DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Oklahoma City VA Health Care System in Oklahoma

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

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
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 Oklahoma City VA Health Care System, which includes multiple outpatient clinics in Oklahoma and one in Texas. 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 Oklahoma City 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

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[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 five recommendations to the System Director, Chief of Staff, and Associate Director of Patient Care Services. 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 System Director, Chief of Staff, Associate Director for Patient Care Services, Associate Director, and Assistant Director. Organizational communications and accountability were managed through a committee reporting structure, with the Quality, Safety, and Value Committee providing oversight of several working groups.

When the team conducted this inspection, the healthcare system's leaders had worked together for over two years. The Director, assigned in June 2016, was the most tenured leader. The Assistant Director, assigned in May 2018, was the newest executive leader.

The OIG reviewed selected employee satisfaction and patient experience survey items. The results demonstrated employee satisfaction with leaders in multiple areas. However, opportunities appeared to exist for the Associate Director for Patient Care Services, Associate Director, and Assistant Director to reduce employee feelings of moral distress at work.[2] Although the selected patient experience survey scores generally reflected lower care ratings than the VHA averages, system leaders described strategies that were implemented to promote engagement with male and female patients. The inspection team also reviewed accreditation agency findings, sentinel events, and disclosures of adverse patient events and did not identify any substantial organizational risk factors.[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

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[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. The 2020 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."

[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."

way to understand the similarities and differences between the top and bottom performers within VHA.[4]

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

Registered Nurse Credentialing

The OIG found that registered nurses hired between January 1 and October 26, 2020, were free from potentially disqualifying licensure actions. However, credentialing staff did not consistently complete primary source verification of each registered nurse license prior to appointment.

Medication Management

The OIG found the healthcare system addressed many of the indicators of expected performance, including availability of staff to receive remdesivir shipments, confirmation of COVID-19 infection and inclusion criteria, completion of required testing prior to medication administration, and reporting of adverse events to the Food and Drug Administration. However, the OIG found deficiencies with the provision of patient/caregiver education.

Mental Health

The healthcare system complied with requirements related to suicide prevention screening within emergency departments. However, the OIG found that staff responsible for suicide safety plan development had not completed the required training. Additionally, the OIG found that staff who develop suicide safety plans were not available to support all Emergency Department operational hours.

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[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.

Care Coordination

Generally, the healthcare system complied with requirements for an inter-facility transfer policy, completion of the required inter-facility transfer form, and nurse-to-nurse communication at sending and receiving facilities. However, the OIG identified deficiencies with the monitoring and evaluation of inter-facility transfers and transmission of patients' advance directives to receiving facilities.

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 required member attendance at Disruptive Behavior Committee meetings and staff completion of required training.

Conclusion

The OIG conducted a detailed inspection across eight key areas (two administrative and six clinical) and subsequently issued five recommendations for improvement to the System Director, Chief of Staff, and Associate Director for Patient Care Services. 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 the recommendations to help guide improvements in operations and clinical care. The recommendations address issues that may eventually interfere with the delivery of quality health care.

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 G and H, pages 58–59, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendations 1 and 4 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
for Healthcare Inspections

Contents

Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to 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 Oklahoma City 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

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[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)

7. Care coordination (spotlighting inter-facility transfers)

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 Oklahoma City VA Health Care System includes multiple outpatient clinics in Oklahoma and one in Texas. 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 healthcare system leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection examined operations from June 16, 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 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.

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[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)

9. VHA performance data (community living center (CLC))[11]

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 System Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, and Assistant Director. The Chief of Staff and ADPCS oversaw patient care, which required managing service directors and chiefs of programs and practices.

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

[11] VHA Directive 1149, *Criteria for Authorized Absence, Passes, and Campus Privileges for Residents in VA Community Living Centers*, June 1, 2017. CLCs, previously known as nursing home care units, provide a skilled nursing environment and a variety of interdisciplinary programs for persons needing short- and long-stay services.

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│ Chief of   │ │  ADPCS   │ │  Associate  │ │ Assistant   │
│   Staff    │ │          │ │  Director   │ │  Director   │
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System Director

Chief of Staff

Ambulatory Care & Community-Based Outpatient Clinics
Anesthesiology
Associate Chief of Staff Education
Audiology & Speech Pathology
Dental
Geriatrics & Extended Care
Medicine
Neurology & Rehabilitation
Nuclear Medicine
Pathology & Laboratory
Pharmacy
Psychiatry
Psychology
Radiology
Research & Development
Social Work
Surgery

ADPCS

Non-VA Coordination/Fee
Nursing
Sterile Processing Service

Associate Director

Education
Fiscal
Human Resources
Information and Technology
Information Security Office
Logistics
Medical Administration
Privacy Office
Prosthetics & Sensory Aids
Public Affairs & Medical Media
Purchasing & Contracting
Veterans Transportation Service

Assistant Director

Chaplain
Customer Service
Engineering
Environmental Management
Environment of Care
Nutrition & Food
Police & Security
Veterans Canteen Service
Voluntary & Library

Compliance
Equal Employment Opportunity
Group Practice Manager
Office of Quality, Safety and Value
Research Compliance

Figure 3. Healthcare system organizational chart.

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

At the time of the OIG inspection, the executive team had worked together for over two years (since the Assistant Director joined in May 2018). The Director had held the position since June 2016. The Chief of Staff, ADPCS, and Associate Director were assigned in 2017 (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
System Director	June 12, 2016
Chief of Staff	February 19, 2017
Associate Director for Patient Care Services	March 5, 2017
Associate Director	December 10, 2017
Assistant Director	May 13, 2018

Source: Oklahoma City VA Health Care System acting Senior Strategic Business Partner, (received December 7, 2020).

To help assess the healthcare system executive leaders' engagement, the OIG interviewed the System Director, Chief of Staff, ADPCS, Associate Director, and Assistant Director regarding their knowledge of various performance metrics and their involvement and support of actions to

improve or sustain performance. During individual interviews, the leaders openly discussed the challenges the system encountered during the COVID-19 pandemic and were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and patient experiences. The healthcare system leaders were also knowledgeable within their scope of responsibilities about selected VHA data used by the SAIL and CLC SAIL models.[12] These are discussed in greater detail below.

The Director served as the chairperson of the Quality, Safety, and Value Committee, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Quality, Safety, and Value Committee was also responsible for tracking and trending quality care and patient outcomes and oversaw various working groups including the Clinical, Nurse, and Administrative Executive Boards (see figure 4).

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[12] The healthcare system's CLC is a short-stay unit and encompasses rehabilitation, geropsychiatry, and palliative and end of life care.

