel events identified for each month will have an institutional disclosure conducted per VHA Directive 1004.08. The Chief of Quality, Safety, and Value will complete monthly electronic health record reviews to validate that all sentinel events have had an institutional disclosure, and institutional disclosures will be monitored until a 90% or better compliance rate is achieved, then monthly monitoring for six consecutive months or two quarters. The compliance data will be reported quarterly to the Quality, Safety, and Value Committee.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[36] VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.[37]

During this time, VA continued providing care to veterans and engaged its fourth mission, the "provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have VA eligibility for such care and services."[38] "In effect, VHA facilities provide a safety net for the nation's hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans."[39]

Due to VHA's mission-critical work in supporting both veteran and civilian populations during the pandemic, the OIG conducted an evaluation of the pandemic's effect on the healthcare system and its leaders' subsequent responses. The OIG analyzed performance in the following domains:

- Emergency preparedness
- Supplies, equipment, and infrastructure
- Staffing
- Access to care

The OIG also surveyed healthcare system staff to solicit their feedback and potentially identify any problematic trends and/or issues that may require follow-up.

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[40]

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[36] "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization, accessed December 8, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

[37] VHA Office of Emergency Management, *COVID-19 Response Plan*, March 23, 2020.

[38] 38 U.S.C. § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the provision of hospital care and medical services during certain disasters and emergencies: "During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

[39] VA OIG, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness*, *March 19–24, 2020*, Report No. 20-02221-120, March 26, 2020.

[40] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19*, Report No. 21-01699-175, July 7, 2021.

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.[41] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[42] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[43]

To determine whether VHA facilities have implemented and incorporated OIG identified key processes for quality and safety into local activities, the inspection team evaluated the healthcare system's committee responsible for quality, safety, and value (QSV) oversight functions; its ability to review data, information, and risk intelligence; and its ability to ensure that key QSV functions are discussed and integrated on a regular basis. Specifically, OIG inspectors examined the following requirements:

- Review of aggregated QSV data
- Recommendation and implementation of improvement actions
- Monitoring of fully implemented improvement actions

The OIG reviewers also assessed the healthcare system's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High-Reliability Organization." Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[44] The OIG team examined various requirements related to systems redesign and improvement:

- Designation of a systems redesign and improvement coordinator
- Tracking of facility-level performance improvement capability and projects
- Participation on the facility quality management committee and VISN Systems Redesign Review Advisory Group
- Staff education on performance improvement principles and techniques

[41] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[42] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.
[43] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.
[44] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

Next, the OIG assessed the healthcare system's processes for conducting protected peer reviews of clinical care.[45] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[46] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[47] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- 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[48]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[49]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed the healthcare system's surgical program. The VHA National Surgery Office provides oversight for surgical programs and "promotes systems and practices that enhance high quality, safe, and timely surgical care." The National Surgery Office's principles, which guide the delivery of comprehensive surgical services at local, regional, and national levels, include "(1) Operational oversight of surgical services and quality improvement activities; (2) Policy development; (3) Data stewardship; and (4) Fiduciary responsibility for select

[45] 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, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. In the context of protected peer reviews, "protected" refers to the designation of review as a confidential quality management activity under 38 U.S.C. § 5705 as "a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department for improving the quality of medical care or the utilization of health-care resources in VA facilities."

[46] VHA Directive 1190.

[47] VHA Directive 1190.

[48] VHA Directive 1190.

[49] VHA Directive 1190. A peer review is assigned a Level 3 when "most experienced and competent clinicians would have managed the case differently."

specialty programs."[50] The healthcare system's performance was assessed on several dimensions:

- Assignment and duties of a chief of surgery
- Assignment and duties of a surgical quality nurse (registered nurse)
- Establishment of a surgical work group with required members who meet at least monthly
- Surgical work group tracking and review of quality and efficiency metrics
- Investigation of adverse events[51]

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, National Surgery Office reports, and other relevant information.[52]

Quality, Safety, and Value Findings and Recommendations

The healthcare system complied with requirements for a committee responsible for QSV oversight functions and protected peer reviews. However, the OIG identified weaknesses with a designated systems redesign and improvement coordinator and the Surgical Work Group.

VHA requires facilities to have a designated systems redesign and improvement coordinator.[53] The Chief of QSV reported that the systems redesign and improvement coordinator position became vacant on November 8, 2020, and the Executive Assistant to the Director reported that an acting coordinator was not identified to assume the duties. This may have resulted in inadequate program oversight and contributed to missed opportunities for continuous system improvement. The Executive Assistant to the Director stated that system staff were significantly affected by COVID-19, which made it difficult to assign personnel to the systems redesign and improvement coordinator position, and that clinical needs were the priority.

Recommendation 2

2. The System Director evaluates and determines any additional reasons for noncompliance and designates a systems redesign and improvement coordinator.