Quality, Safety, and Value Committee

Clinical Executive Board

Cancer Committee
Cardiopulmonary Resuscitation
Clinical Product Review
Education
Geriatrics and Extended Care
Homeless
Infection Prevention & Control
Intensive Care Unit
Medical Records
Mental Health Executive Board
Nutrition
Operative & Invasive
Outreach
Pain Management
Patient Aligned Care Team
Peer Review
Pharmacy & Therapeutics
Professional Standards Board-Credentialng Committee
Research & Development
Telehealth
Utilization Management
Women Veteran's Health

Nurse Executive Board

Clinical Bar Coded Medication Administration Committee
Clinical Practice Council
Community Care Council
Evidenced Based Practice
Recruitment & Retention
Restraint & Seclusion
Reusable Medical Equipment
Safe Patient Handling
Skin Integrity
VA Nursing Academic Partnership

Strategic Improvement Board

Customer Service
Environment of Care
Facility Operations Committee
VA Voluntary Service
Veteran Family Advisory

Administrative Executive Board

Access/Consult
Automated Data Processing Application Coordinator
Contract Management
Data Validation
Equipment
Executive Resources Board
Major Medical Equipment
Travel
Veterans Equitable Resource Allocation
Workforce Development

Compliance
Controlled Substance
Integrated Ethics
Patient Safety
Systems Redesign

Figure 4. Healthcare system committee reporting structure.

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

Budget and Operations

The healthcare system's FY 2020 annual medical care budget of $686,667,275 increased over 16 percent compared to the previous year's budget of $590,212,245.[13] When asked about the effect of this change on the healthcare system's operations, the Director verified that funding had been adequate and indicated the extra funding received for the pandemic response was beneficial for hiring staff. The Director reported that with the market expanding and patient volume increasing, the system was also establishing new outpatient clinics and expanding services in the community at the time of this virtual review.

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[13] VHA Support Service Center.

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 occupational shortages as noted in the *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[17] System leaders confirmed that several of the occupations listed in table 2 remained in the top clinical and nonclinical shortages at the time of the OIG inspection. The System Director reported that they were able to hire more staff due to pandemic hiring flexibilities but there were still shortages. The leaders discussed recruitment and retention challenges related to the pandemic, salary competition, rural location, and proximity of academic affiliates. System leaders described strategies implemented to address clinical and nonclinical occupational shortages. These strategies included staff conducting job fairs, working with national physician recruiters, establishing contracts with local vendors to clean and disinfect public spaces, and recruiting students enrolled in VA nursing programs and nurse practitioner fellowships.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Cardiology Non-Interventionist	1. General Engineering
2. Cardiology-Interventional	2. Custodial Worker
3. Orthopedic	3. Human Resources Management
4. Hematology/Oncology	4. –
5. Orthopedic Surgery	5. –

Source: VA OIG.

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[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*.

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, 2019, through September 30, 2020.[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 averages for the selected survey leadership questions were similar to the VHA average; but the scores for the Director, Chief of Staff, and Associate Director were consistently higher than those for VHA and the healthcare system.[20]

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[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, Associate Director, and Assistant Director.

[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 3. Survey Results on Employee Attitudes toward Healthcare System Leaders (October 1, 2019, through September 30, 2020)

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *Servant Leader Index Composite.**	0–100 where higher scores are more favorable	72.6	72.6	95.3	86.8	75.6	80.4	72.5
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	3.4	4.6	4.3	3.4	3.9	3.6
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.6	3.7	4.6	4.5	3.8	3.9	3.9
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree)– 5 (Strongly Agree)	3.6	3.7	4.7	4.5	3.9	4.1	4.2

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.*

During interviews, multiple examples were provided that demonstrate system leaders' active engagement and commitment to servant leadership. One example included the Director changing into medical scrubs to assist with transporting lab specimens, as well as completing various other tasks to assist frontline staff as needed. Another example included leaders sleeping in the facility to meet with evening, night, and weekend staff to better understand concerns. This appeared consistent with leaders' message to staff that "we are all in this together." The Director identified

the employees as the "unsung heroes" and communicated how their resilience during the previous nine months was astonishing.

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey.[21] The healthcare system's average for the selected survey questions was similar to the VHA average. Scores for the Director were consistently better than VHA and healthcare system averages. Scores for the Chief of Staff were equal to or better than those for VHA and the healthcare system. However, opportunities appeared to exist for the ADPCS, Associate Director, and Assistant Director 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, 2019, through September 30, 2020)

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. 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	3.8	4.6	4.5	4.2	4.3	3.9
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	3.8	4.5	4.4	3.6	4.1	3.5

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

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. 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	1.4	0.6	1.4	1.8	2.1	1.9

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 implementing strategies from VA's "Stand Up to Stop Harassment Now!" campaign.[23] To demonstrate a commitment to a culture of safety, system leaders implemented a "See Something, Say Something" campaign through Education Service and a "Safe Harbor" campaign through Chaplain Service. The Assistant Director also described how system leaders signed the "Stand Up to Stop Harassment Now!" campaign declaration. A poster of the signed declaration is displayed in a high-traffic area within the healthcare system.

Table 5 summarizes employee perceptions related to respect and discrimination based on VHA's All Employee Survey responses. The healthcare system and executive leadership team averages for the selected survey questions were similar to or better than the VHA averages. Leaders appeared to maintain an environment where staff felt respected and safe and discrimination was not tolerated.

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[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, 2019, through September 30, 2020)

Questions/ Survey Items	Scoring	VHA Average	Health-care System Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.9	4.7	4.5	3.9	3.8	4.0
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree) –5 (Strongly Agree)	4.0	4.0	4.8	4.4	4.3	4.2	4.0
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	4.8	4.6	4.1	3.9	4.1

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 31, 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 Oklahoma City VA Health Care System.[24] For this system, the overall patient satisfaction survey results reflected lower care ratings than the VHA average.

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

The leaders described strategies used to improve the inpatient experience. These strategies included relocating inpatient pharmacists to inpatient units to meet with patients, review their medications, provide education and training, and perform medication reconciliation.

System leaders provided multiple reasons for lower outpatient scores, including cultural differences among staff and patients, as well as geographic rurality that made access to specialty care challenging for some patients. Actions taken in response to the scores included leaders holding staff accountable for customer service, relocating gynecology services to primary care, training women's health primary care providers, and adding customer service as an element to providers' pay-for-performance plans.

The ADPCS reported the system began scheduling patients for a 15-minute appointment with a licensed practical nurse prior to seeing a physician in an effort to facilitate patient concerns prior to the appointment. System leaders also spoke of implementing pre-visit comment cards where patients list topics they want to discuss with the provider. At the beginning of the visit, the patient gives the card to the provider, which helps ensure their needs are met.

Additionally, the Associate Director reported that inpatient schedulers were trained to schedule follow-up outpatient appointments for patients to be seen by their primary care provider within seven days of discharge. This streamlines the process and provides continuity of care.

The healthcare system also implemented strategies to minimize patient care barriers during the COVID-19 pandemic. The system provided the OIG with a video highlighting the implementation of a centralized area for high-volume services. Multiple services were relocated to the ground floor to reduce the need for patients to travel throughout the facility. These services included the laboratory, pharmacy, hearing aid repairs, a flu and allergy injection clinic, and COVID-19 screening.

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

Questions	Scoring	VHA Average	Health-care 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	62.4
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	80.9

Questions	Scoring	VHA Average	Health-care System Average
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	81.7

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 OIG found that selected survey results for both male and female respondents were generally less favorable than the corresponding VHA averages. However, system leaders described strategies implemented to promote engagement with male and female patients.

Regarding appointment availability, system leaders discussed the significant increase in telehealth appointments. The System Director reported that, prior to the pandemic, there were approximately 50 telehealth appointments per week, but since the pandemic, the number dramatically increased to over 800 per week.

The Associate Director stated the lack of obstetrics services may be a source of dissatisfaction for female patients. Several leaders also acknowledged that the women's health clinic shared space with the agent cashier, which was a heavily-accessed area by veterans.[26] Plans were underway to relocate the agent cashier away from this area. The healthcare system also hired a full-time gynecologist.

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[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.

[26] Agent cashiers are designated employees who are responsible for disbursing cash and performing other cash operations.

**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	62.2	–
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	78.9	–
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	82.0	–

Source: VHA Office of 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 402–406 male respondents, depending on the question.

‡Due to the low number of respondents, no data were available.

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	49.8	46.9

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
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	59.1	54.8
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	69.3	62.9

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 652–1,689 male and 62–124 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	41.5	40.1
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	54.3	32.7

Questions	Scoring	VHA*		Healthcare System	
		Male Average	Female Average	Male Average	Female Average
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	74.2	52.1

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

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

The healthcare system averages are based on 448–1,367 male and 26–76 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.[27] Table 10 summarizes the relevant system inspections most recently performed by the OIG and The Joint Commission (TJC).[28] At the time of the OIG review, the system had closed all recommendations for improvement issued since the previous CHIP site visit conducted in June 2018.

The OIG team also noted the system's current accreditation by the Commission on Accreditation of Rehabilitation Facilities.[29] Additional external survey results included the Long Term Care

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[27] "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."

[28] 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."

[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 collaboration with CARF [Commission on Accreditation of Rehabilitation Facilities] to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs."

Institute's inspection of the system's CLC.[30] Although the facility's accreditation with the College of American Pathologists had ended in August 2020, the facility received a certificate of accreditation from the Department of VA Pathology and Laboratory Medicine Service National Enforcement Office on February 1, 2019, which was effective for two years.[31]

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 Program Review of the Oklahoma City VA Health Care System, Oklahoma*, Report No. 18-01141-309, September 27, 2018)	June 2018	2	0
TJC For Cause (Hospital)	August 2018	0	–
TJC Hospital Accreditation	February 2020	45	0
TJC Behavioral Health Care Accreditation		8	0
TJC Home Care Accreditation		4	0
TJC Behavioral Health Care and Human Services Accreditation	October 2020	5	5

Source: OIG and TJC (inspection/survey results received from the Chief, Office of Quality Safety Value on December 7, 2020).

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.

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[30] "About Us," Long Term Care Institute, accessed December 8, 2020, http://www.ltciorg.org/about-us/. The Long Term Care Institute is "focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice, and other residential care settings."

[31] The system was transitioning to The Joint Commission accreditation for laboratory services. "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 11 lists the reported patient safety events from June 11, 2018 (the prior OIG CHIP site visit), through December 6, 2020.[32]

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

Factor	Number of Occurrences
Sentinel Events	19
Institutional Disclosures	16
Large-Scale Disclosures	0

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

The Director spoke knowledgeably about serious adverse event reporting and indicated that staff report adverse events during the daily reports. The Director also explained that the Risk Manager and Chief of Staff initiate the adverse event follow-up process after conferring with the Director and legal representatives to collaboratively decide if an institutional disclosure is warranted.

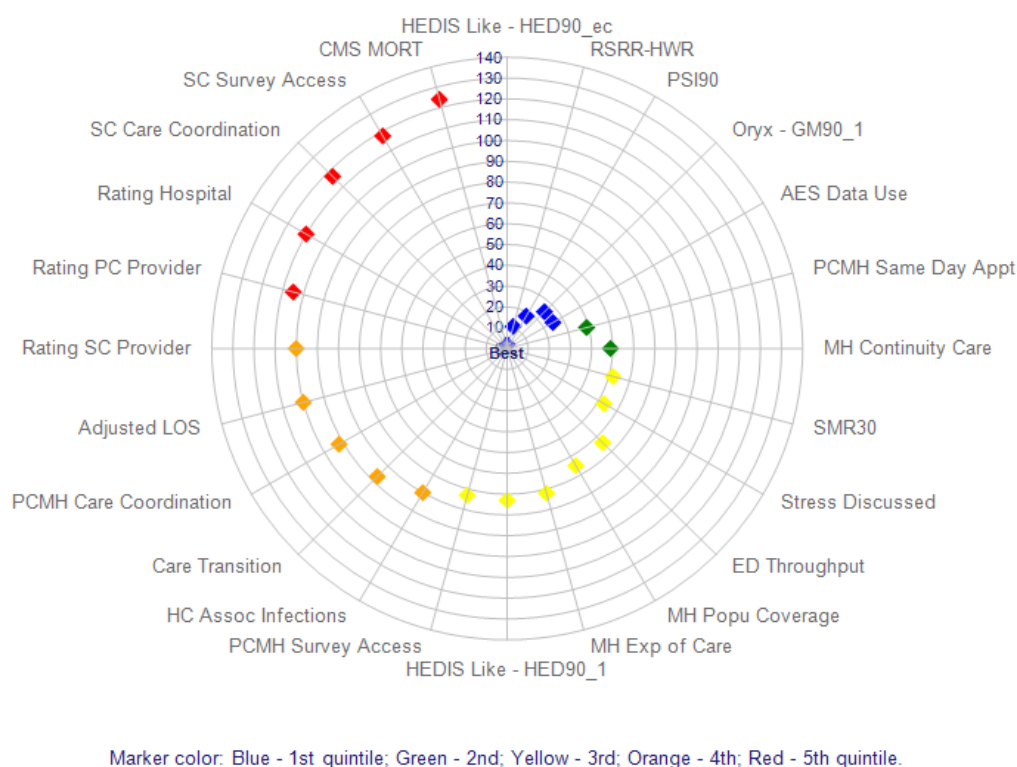## Veterans Health Administration Performance Data for the Healthcare System

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

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[32] 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 Oklahoma City VA Health Care is a high complexity (1b) 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."

clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[33]

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 Oklahoma City VA Health Care System's performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of Healthcare Effectiveness Data and Information Set (HEDIS) composite score related to outpatient care for diabetes and ischemic heart disease (HED90_ec), patient-centered medical home (PCMH) same day appointment (appt), and mental health (MH) continuity (of) care). 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) specialty care (SC) provider, rating (of) hospital, and specialty care (SC) survey access).[34]

Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

Figure 5. System quality of care and efficiency metric rankings for FY 2020 quarter 3 (as of June 30, 2020).