[50] "NSO Reporting, Resources, & Tools," VA Surgical Quality Improvement Program, accessed November 21, 2020, https://dvagov.sharepoint.com/sites/VHANSOVASQIP/SitePages/Default.aspx (This is an internal VA website not publicly accessible.)

[51] VHA Directive 1102.01(1), *National Surgery Office,* April 24, 2019, amended May 22, 2019.

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

[53] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

Healthcare system concurred.

Target date for completion: September 1, 2021

Healthcare system response: The System Director evaluated the deficiency and identified no additional reasons for noncompliance. An offer for the System Redesign and Improvement Coordinator position was accepted on June 30, 2021, with a start date of July 19, 2021.

VHA requires medical facilities with surgery programs to have a surgical work group that meets at least monthly and includes the Chief of Surgery, Chief of Staff, Surgical Quality Nurse, and operating room nurse manager as core members.[54] The OIG reviewed the Surgical Work Group meeting minutes from November 2019 through November 2020 and found that the Chief of Staff did not attend 10 of 12 (83 percent) meetings, and the operating room nurse manager (known as the Nurse Manager, Peri-Operative Services at this system) did not attend 3 of 12 (25 percent) meetings. The lack of surgical and medical leaders' involvement resulted in the review and analysis of surgery program data without the perspectives of key staff. The Chief of Staff and Nurse Manager, Peri-Operative Services cited competing priorities as the reason for inconsistent attendance.

Recommendation 3

3. The System Director evaluates and determines any additional reasons for noncompliance and ensures that required members regularly attend Surgical Work Group meetings.

Healthcare system concurred.

Target date for completion: August 31, 2021

Healthcare system response: The System Director evaluated the deficiency and identified no additional reasons for noncompliance. Beginning March 1, 2021, all members required by VHA Handbook 1102.01(1) or their representative, will be present at all Surgical Work Group meetings. Attendance will be taken and tracked for each meeting. Compliance will be monitored by the Chief of Quality, Safety, and Value monthly by reviewing the attendance log for each required member or their representative until a 90% or better compliance rate is achieved then monthly for six consecutive months or two consecutive quarters. The required members attendance will be reported monthly to the Quality, Safety, and Value Committee.

[54] VHA Directive 1102.01(1) *National Surgery Office*, April 24, 2019, amended May 22, 2019.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[55] Licensure is defined by VHA as "the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration."[56]

VA requires all RNs to hold at least one active, unencumbered license.[57] Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.[58] When an action has been "taken against [an] applicant's sole license or against any of the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA's licensure requirements," and documented as required.[59] Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA's electronic credentialing system, prior to appointment to a VA medical facility.[60]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 28 RNs hired from January 1 through October 26, 2020. The OIG determined whether

- the RNs were free from potentially disqualifying licensure actions, or
- the Chief, Human Resources Management Service or Regional Counsel determined that the RNs met VA licensure requirements.

The OIG also reviewed the RNs' credentialing files to determine whether healthcare system staff completed primary source verification prior to the appointment.

[55] VHA Directive 2012-030, *Credentialing of Health Care Professionals*, October 11, 2012.

[56] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021.

[57] VHA Directive 2012-030. "Definition of *Unencumbered license,"* Law Insider, accessed December 3, 2020, https://www.lawinsider.com/dictionary/unencumbered-license. An unencumbered license is "a license that is not revoked, suspended, or made probationary or conditional by the licensing or registering authority in the respective jurisdiction as a result of disciplinary action."

[58] 38 U.S.C. § 7402.

[59] VHA Directive 2012-030.

[60] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

The healthcare system generally met the requirements listed above. The OIG made no recommendations.

Medication Management: Remdesivir Use in VHA

On May 1, 2020, the Food and Drug Administration (FDA) authorized the emergency use of remdesivir. At that time, remdesivir was an unapproved, investigational antiviral medication for the treatment of adults and children hospitalized with severe COVID-19.[61] The FDA provided information on specific laboratory tests to be ordered prior to and during the administration of remdesivir. Additionally, the FDA required providers to report potentially related adverse events.[62]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[63] Due to the limited supply and specific storage requirements of remdesivir, VA needed someone to be available 24 hours a day, 7 days a week to accept overnight, cold-chain shipments of the drug and report any unused medication to the Emergency Pharmacy Services group.[64]

On August 28, 2020, the FDA amended the Emergency Use Authorization criteria for remdesivir to include "suspected or laboratory-confirmed COVID-19 in all hospitalized adult and pediatric patients."[65] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[66]

To determine whether VHA facilities complied with requirements related to the administration of remdesivir, the OIG interviewed key employees and managers and reviewed electronic health records of 40 patients who were administered remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. The OIG assessed the following performance indicators:

- Staff availability to receive medication shipments
- Medication orders used proper name

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[61] Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*, May 1, 2020, revised August 2020. Food and Drug Administration, *Frequently Asked Questions for Veklury (remdesivir),* updated February 4, 2021.