Source: VHA Support Service Center.

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

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[33] "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.)

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

Veterans Health Administration Performance Data for the Community Living Center
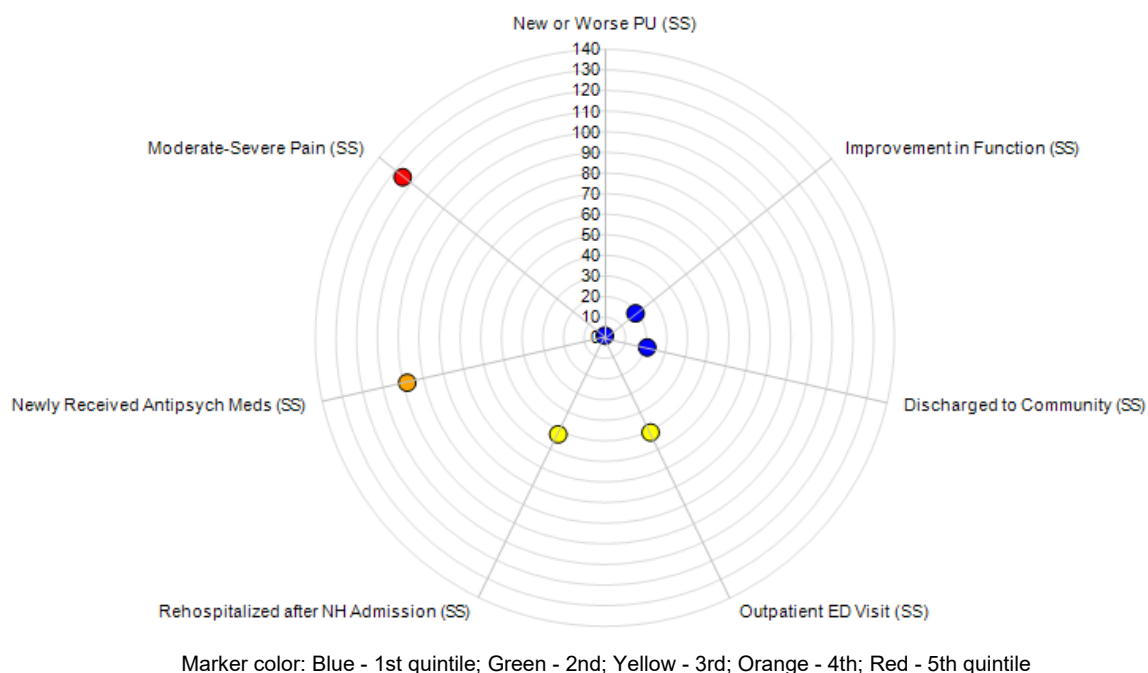
The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA." The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[35]

Figures 6 illustrates the healthcare system's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. Figure 6 displays the Oklahoma City VA Health Care System's CLC metrics with high performance (blue data points) in the first quintile (for example, in the areas of improvement in function–short-stay (SS) and discharged to community (SS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (newly received antipsychotic medications (antipsych meds) (SS) and moderate-severe pain (SS)).[36]

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[35] Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, July 23, 2020. "In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several "star" ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes."

[36] For data definitions of acronyms in the SAIL CLC measures, please see appendix F.

Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile

Figure 6. *Oklahoma City CLC quality measure rankings, FY 2020 quarter 3 (as of June 30, 2020).*

SS = Short-Stay Measure.

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

The system's executive leadership team had worked together for over two years. The Director indicated the increased FY 2020 budget for the pandemic response was beneficial for hiring staff, and executive leaders were able to discuss interim strategies to address clinical and nonclinical occupational shortages.

Selected employee satisfaction survey items demonstrated satisfaction in multiple areas with the System Director and Chief of Staff. However, opportunities appeared to exist for the ADPCS, Associate Director, and Assistant Director to reduce employee feelings of moral distress at work. Selected patient experience survey scores generally reflected lower care ratings than the VHA average. However, system leaders described strategies implemented to promote engagement with male and female patients. The OIG's review of the system's accreditation findings, sentinel events, and disclosures did not identify any substantial organizational risk factors.

System leaders were knowledgeable within their scope of responsibilities about VHA data and/or system-level factors contributing to poor performance on specific SAIL measures. In individual interviews, system leaders were able to speak in depth about actions taken during the previous

12 months to maintain or improve organizational performance, employee satisfaction, and patient experiences.

The OIG made no recommendations.

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.[37] 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.[38]

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."[39] "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."[40]

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 system and its leaders' subsequent responses. The OIG analyzed performance in the following domains:

- Emergency preparedness

- Supplies, equipment, and infrastructure

- Staffing

- Access to care

- CLC patient care and operations

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.[41]

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[37] "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.

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

[39] 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."

[40] 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.

[41] 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.[42] 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.[43] 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."[44]

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 support "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."[45] 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

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[42] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[43] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

[44] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

[45] 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.[46] 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."[47] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[48] 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[49]

- Completion of final reviews within 120 calendar days

- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[50]

- 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

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[46] 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."

[47] VHA Directive 1190.

[48] VHA Directive 1190.

[49] VHA Directive 1190.

[50] 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."[51] 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[52]

The OIG 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.[53]

Quality, Safety, and Value Findings and Recommendations

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

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[51] "NSO Reporting, Resources, & Tools," VA Surgical Quality Improvement Program, accessed November 21, 2020, https://vaww.nso.med.va.gov/apps/VASQIP/Pages/Default.aspx. (This is an internal VA website not publicly accessible.)

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

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

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."[54] 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."[55]

VA requires all RNs to hold at least one active, unencumbered license.[56] 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.[57] 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.[58] 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.[59]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key employees and managers and reviewing relevant documents for 80 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 credentialing files for 30 of the 80 RNs to determine whether healthcare system staff completed primary source verification prior to the appointment.

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

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

[56] 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."

[57] 38 U.S.C. § 7402.

[58] VHA Directive 2012-030.

[59] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

The OIG found that RNs hired between January 1 and October 26, 2020, were free from potentially disqualifying licensure actions. However, the OIG found vulnerabilities in the primary source verification process.

VHA requires the System Director to ensure that "all licenses including not only current licenses, but all previously held, must be verified through primary source verification," which "must be completed at the time of initial application."[60] The OIG found that 5 of 30 RNs' credentialing files reviewed lacked documentation of primary source verification for each license held prior to entrance on duty. Failure to verify each nursing license may have resulted in the inappropriate hiring of nurses, which could have subsequently affected the provision of quality care. The Credentialing and Privileging Supervisor reported believing they were meeting the requirement by verifying the primary source for the license(s) provided by the nurses in VetPro. Additionally, the Credentialing and Privileging Supervisor stated that these five RNs did not have complete records despite being instructed to include all licenses in VetPro.

Recommendation 1

1. The System Director evaluates and determines any additional reasons for noncompliance and ensures that credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment.[61]

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[60] VHA Directive 2012-030.

[61] The OIG reviewed evidence sufficient to demonstrate that the healthcare system had completed improvement actions, and therefore, closed the recommendation before publication of the report.

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The System Director reviewed and determined that there were no additional reasons for noncompliance. The Credentialing and Privileging (C&P) Supervisor provided education to all C&P staff instructing them to utilize the Nursys system to verify all nurse licensure. The C&P supervisor also updated the initial email correspondence sent to new providers undergoing credentialing. The email correspondence stresses the importance of entering all licensure, to include expired licenses into VetPro.

The C&P Supervisor conducts monthly audits to ensure each licensure for all newly selected Registered Nurses (RNs) were verified and have appropriate Nursys verified license uploaded.

Compliance has been continuously monitored by the C&P Supervisor. This metric is tracked as follows: the numerator is the total number of Registered Nurses with initial appointments during the month reviewed that had all licensure verified through Nursys. The denominator is the total number [of] Registered Nurses with initial appointments during the month reviewed. The target is 90 percent compliance for two consecutive quarters. Ongoing review shows >90% compliance for two consecutive quarters was met.

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.[62] 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.[63]

VA issued a memorandum on May 8, 2020, which outlined the use of remdesivir under the FDA's Emergency Use Authorization criteria.[64] 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.[65]

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."[66] The FDA subsequently approved remdesivir on October 22, 2020, for use in adult patients requiring hospitalization for the treatment of COVID-19.[67]

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 50 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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[62] 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.

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

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

[65] 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*.

[66] 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.

[67] Food and Drug Administration, "FDA News Release: FDA Approved 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

   o Potential pregnancy

   o Kidney assessment (estimated glomerular filtration rate)[68]

   o Liver assessment (alanine transferase or serum glutamic pyruvic transaminase)[69]

- Patient/caregiver education provided

- Staff reported any adverse events to the FDA

Medication Management Findings and Recommendations

The OIG found the healthcare system addressed many of the indicators of expected performance, including availability of staff to receive medication shipments, confirmation of COVID-19 infection and inclusion criteria, completion of required testing prior to medication administration, and reporting of adverse events to the FDA. However, the OIG found deficiencies with the provision of patient/caregiver education.

Under the Emergency Use Authorization, VA Pharmacy Benefits Management Services required healthcare providers to provide the "Fact Sheet for Patients and Parents/Caregivers," inform patients or caregivers that remdesivir was not an FDA-approved medication, provide the option to refuse the medication, and advise patients or caregivers of known risks, benefits, and alternatives to remdesivir prior to administration.[70] For the 50 electronic health records reviewed, the OIG found that clinical staff did not

- provide the "Fact Sheet for Patients and Parents/Caregivers" to 94 percent of patients or caregivers before administering remdesivir,"

- inform 80 percent of patients or caregivers that remdesivir was not an FDA-approved medication,

- inform 48 percent of patients or caregivers of the option to refuse remdesivir,

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[68] "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."

[69] "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," of which a high level may be indicative of liver damage.

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

- inform 68 percent of patients or caregivers of the potential risks and benefits, and

- advise 92 percent of patients or caregivers of alternatives to receiving remdesivir prior to administration.

This could have resulted in patients or caregivers lacking the information needed to make a fully informed decision to receive the medication. The Chief of Medical Service stated that the fact sheet was not always shared with a patient due to the individual's medical condition. The Chief of Medical Service also shared that providers spoke with caregivers via telephone, and therefore, it was not possible to provide a paper copy of the fact sheet.

Given the FDA's approval of remdesivir for use in adult patients requiring hospitalization for the treatment of COVID-19, the OIG made no recommendations related to Emergency Use Authorization requirements.[71]

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

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.[72] 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.[73] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[74]

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.[75] 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.[76] 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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[72] "Preventing Suicide," Centers for Disease Control and Prevention, accessed December 9, 2020, https://www.cdc.gov/violenceprevention/suicide/fastfact.html.

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

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

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

[76] 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 50 randomly selected patients who were seen in the emergency department from December 1, 2019, through August 31, 2020; and

- staff training records.

Mental Health Findings and Recommendations

The OIG found the healthcare system generally complied with the initiation of the Columbia-Suicide Severity Rating Scale and completion of all required elements of the rating scale note. However, the OIG identified a deficiency with staff training.

VHA has identified various staff members who, with proper training, can complete suicide safety plans for patients. Additionally, VHA requires staff who develop these safety plans to complete specific training.[77] The OIG was told that the five staff members responsible for developing suicide safety plans were all social workers, and incidentally, were not providing 24/7 coverage to support Emergency Department hours.[78] Further, the OIG determined that all five staff had not completed the required training. Lack of training and unavailability afterhours could prevent staff from providing optimal treatment to veterans who are at risk for suicide. The Chief of Staff confirmed that social workers were the only discipline identified by the facility to create suicide safety plans and were scheduled to work Monday through Friday, 7:00 AM to 11:00 PM. The Emergency Department Social Work Supervisor reported not being aware of the required training and learned during the OIG inspection that other disciplines could also complete safety plans.

Recommendation 2

2. The Chief of Staff evaluates and determines any additional reasons for noncompliance and ensures that staff complete suicide safety plan training prior to developing suicide prevention safety plans.

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[77] *VA Suicide Prevention Safety Plan and Suicide Behavior and Overdose Report (SBOR) Templates, Staff Specific Guidance*, April 17, 2019. (This document was updated on June 18, 2020. The two documents contain similar language related to training requirements.)

[78] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017. (The amended document contains similar language related to emergency department operating hours.)

Healthcare system concurred.

Target date for completion: December 31, 2021

Healthcare system response: The Chief of Staff reviewed and determined that there were no additional reasons for noncompliance. The Associate Chief of Staff (ACOS), Behavioral Health Services, who reports to the Chief of Staff, identified the individuals responsible for completing safety plan training and ensured the Talent Management System (TMS) Safety Plan Trainings were assigned to the employees in TMS.

The ACOS, Behavioral Health Services conducts monthly audits to ensure staff complete the Suicide Safety Planning Training (TMS Course 36232) prior to developing suicide prevention safety plans. This metric is tracked as follows: the numerator is the total number of reviewed suicide prevention safety plans that were developed during the month by staff who have completed the TMS Course: Suicide Safety Planning Training. The denominator is the total number of suicide prevention safety plans reviewed during the month. Compliance will be measured and reported quarterly to the Clinical Executive Board until 90% compliance is met for six consecutive months.

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.[79]

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.[80]

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 38 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

The OIG found general compliance with requirements for an inter-facility transfer policy, completion of the required VA *Inter-Facility Transfer Form* or facility-defined equivalent, and nurse-to-nurse communication at sending and receiving facilities. However, the OIG identified deficiencies with the monitoring and evaluation of inter-facility transfers and transmission of patients' advanced directives to receiving facilities.