[62] Gilead Sciences, *Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Veklury (remdesivir)*.

[63] Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients*, May 8, 2020.

[64] Centers for Disease Control and Prevention, *Vaccine Storage and Handling Kit*, May 2014. "The cold chain begins with the cold storage unit at the manufacturing plant, extends through transport of vaccine(s) to the distributor, then delivery and storage at the provider facility, and ends with administration of vaccine to the patient. Appropriate storage conditions must be maintained at every link in the cold chain." Assistant Under Secretary for Health for Operations Memorandum, *Remdesivir Distribution for Department of Veterans Affairs (VA) Patients*.

[65] Food and Drug Administration, "FDA News Release: COVID-19 Update: FDA Broadens Emergency Use Authorization for Veklury (remdesivir) to Include All Hospitalized Patients for Treatment of COVID-19," August 28, 2020.

[66] Food and Drug Administration, "FDA News Release: FDA Approves First Treatment for COVID-19," October 22, 2020.

- Staff determined patients met criteria for receiving medication prior to administration
- Required testing completed prior to medication administration for
  - Potential pregnancy
  - Kidney assessment (estimated glomerular filtration rate)[67]
  - Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[68]
- Patient/caregiver education provided
- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The healthcare system complied with many elements of expected performance, including staff availability to receive remdesivir shipments, medication orders, medication administration criteria, and required testing. However, the OIG found a deficiency with patient and caregiver education.

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the "Fact Sheet for Patients and Patients/Caregivers" and inform patients and/or caregivers that remdesivir was not an FDA-approved medication. Providers were also required to offer the option to refuse the medication and advise patients and/or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[69] For the 40 electronic health records reviewed, the OIG determined that

- ten (25 percent) lacked evidence that the patient or caregiver was given the "Fact Sheet for Patients and Parents/Caregivers,"
- ten (25 percent) lacked evidence that the patient or caregiver was informed that remdesivir was not an FDA-approved drug,
- eight (20 percent) lacked evidence that the patient or caregiver was offered the option to refuse remdesivir,

[67] "Estimated Glomerular Filtration Rate (eGFR)," National Kidney Foundation, accessed December 9, 2020, https://www.kidney.org/atoz/content/gfr. "Estimated glomerular filtration rate [eGFR] is the best test to measure your level of kidney function and determine your stage of kidney disease."

[68] "Alanine transferase," National Cancer Institute, accessed December 9, 2020, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/alanine-transferase. Alanine transferase, also referred to as serum glutamate pyruvate transaminase, is "an enzyme found in the liver and other tissues." A high level may be indicative of liver damage.

[69] VA Pharmacy Benefits Management Services, *Remdesivir Emergency Use Authorization (EUA) Requirements*, May 2020.

- eight (20 percent) lacked evidence that the patient or caregiver was advised of the risks and benefits, and
- ten (25 percent) lacked evidence that the patient or caregiver was advised of alternatives to remdesivir.

This could have resulted in the patient or caregiver lacking information needed to make a fully-informed decision to receive the medication. The Chief of Medicine reported that patient education information was documented on a paper informed consent; however, infection control restrictions related to COVID-19 prevented staff from taking the consents out of the unit to scan into the electronic health record.

Given the FDA's approval of remdesivir for use in adult patients hospitalized with COVID-19, the OIG made no recommendations related to the Emergency Use Authorization requirements.[70]

[70] Food and Drug Administration, "FDA News Release: FDA Approves First Treatment for COVID-19." October 22, 2020.

Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[71] The suicide rate for veterans was 1.5 times greater than for nonveteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018.[72] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[73]

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.[74] The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.[75] The healthcare system was assessed for its adherence to the following requirements for suicide safety plans:

- Completion of suicide safety plans by required staff
- Completion of mandatory training by staff who develop suicide safety plans

To determine whether VHA facilities complied with selected requirements for suicide risk screening and evaluation within emergency departments and urgent care centers, the OIG inspection team interviewed key employees and reviewed

- relevant documents;

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[71] "Preventing Suicide," Centers for Disease Control and Prevention, accessed December 9, 2020, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.

[72] Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, November 2020.

[73] Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*.

[74] Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Suicide Risk Screening and Assessment Requirements*, May 23, 2018.

[75] DUSHOM Memorandum, *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives*, October 17, 2019.

- the electronic health records of 48 randomly selected patients who were seen in the emergency department/urgent care center from December 1, 2019, through August 31, 2020; and
- staff training records.

Mental Health Findings and Recommendations

Generally, the healthcare system met the above requirements. The OIG made no recommendations.

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[76]

VHA medical facility directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients." Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.[77]

The healthcare system was assessed for its adherence to various requirements:

- Existence of a facility policy for inter-facility transfers
- Monitoring and evaluation of inter-facility transfers
- Completion of all required elements of the *Inter-Facility Transfer Form* or facility-defined equivalent by the appropriate provider(s) prior to patient transfer
- Transmission of patient's active medication list and advance directive to the receiving facility
- Communication between nurses at sending and receiving facilities

To determine whether the healthcare system complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 49 patients who were transferred from the healthcare system due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

Generally, the healthcare system met expectations for an inter-facility transfer policy, monitoring and evaluation of transfers, and nurse-to-nurse communication. However, the OIG identified deficiencies with completion of transfer forms and transmission of medical records to the receiving facility.

VHA requires providers to complete the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record prior to a patient's transfer. VHA also requires

[76] VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

[77] VHA Directive 1094. A completed VA *Inter-Facility Transfer Form* or an equivalent note communicates critical information to facilitate and ensure safe, appropriate, and timely transfer. Critical elements include documentation of patients' informed consent, medical and/or behavioral stability, mode of transportation and appropriate level of care required, identification of transferring and receiving physicians, and proposed level of care after transfer.

appropriately privileged providers to co-sign transfer forms or notes that are completed by non-physician designees.[78] The OIG estimated that 45 percent of patient transfer forms were not co-signed by an appropriately privileged provider.[79] This lack of oversight could have resulted in unsafe patient transfers. The Chief of Medicine reported believing that the system's medical staff bylaws and privileging forms were sufficient to allow non-physician providers to independently transfer patients. Due to the low number of patients identified, the OIG made no recommendation.

VHA policy states that transferring physicians must record specific elements on the transfer form, such as the transfer date and time, documentation of informed consent, and the transferring and receiving physicians' identities.[80] The OIG estimated that transferring physicians did not identify the receiving physician on 24 percent of inter-facility transfer forms.[81] These deficiencies could result in the unsafe transfer of patients to other healthcare facilities. The Chief of Medicine reported that some community hospitals have an automatic transfer acceptance process based on patient criteria and do not provide the receiving physician's name. The Chief of Medicine stated that for community hospitals using this transfer system, provider-to-provider communication does not take place, which affects the system's inter-facility transfer process.

Recommendation 4

4. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that the transferring physician records all required elements on the *Inter-Facility Transfer Form* or facility-defined equivalent note prior to patient transfers.

[78] VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

[79] The OIG estimated that 95 percent of the time, the true compliance rate is between 22.2 and 85.7 percent, which is statistically significantly below the 90 percent benchmark.

[80] VHA Directive 1094.

[81] The OIG estimated that 95 percent of the time, the true compliance rate is between 63.3 and 87.5 percent, which is statistically significantly below the 90 percent benchmark.

Healthcare system concurred.

Target date for completion: February 1, 2022

Healthcare system response: The Chief of Staff evaluated the deficiency and identified no additional reasons for noncompliance. Beginning January 1, 2021, the Utilization Nurse Manager began auditing 100% of Inter-facility transfer records for all required elements. Audits will continue at 100% until a compliance rate of 90% or better is achieved on each element for a minimum of six consecutive months or two consecutive quarters. Performance will be sustained by continuing monthly audits thereafter. Audit results will be reported quarterly to the Quality, Safety and Value Committee.

VHA requires transferring providers to send "all pertinent medical records available, including an active patient medication list and…documentation of the patient's advance directive" to the receiving facility during inter-facility transfers.[82] The OIG estimated that transferring providers did not send an active medication list to the receiving facility for 31 percent of patient transfers or an advanced directive for 91 percent of transfers.[83] This may have resulted in suboptimal treatment decisions that compromised patient safety. The Utilization Management Nurse Manager reported that medical support assistants gather and print all clinical notes for transmission to the receiving facility. The Utilization Management Nurse Manager also reported that staff assessed transfer forms for completion but did not validate the accuracy of responses. Due to the low number of patients identified for the advance directive requirement, the OIG made no recommendation.

Recommendation 5

5. The Chief of Staff determines the reasons for noncompliance and ensures that transferring providers send patients' active medication lists to receiving facilities during inter-facility transfers.

[82] VHA Directive 1094.

[83] For the medication list, the OIG estimated that 95 percent of the time, the true compliance rate is between 56.0 and 82.0 percent, which is statistically significantly below the 90 percent benchmark. For advanced directives, the OIG estimated that 95 percent of the time, the true compliance rate is between 0.0 and 22.7 percent, which is statistically significantly below the 90 percent benchmark.

Healthcare system concurred.