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

[80] 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.

VHA requires the Chief of Staff and ADPCS to ensure that "all transfers are monitored and evaluated as part of VHA's Quality Management Program."[81] The OIG did not find evidence of monitoring and evaluation of patient transfers from October 1, 2019, through September 30, 2020. Failure to monitor patient transfer data could prevent the identification of system-level deficiencies that put patients at risk. The Clinical Transfer Coordinator and former Nurse Manager, Patient Flow and Coordination stated they had not reported patient transfer data in the past. The Chief Nurse, Intensive Services reported being unaware of this requirement.

Recommendation 3

3. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine additional reasons for noncompliance and make certain that all transfers are monitored and evaluated as part of Veterans Health Administration's Quality Management Program.

Healthcare system concurred.

Target date for completion: December 31, 2021

Healthcare system response: The Chief of Staff and Associate Director of Patient Care Services reviewed and determined that there were no additional reasons for noncompliance. The Chief of Staff and Associate Director for Patient Care Services reviewed the transfer process at the Oklahoma City VA Health Care System and ensured documentation included all required elements.

The Associate Director of Patient Care Services or designee is responsible for monitoring and evaluating all transfers as part of the Quality Management Program to ensure compliance with VHA Directive 1094. The results of the ongoing monitoring will be reported to the Utilization Management Committee. The metric will be monitored until reporting transfer data to the Utilization Management Committee for 90% of committee meetings is met for 6 months.

VHA requires the Chief of Staff and ADPCS to ensure that transferring physicians or the assigned designees "send all pertinent medical records available, including…documentation of the patient's advance directive made prior to transfer, if any" to the receiving facility.[82] The OIG found eight electronic health records where the patient had an advanced directive but the records lacked evidence that staff sent a copy to the receiving facility. As a result, there was no assurance that receiving facility staff could determine the patient's healthcare preferences. Due to the low number of patients identified for this review element, the OIG made no recommendation.

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[81] VHA Directive 1094.
[82] VHA Directive 1094.

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."[83] 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."[84] 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[85]

- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[86]

- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[87]

- Patient notification of an Order of Behavioral Restriction

- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[88]

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

[84] VHA Directive 2012-026.

[85] 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."

[86] 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."

[87] 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."

[88] 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 the assessment results deem a facility location as high risk, staff are required to complete parts 1, 2, and 3 of the training.[89] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[90] 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, training records, and interviewed key managers and staff.

High-Risk Processes Findings and Recommendations

The OIG determined that the healthcare system complied with many of the requirements for the management of disruptive and violent behavior. However, the OIG identified deficiencies with required member attendance at Disruptive Behavior Committee meetings and staff completion of required training.

VHA requires that the Chief of Staff and ADPCS establish a disruptive behavior committee or board that includes a senior clinician chairperson, and representation from the Prevention Management of Disruptive Behavior Program, VA police, patient safety or risk management, patient advocacy, the Union Safety Committee, and clerical and administrative support staff.[91] The OIG reviewed attendance for the Disruptive Behavior Committee meetings from July 2 through December 3, 2020, and found clerical and administrative support staff did not attend 7 of 12 of meetings.[92] Absence of clerical and administrative support staff may impede the accomplishment of required tasks. The Chief of Education reported that staffing shortages negatively affected the ability of clerical and administrative support staff to attend meetings.

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

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

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

[92] Union Safety Committee representative also did not attend but was not included in the finding based on *Executive Order Ensuring Transparency, Accountability, and Efficiency in Taxpayer Funded Union Time Use*, Issued May 25, 2018.

Recommendation 4

4. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and make certain that required members attend Disruptive Behavior Committee meetings.[93]

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Chief of Staff and Associate Director of Patient Care Services reviewed and determined that there were no additional reasons for noncompliance. The required Disruptive Behavior Committee members were identified and appointed to the committee. The attendance of all required members, as identified by VHA Directive, of the Disruptive Behavior Committee will be monitored.

The Workplace Violence Prevention Program (WVPP) Program Specialist will monitor for required attendance at the Disruptive Behavior Committee. The metric will be tracked as: the numerator is the attendance of required Disruptive Behavior Committee members during each Disruptive Behavior Committee meeting held. The denominator is the number of required committee members. Ninety percent of members required by VHA Directive will attend each meeting. Monitoring will continue until compliance has been maintained for 2 consecutive quarters.

Ongoing reviews show >90% compliance for two consecutive quarters was met.

VHA requires employees to complete prevention and management of disruptive behavior training based on the risk level assigned to their work areas.[94] The OIG found 30 percent of employees did not complete the required trainings based on the risk level for their work areas. This could result in employees' lack of awareness, preparedness, and precautions when responding to disruptive behavior. The Chief of Education and the Workplace Violence Prevention Program Coordinator reported that all face-to-face trainings had been placed on hold due to the pandemic.

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[93] The OIG reviewed evidence sufficient to demonstrate that the healthcare system had completed improvement actions, and therefore, closed the recommendation before publication of the report.

[94] DUSHOM Memorandum, *Update to Prevention Management of Disruptive Behavior (PMDB) Training Assignments*.

Recommendation 5

5. The System Director evaluates and determines any additional reasons for noncompliance and ensures employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work area.[95]

Healthcare system concurred.

Target date for completion: April 1, 2022

Healthcare system response: The System Director reviewed and determined that there were no additional reasons for noncompliance. Oklahoma City VA Health Care System [OKC VAHCS] resumed Face-to-Face PMDB on January 27th, 2021. PMDB training, to include Part 2 Low, Part 2 Mod-High, and Part 3 High, is now being offered weekly. All parts of PMDB training as of March 29th, 2021, are included in the OKC VAHCS New Employee Orientation to ensure all new employees meet the 90-day training requirement. In order to meet the PMDB training demands of the OKCVAHCS, a Train the Trainer (TTT) was requested and approved by the National PMDB Program Office. The OKC VAHCS PMDB TTT was conducted April 12-16th, 2021. The TTT resulted in 13 newly certified PMDB instructors. PMDB training compliance will be continually monitored. Service and facility leadership will be provided a deficiency report on a monthly basis. The OKC VAHCS PMDB program's current goal is to achieve 90% or greater training compliance by April 1, 2022. This metric is tracked as follows: the numerator is the total number of staff who completed Prevention and Management of Disruptive Behavior (PMDB) training at the appropriate level. The denominator is 100 percent of TMS users required to complete PMDB based on the risk level assigned. The target is 90 percent compliance for 2 consecutive quarters.

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[95] 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 five recommendations on 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 guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines five 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, Chief of Staff, and Associate Director for Patient Care Services. The intent is for the leaders to use these recommendations to guide improvements in operations and clinical care. The recommendations address 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) • VHA performance data (CLC)	• None	• None
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • 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	• None	• None
RN Credentialing	• RN licensure requirements • Primary source verification	• Credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment.	• 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	• Staff complete suicide safety plan training prior to developing suicide prevention safety plans.	• 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	• None	• All transfers are monitored and evaluated.
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	• Employees complete all required prevention and management of disruptive behavior training based on the risk level assigned to their work area.	• Required members attend Disruptive Behavior Committee meetings.

Appendix B: Healthcare System Profile

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

Table B.1. Profile for Oklahoma City VA Health Care System (635)
(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	$541,670,945	$590,212,245	$686,667,275
Number of:			
• Unique patients	61,414	62,516	63,470
• Outpatient visits	679,867	713,943	678,249
• Unique employees§	2,263	2,271	2,374
Type and number of operating beds:			
• Community living center	33	33	31
• Medicine	60	70	70
• Mental health	25	25	40
• Neurology	6	5	5
• Rehabilitation medicine	8	4	4
• Residential rehabilitation	16	16	16
• Surgery	26	14	14
Average daily census:			
• Community living center	25	27	26
• Medicine	60	58	62
• Neurology	3	2	2
• Rehabilitation medicine	3	3	2
• Residential rehabilitation	15	15	11

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[1] An affiliated healthcare system is associated with a medical residency program. VHA medical centers are classified according to a facility complexity model; a designation of "1b" indicates a facility with "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs."

Profile Element	Healthcare System Data FY 2018*	Healthcare System Data FY 2019	Healthcare System Data FY 2020‡
• Surgery	9	8	6

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).

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
Fort Sill, OK	635GA	13,363	3,977	Anesthesia Dermatology Endocrinology Eye Nephrology Orthopedics	Laboratory & Pathology	Dental Nutrition Pharmacy Prosthetics Social work Weight management
Wichita Falls, TX	635GB	4,340	2,739	Allergy Dermatology Endocrinology Nephrology	–	Nutrition Pharmacy Social work Weight management

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[1] The OIG omitted (635QD) Lawton North, OK; (635GI) Norman, OK; and (635GJ) Yukon, OK 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
Blackwell, OK	635GC	1,480	37	Endocrinology	–	Nutrition
Ada, OK	635GD	3,113	534	Anesthesia Dermatology Endocrinology Nephrology	–	Nutrition Pharmacy Social work Weight management
Stillwater, OK	635GE	2,934	919	Dermatology Endocrinology Nephrology	–	Nutrition Pharmacy Weight management
Altus, OK	635GF	1,429	562	Anesthesia Dermatology Endocrinology Nephrology	–	Nutrition Pharmacy Social work Weight management
Enid, OK	635GG	2,057	126	Dermatology Endocrinology Nephrology	–	Nutrition Social work Weight management
Clinton, OK	635GH	447	–	Cardiology	–	–
Ardmore, OK	635HB	2,522	761	Dermatology Endocrinology Nephrology	–	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
Oklahoma City, OK	635QA	9,247	348	Allergy Cardiology Endocrinology	–	Nutrition Pharmacy Weight management
Oklahoma City, OK	635QB	15,024	4,419	Anesthesia Cardiology Dermatology Endocrinology Eye Gastroenterology Hematology/ Oncology Nephrology Podiatry Pulmonary/ Respiratory disease	–	Nutrition Pharmacy Prosthetics Social work Weight management
Oklahoma City, OK	635QC	737	–	–	–	–
Tinker AFB, OK	635QE	119	–	–	–	–

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	(635) Oklahoma City, OK	(635GA) Lawton, OK	(635GB) Wichita Falls, TX	(635GC) Blackwell, OK	(635GD) Ada, OK	(635GE) Stillwater, OK	(635GF) Altus, OK	(635GG) Enid, OK	(635GH) Clinton, OK	(635HB) Ardmore, OK	(635QA) North May, OK	(635QB) South Oklahoma City, OK	(635QC) Fourteenth Street, OK	(635QE) Tinker, OK
OCT-FY20	6.9	2.3	1.1	0.1	1.2	0.0	0.0	2.8	0.9	n/a	3.2	2.6	1.2	0.0	n/a
NOV-FY20	7.1	2.5	0.7	0.0	0.0	0.0	0.9	2.1	1.2	n/a	0.9	5.6	0.9	0.0	n/a
DEC-FY20	7.8	2.0	0.9	0.0	0.0	0.0	0.0	2.9	1.7	n/a	2.3	3.6	0.6	0.0	n/a
JAN-FY20	8.3	4.5	2.7	0.0	1.4	0.0	0.1	2.5	0.0	n/a	6.2	2.4	0.7	0.0	n/a
FEB-FY20	8.1	1.8	2.9	0.0	0.0	0.0	1.0	2.1	0.1	n/a	5.0	1.7	1.3	0.0	n/a
MAR-FY20	6.9	1.2	4.7	0.3	0.0	0.0	1.0	0.7	0.2	n/a	1.9	1.5	0.5	0.0	n/a
APR-FY20	3.6	0.2	0.0	0.0	0.0	0.0	0.0	0.8	n/a	n/a	n/a	n/a	0.0	0.0	n/a
MAY-FY20	4.0	0.0	0.0	0.0	0.0	0.9	0.0	n/a	0.0	n/a	0.0	n/a	0.0	0.0	n/a
JUN-FY20	4.9	0.2	0.0	0.0	3.0	0.0	0.0	1.2	0.0	0.1	0.0	0.0	1.2	0.0	n/a
JUL-FY20	5.9	3.5	9.2	0.0	0.0	1.0	0.7	1.8	4.9	0.0	1.0	0.9	2.1	0.0	n/a
AUG-FY20	5.6	2.4	0.2	0.0	0.0	0.2	0.1	2.3	0.6	2.6	0.0	0.2	1.0	1.0	2.9
SEP-FY20	6.1	3.5	1.6	0.0	0.0	0.0	1.6	1.3	2.9	2.2	1.7	3.3	2.0	6.0	0.1

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 (635QD) Fort Sill, OK; (635GI) Norman, OK; and (635GJ) Yukon, OK, 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. The absence of reported data is indicated by "n/a."