Target date for completion: December 31, 2021

Healthcare system response: The Chief of Staff evaluated the deficiency and identified no additional reasons for noncompliance. The electronic Inter-facility transfer note was updated June 29, 2021, to automatically print a list of the patients' active medications as part of the routine transfer documentation. The Utilization Nurse Manager will conduct monthly audit of the transfer packets for each patient transfer to validate the active medication list was included. The monthly audits will be conducted until a 90% or higher compliance rate is achieved then monthly for six consecutive months or two quarters. The results of the audit will be reported to the Quality, Safety, and Value Committee monthly.

High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[84] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff poses a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[85] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team[86]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[87]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[88]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[89]

[84] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

[85] VHA Directive 2012-026.

[86] VHA Directive 2012-026. An employee threat assessment team is "a facility-level, interdisciplinary team whose primary charge is using evidence-based and data-driven practices for addressing the risk of violence posed by employee-generated behavior(s), that are disruptive or that undermine a culture of safety."

[87] VHA Directive 2012-026. VHA defines a disruptive behavior committee or board as "a facility-level, interdisciplinary committee whose primary charge is using evidence-based and data-driven practices for preventing, identifying, assessing, managing, reducing, and tracking patient-generated disruptive behavior."

[88] DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018. VA requires each medical facility's disruptive behavior committee "to use the Disruptive Behavior Reporting System (DBRS) to document a decision to implement an Order of Behavioral Restriction (OBR) and to document notification of a patient when an OBR is issued."

[89] DUSHOM Memorandum, *Workplace Behavioral Risk Assessment (WBRA)*, October 19, 2012. The Workplace Behavioral Risk Assessment is a "data-driven process that evaluates the unique constellation of factors that affect workplace safety. It enables facilities to make informed, supportable decisions regarding the level of PMDB [Prevention and Management of Disruptive Behavior] training needed to sustain a culture of safety in the workplace."

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high-risk, staff are required to complete parts 1, 2, and 3 of the training.[90] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[91] The OIG assessed staff compliance with the completion of required training.

To determine whether VHA facilities implemented and incorporated OIG-identified key processes for the management of disruptive and violent behavior, the inspection team examined relevant documents and training records and interviewed key managers and staff.

High-Risk Processes Findings and Recommendations

The OIG found the healthcare system complied with many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with Disruptive Behavior Committee meeting attendance, patient notification of behavior restriction orders, and staff training.

VHA requires facilities to have a disruptive behavior committee or board that includes a senior clinician chairperson; administrative support staff; and representation from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and patient advocate.[92]

The OIG found that from January through November 2020, none of the required members consistently attended the Disruptive Behavior Committee meetings, except for the chair. Of the 16 meetings held, administrative support staff did not attend 15 meetings (94 percent) and a Prevention and Management of Disruptive Behavior Program representative did not attend 13 meetings (81 percent). Additionally, VA police did not attend 8 meetings (50 percent), the Patient Safety Manager was absent for 5 (31 percent), and the Patient Advocate did not attend 12 (75 percent). This could have resulted in a potential lack of knowledge and expertise when assessing patients' disruptive behavior. The Chair of the Disruptive Behavior Committee stated that staffing shortages and competing priorities related to the COVID-19 pandemic contributed to inconsistent attendance.

[90] DUSHOM Memorandum, *Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.

[91] DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018.

[92] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.

Recommendation 6

6. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that all required members attend Disruptive Behavior Committee meetings.

Healthcare system concurred.

Target date for completion: December 31, 2021

Healthcare system response: The Chief of Staff evaluated the deficiency and identified no additional reasons for noncompliance. On January 1, 2021, the Chief of Behavioral Medicine began reviewing meeting attendance for all required members to ensure compliance. The attendance for all required member will be monitored at each Disruptive Behavior Committee meeting until a 90% or higher compliance rate is achieved then monthly for six consecutive months or two quarters. Beginning July 1, 2021, meeting attendance audit results will be reported monthly to the Chief of Staff and the Quality, Safety, and Value Committee.

VHA requires the disruptive behavior committee or board to document the decision to implement an Order of Behavioral Restriction, patient notification, and right to appeal the contents in the Disruptive Behavior Reporting System.[93] The OIG requested evidence of patient notification in the system for orders issued from January 1 through December 7, 2020. The review revealed that four patients were issued an order, but the OIG did not find evidence of notification. This could have resulted in the issuance of restriction orders without patients' knowledge or opportunity to appeal. The Chair of the Disruptive Behavior Committee reported the committee was not aware of this requirement until recently.

Recommendation 7

7. The Chief of Staff evaluates and determines any additional reasons for noncompliance and makes certain the Disruptive Behavior Committee documents patient notification for an Order of Behavioral Restriction in the Disruptive Behavior Reporting System.

[93] DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

Healthcare system concurred.

Target date for completion: September 1, 2021

Healthcare system response: The Chief of Staff evaluated the deficiency and identified no additional reasons for noncompliance. The Chief of Behavioral Medicine reinforced expectation for use of the templated letter for Order of Behavioral Restriction on December 22, 2020. The Chief of Behavioral Health will review the monthly disruptive behavior events then review the electronic health record to determine if the patient was notified of the Order of Behavioral Restriction. Monthly audits will be done until 90% compliance or higher is met then monthly for six consecutive months or two quarters. Audit results will be reported quarterly to the Quality, Safety, and Value Committee.

VHA requires the chair and members of the Employee Threat Assessment Team to complete specific workplace violence prevention program trainings.[94] The OIG found that two of five Employee Threat Assessment Team members did not complete the required training. This could result in ineffective de-escalation of disruptive behaviors in times of crisis. The Employee Threat Assessment Team Chair reported being unaware of the training requirement.

Recommendation 8

8. The System Director evaluates and determines any additional reasons for noncompliance and makes certain that Employee Threat Assessment Team members complete the required training.

Healthcare system concurred.

Target date for completion: September 1, 2021

Healthcare system response: The System Director evaluated the deficiency and identified no additional reasons for noncompliance. All required Employee Threat Assessment Team members had completed the required training by December 8, 2020. A compliance report will be generated by the Education Department quarterly for two consecutive quarters with 90% or above compliance for newly assigned Employee Threat Assessment Team members to monitor for sustainment and report to the Administrative Executive Board.

VHA requires that staff are assigned the prevention and management of disruptive behavior training part 1 at hire and "additional levels of PMDB [prevention and management of disruptive behavior] training based on the risk for exposure to disruptive behaviors as determined in the

[94] DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*.

facility Workplace Behavioral Risk Assessment."[95] The OIG found that 12 of 17 selected staff did not complete the assigned part 2 training. Further, none of the six staff who were assigned part 3 completed it as required. This could result in staff's lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Chair of the Disruptive Behavior Committee reported delays for parts 2 and 3 of the training due to pandemic-related limits on the number of participants per class.

Recommendation 9

9. The System Director evaluates and determines any additional reasons for noncompliance and ensures staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[96]

Healthcare system concurred.

Target date for completion: January 31, 2022

Healthcare system response: The System Director evaluated the deficiency and identified no additional reasons for noncompliance. The Chief of Inpatient Nursing will ensure all staff identified during December 2020 OIG survey as non-compliant will have completed the required training by September 1, 2021.

Beginning August 1, 2021, new employee orientation will include Prevention and Management of Disruptive Behavior training as part of their onboarding training. All staff will complete the required level one Prevention and Management of Disruptive Behavior training during new employee orientation in the Talent Management System. Within 90 days following their official start date, all employees will complete their appropriate level of training, as determined by their work location. Completion of all training will be monitored by the Chief of Education via Talent Management System and reported quarterly to the Quality, Safety, and Value Committee.

[95] VHA DUSHOM Memorandum, *Update to Prevention Management of Disruptive Behavior (PMDB) Training Assignments*, February 24, 2020.

[96] The OIG recognizes that COVID-19 has affected facility operations and makes no comment on the timeline for safely accomplishing this important training.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed review of eight clinical and administrative areas and provided nine recommendations on systemic issues that may adversely affect patients. While the OIG's recommendations are not intended to serve as a comprehensive assessment of the caliber of services delivered at this healthcare system, they illuminate areas of concern and provide a road map for improvement. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines nine OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Director and Chief of Staff. The intent is for these leaders to use the 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.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Budget and operations • Staffing • Employee satisfaction • Patient experience • Accreditation surveys and oversight inspections • Identified factors related to possible lapses in care and healthcare system response • VHA performance data (healthcare system)	• Staff conduct institutional disclosures for all sentinel events.	• None
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • Staff feedback	The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this healthcare system and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews • Surgical program	• The System Director designates a systems redesign and improvement coordinator.	• Required members regularly attend Surgical Work Group meetings.
RN Credentialing	• RN licensure requirements • Primary source verification	• None	• None
Medication Management: Remdesivir Use in VHA	• Staff availability for medication shipment receipt • Medication order naming • Satisfaction of inclusion criteria prior to medication administration • Required testing prior to medication administration • Patient/caregiver education • Adverse event reporting to the FDA	• None	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-Facility Transfer Form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Communication between nurses at sending and receiving facilities	• The transferring physician records all required elements of the *Inter-Facility Transfer Form* or facility-defined equivalent note prior to patient transfers. • Transferring providers send patients' active medication lists to receiving facilities during inter-facility transfers.	• None
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• The Disruptive Behavior Committee documents patient notification for an Order of Behavioral Restriction in the Disruptive Behavior Reporting System.	• Required members attend Disruptive Behavior Committee meetings. • Employee Threat Assessment Team members complete the required training. • Staff complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work areas.