Established Primary Care Patient Average Wait Time in Days

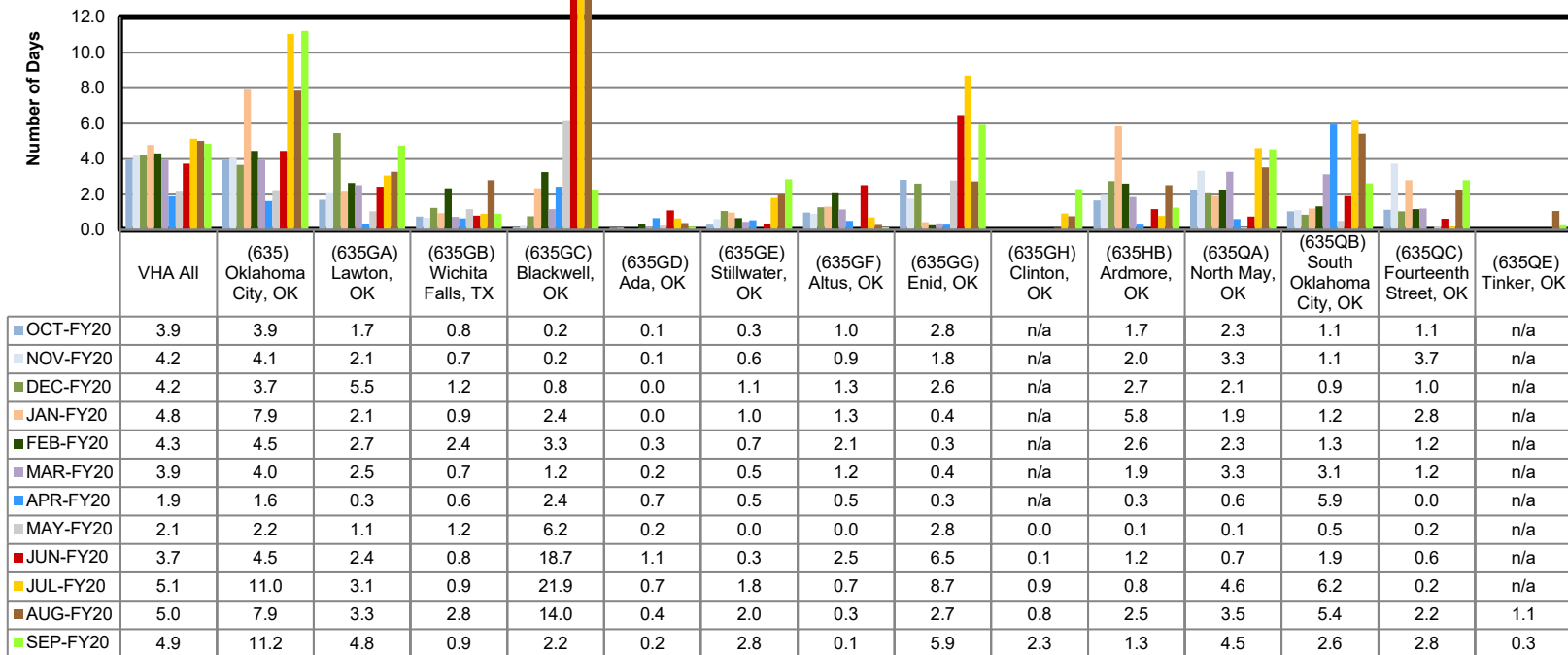|	VHA All	(635) Oklahoma City, OK	(635GA) Lawton, OK	(635GB) Wichita Falls, TX	(635GC) Blackwell, OK	(635GD) Ada, OK	(635GE) Stillwater, OK	(635GF) Altus, OK	(635GG) Enid, OK	(635GH) Clinton, OK	(635HB) Ardmore, OK	(635QA) North May, OK	(635QB) South Oklahoma City, OK	(635QC) Fourteenth Street, OK	(635QE) Tinker, OK
OCT-FY20	3.9	3.9	1.7	0.8	0.2	0.1	0.3	1.0	2.8	n/a	1.7	2.3	1.1	1.1	n/a
NOV-FY20	4.2	4.1	2.1	0.7	0.2	0.1	0.6	0.9	1.8	n/a	2.0	3.3	1.1	3.7	n/a
DEC-FY20	4.2	3.7	5.5	1.2	0.8	0.0	1.1	1.3	2.6	n/a	2.7	2.1	0.9	1.0	n/a
JAN-FY20	4.8	7.9	2.1	0.9	2.4	0.0	1.0	1.3	0.4	n/a	5.8	1.9	1.2	2.8	n/a
FEB-FY20	4.3	4.5	2.7	2.4	3.3	0.3	0.7	2.1	0.3	n/a	2.6	2.3	1.3	1.2	n/a
MAR-FY20	3.9	4.0	2.5	0.7	1.2	0.2	0.5	1.2	0.4	n/a	1.9	3.3	3.1	1.2	n/a
APR-FY20	1.9	1.6	0.3	0.6	2.4	0.7	0.5	0.5	0.3	n/a	0.3	0.6	5.9	0.0	n/a
MAY-FY20	2.1	2.2	1.1	1.2	6.2	0.2	0.0	0.0	2.8	0.0	0.1	0.1	0.5	0.2	n/a
JUN-FY20	3.7	4.5	2.4	0.8	18.7	1.1	0.3	2.5	6.5	0.1	1.2	0.7	1.9	0.6	n/a
JUL-FY20	5.1	11.0	3.1	0.9	21.9	0.7	1.8	0.7	8.7	0.9	0.8	4.6	6.2	0.2	n/a
AUG-FY20	5.0	7.9	3.3	2.8	14.0	0.4	2.0	0.3	2.7	0.8	2.5	3.5	5.4	2.2	1.1
SEP-FY20	4.9	11.2	4.8	0.9	2.2	0.2	2.8	0.1	5.9	2.3	1.3	4.5	2.6	2.8	0.3

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 (635QD) Fort Sill, OK; (635GI) Norman, OK; and (635GJ) Yukon, OK, 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." The absence of reported data is indicated by "n/a."

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	Patient-centered medical home (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: Community Living Center (CLC) Strategic Analytics for Improvement and Learning (SAIL) Measure Definitions

Measure	Definition
Discharged to Community (SS)	Short-stay measure: percentage of short-stay residents who were successfully discharged to the community.
Improvement in function (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
Moderate-severe pain (SS)	Short-stay measure: percent of residents who self-report moderate to severe pain.
New or worse PU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
Newly received antipsych meds (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Outpatient ED visit (SS)	Short-stay measure: percent of short-stay residents who have had an outpatient emergency department (ED) visit.
Rehospitalized after NH Admission (SS)	Short-stay measure: percent of residents who were re-hospitalized after a nursing home admission.

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 28, 2021

From: Director, Rocky Mountain Network (10N19)

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

To: Director, Office of Healthcare Inspections (54CH03)

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

1. Thank you for the opportunity to provide a status report to the findings from the Comprehensive Healthcare Inspection of the Oklahoma City VA Health Care System in Oklahoma.

2. I concur with your findings and recommendations, as well as the submitted action plans.

(Original signed by:)

Ralph Gigliotti

Appendix H: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: July 19, 2021

From: Director, Oklahoma City VA Healthcare System (635/00)

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

To: Director, Rocky Mountain Network (10N19)

1. Thank you for the opportunity to provide a status report to the findings from the Comprehensive Healthcare Inspection of the Oklahoma City VA Health Care System in Oklahoma.

2. I concur with your findings and recommendations and will ensure that actions to correct these findings are completed as described in the response.

(Original signed by:)

Wade Vlosich

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