Appendix B: Healthcare System Profile

The table below provides general background information for this medium complexity (2) affiliated healthcare system reporting to VISN 19.[1]

Table B.1. Profile for Eastern Oklahoma VA Health Care System (623) (October 1, 2017, through September 30, 2020)

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019†	Healthcare System Data FY 2020‡
Total medical care budget	$362,716,022	$394,476,762	$479,449,801
Number of:			
• Unique patients	39,617	40,031	40,405
• Outpatient visits	473,176	518,149	472,027
• Unique employees§	1,274	1,270	1,353
Type and number of operating beds:			
• Medicine	50	34	34
• Mental health	16	6	8
• Rehabilitation medicine	15	15	15
• Surgery	10	8	6
Average daily census:			
• Domiciliary	0	–	–
• Intermediate	0	–	–
• Medicine	30	25	23
• Mental health	12	11	5
• Rehabilitation medicine	9	10	7
• Surgery	3	2	1

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.

**October 1, 2017, through September 30, 2018.*

†*October 1, 2018, through September 30, 2019.*

‡*October 1, 2019, through September 30, 2020.*

§*Unique employees involved in direct medical care (cost center 8200).*

[1] An affiliated healthcare system is associated with a medical residency program. VHA facilities are classified according to a complexity model; a designation of "2" indicates a facility with "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs."

Appendix C: VA Outpatient Clinic Profiles

The VA outpatient clinics in communities within the catchment area of the healthcare system provide primary care integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table C.1. provides information relative to each of the clinics.[1]

Table C.1. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2019, through September 30, 2020)

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Tulsa, OK	623BY	36,526	728	Anesthesia Cardiology Dermatology Endocrinology Eye General surgery Hematology/ Oncology Orthopedics Otolaryngology Infectious disease	EKG Laboratory & Pathology Radiology	Nutrition Pharmacy Prosthetics Social work Weight management

[1] The OIG omitted Yale Avenue VA Clinic, Tulsa, OK (623QC) as no workload/encounters or services were reported. VHA Directive 1230(4), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended June 17, 2021. An encounter is a "professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition." Specialty care services refer to non-primary care and non-mental health services provided by a physician.

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Tulsa, OK Cont.				Nephrology Neurology Podiatry Poly-Trauma Pulmonary/ Respiratory disease Rehab physician Spinal cord injury Urology Vascular		
McAlester, OK	623GA	4,393	2,281	Anesthesia Dermatology Endocrinology General surgery	Radiology	Nutrition Pharmacy Social work Weight management
Vinita, OK	623GB	3,885	1,711	Anesthesia Dermatology General surgery	EKG	Nutrition Pharmacy Social work Weight management
Idabel, OK	623GC	2,577	552	Dermatology General surgery	–	Nutrition Pharmacy Social work Weight management

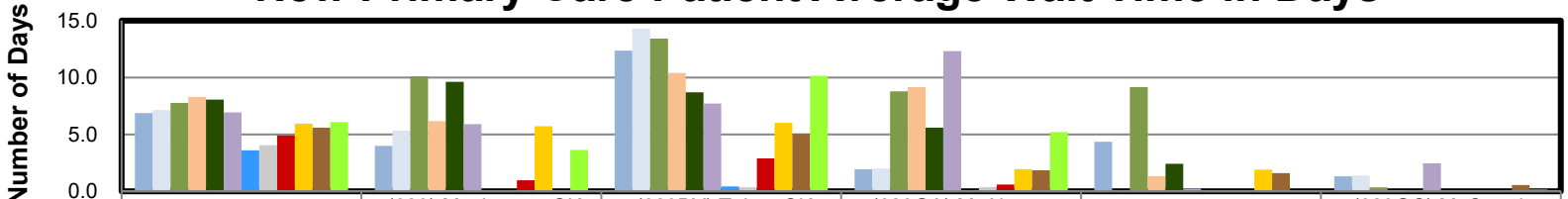
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Muskogee, OK	623QA	–	3,973	–	–	–
Tulsa, OK	623QB	–	15,791	Anesthesia	–	Pharmacy

Source: VHA Support Service Center and VA Corporate Data Warehouse.

Note: The OIG did not assess VA's data for accuracy or completeness.

Appendix D: Patient Aligned Care Team Compass Metrics

New Primary Care Patient Average Wait Time in Days

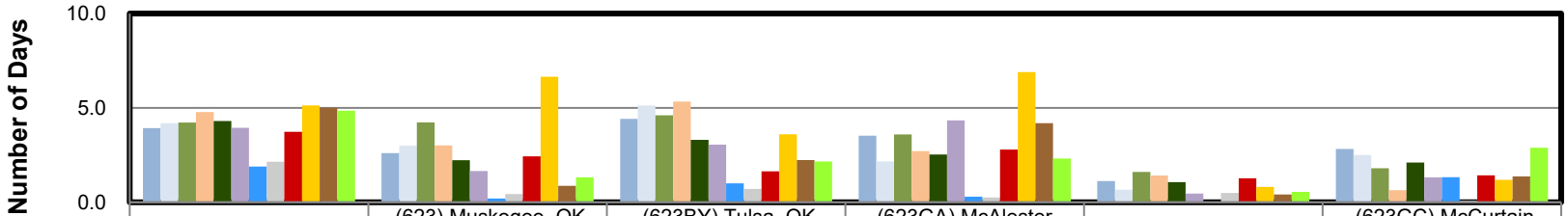


	VHA All	(623) Muskogee, OK (Jack C. Montgomery)	(623BY) Tulsa, OK (Ernest Childers)	(623GA) McAlester, OK	(623GB) Vinita, OK	(623GC) McCurtain County, OK
OCT-FY20	6.9	4.0	12.4	1.9	4.4	1.3
NOV-FY20	7.1	5.3	14.3	2.0	0.0	1.4
DEC-FY20	7.8	10.1	13.4	8.8	9.2	0.3
JAN-FY20	8.3	6.2	10.4	9.2	1.3	0.1
FEB-FY20	8.1	9.6	8.7	5.6	2.4	0.0
MAR-FY20	6.9	5.9	7.7	12.3	0.3	2.5
APR-FY20	3.6	0.0	0.4	0.0	0.0	0.0
MAY-FY20	4.0	0.0	0.4	0.4	0.0	0.0
JUN-FY20	4.9	1.0	2.9	0.6	0.0	0.0
JUL-FY20	5.9	5.7	6.0	1.9	1.9	0.0
AUG-FY20	5.6	0.0	5.1	1.9	1.6	0.5
SEP-FY20	6.1	3.6	10.1	5.2	0.0	0.2

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019.

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Muskogee East, OK (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." Prior to FY 2015, this metric was calculated using the earliest possible create date.



	VHA All	(623) Muskogee, OK (Jack C. Montgomery)	(623BY) Tulsa, OK (Ernest Childers)	(623GA) McAlester, OK	(623GB) Vinita, OK	(623GC) McCurtain County, OK
OCT-FY20	3.9	2.6	4.4	3.5	1.1	2.8
NOV-FY20	4.2	3.0	5.1	2.2	0.7	2.5
DEC-FY20	4.2	4.2	4.6	3.6	1.6	1.8
JAN-FY20	4.8	3.0	5.3	2.7	1.4	0.6
FEB-FY20	4.3	2.2	3.3	2.5	1.1	2.1
MAR-FY20	3.9	1.7	3.1	4.3	0.5	1.3
APR-FY20	1.9	0.2	1.0	0.3	0.0	1.3
MAY-FY20	2.1	0.4	0.7	0.3	0.5	0.1
JUN-FY20	3.7	2.4	1.6	2.8	1.3	1.4
JUL-FY20	5.1	6.7	3.6	6.9	0.8	1.2
AUG-FY20	5.0	0.9	2.2	4.2	0.4	1.4
SEP-FY20	4.9	1.3	2.2	2.3	0.5	2.9

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019.

Note: The OIG did not assess VA's data for accuracy or completeness. Note: The OIG omitted Muskogee East, OK (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 E: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES Data Use	Composite measure based on three individual All Employee Survey (AES) data use and sharing questions	A higher value is better than a lower value
Care transition	Care transition (inpatient)	A higher value is better than a lower value
CMS MORT	Centers for Medicare and Medicaid Services (CMS) risk standardized mortality rate	A lower value is better than a higher value
ED Throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like – HED90_1	Healthcare Effectiveness Data and Information Set (HEDIS) composite score related to outpatient behavioral health screening, prevention, immunization, and tobacco	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS composite score related to outpatient care for diabetes and ischemic heart disease	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 – GM90_1	ORYX inpatient composite of global measures	A higher value is better than a lower value

Measure	Definition	Desired Direction
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
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
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
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
SC care coordination	SC (specialty care) care coordination	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
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center.

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 7, 2021

From: Director, VA Rocky Mountain Network (10N19)

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

To: Director, Office of Healthcare Inspections (54CH06)

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

1. I have reviewed the findings, recommendations, and action plan of the Eastern Oklahoma VA Health Care System in Muskogee. I am in agreeance with the above.

(Original signed by:)

Ralph Gigliotti

Network Director, VISN 19

Appendix G: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: June 25, 2021

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

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

To: Director, VA Rocky Mountain Network (10N19)

1. I have read and concur with the findings and recommendations in the OIG Report entitled, Comprehensive Healthcare Inspection of the Eastern Oklahoma VA Health Care System in Muskogee.

2. My response to each report recommendation can be found in the attached document.

(Original signed by:)

Mark E. Morgan, MHA, FACHE

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