Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-02676-13

Healthcare Inspection

Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices Oklahoma City VA Health Care System Oklahoma City, Oklahoma

November 2, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to Senator James Inhofe's request to evaluate a range of clinical, supervisory, and administrative practices at the Oklahoma City VA Health Care System (System), Oklahoma City, OK. We also evaluated several concerns reported to us during our inspection by the System Director. We coordinated parts of this review with The Joint Commission. We evaluated the following areas and practices:

a) Continuity of leadership and the System's responsiveness to specified deficient conditions requiring corrective action

b) Performance measure data, including patient and employee satisfaction, and the System's follow-up of deficient conditions identified as "priority"

c) Patient safety practices including incident reporting, evaluation of patient safety events, peer reviews, institutional disclosures, and subordinate committee activities

d) Provider privileging processes including data collection regarding low volume/no volume providers, supervisory and committee recommendations, and leadership approval of privileges

e) Provider access to, and use of, the computerized patient record system (CPRS) to document patient care

f) Selected residency program requirements and supervision practices

g) Staffing in key clinical areas including primary care (PC), mental health (MH), specialty care (SC), Non-VA Care Coordination (NVCC), and nursing

h) Access to PC, MH, and SC clinics, and the System's management of cancelled clinic appointments

i) Veterans Choice and NVCC program management and practices including availability of community providers and timeliness of appointment scheduling and consult completion

j) Quality of clinical care as determined by documentation in the CPRS electronic health record (EHR) of patient assessment, care planning, and follow-up

k) Timeliness of Emergency Department (ED) care, patient dispositions, and System diversion history

l) Environment of care (EOC) including cleanliness and safety

Invoice payment, disbursement agreement, and construction-related concerns will be addressed in a separate report. Several time and attendance irregularities were referred to a separate division of OIG for further investigation.

Our comprehensive review identified multiple program areas, processes, and operations needing improvement. The root cause for many of these issues was the result of poor and unstable leadership at a number of levels, most notably at the Director position prior

to May 2016. Without strong and effective leadership, an inattentive and apathetic organizational culture evolved that allowed problems to arise and persist. Only after new leadership was installed in May 2016 did the culture improve and necessary changes took place.

Leadership. Between April 2012 and November 2014, the System had five acting or permanent directors. In December 2014, the Associate Director was detailed to be the acting System Director where he remained for about 18 months. We found that the lack of a stable, permanent System Director contributed to a weakened organizational environment, as did the leadership and management approaches of other senior leaders. Several of the deficiencies outlined in this report are largely attributable to leadership's failure to take appropriate actions and demand accountability from subordinates, from one another, and from external stakeholders. A permanent System Director started on May 29, 2016, and staff we interviewed commended his efforts to take effective actions and be transparent.

Performance Data. Despite some leadership failures and other deficiencies, in fiscal years (FYs) 2015–2016, the System's performance in multiple quality measures improved. After 5 years ranked as a "1-star in quality" through quarter (Q) 4 FY 2015, the System achieved an overall "3-star in quality" ranking among all Veterans Health Administration (VHA) medical facilities in Q3 FY 2016. The System has implemented workgroups and corrective actions to enhance performance in multiple areas, including acute care mortality, patient satisfaction, and employee satisfaction.

Patient Safety. Healthcare systems assess and respond to patient safety concerns in a variety of ways. They evaluate patient safety incidents, conduct root cause analyses (RCAs) to retrospectively identify factors that contributed to a poor outcome, and complete peer reviews (PRs) of care provided by credentialed and privileged providers. While most of the System's Quality, Safety and Value (QSV) programs appeared to be superficially functional, deeper review revealed that basic elements of the patient safety program continuum were not consistently completed as required. We found that:

- Severity assessment code (SAC) scoring of unanticipated events, RCAs, and PRs did not consistently comply with VHA requirements. These processes are used to evaluate and improve patient care.
- Processes were not in place to ensure consideration of institutional disclosure in cases involving unanticipated outcomes. Institutional disclosure is indicated when poor outcomes occur as a result of System or provider error and involves notifying the patient or the patient's family when the care is less than optimum.
- Subordinate committees' meeting minutes did not include information needed to evaluate and correct deficient patient care.
- The PR Committee did not consistently comply with guidelines regarding Level 3 PR assignments.

Provider Privileging. Provider privileging is the process by which a System ensures that a provider has the requisite skills, abilities, and experience to perform certain

clinical activities for the System. The System failed to follow VHA policy when completing provider practice evaluations during the privileging process, and as a result, some physicians were re-privileged to provide care to veterans despite inadequate documentation of their competency to do so. We did not identify negative patient care events resulting from the systemic breakdown of various aspects of the privileging process. However, the lack of a functional privileging process left patients and other providers vulnerable to adverse outcomes. We found that 65 of 75 professional practice evaluation folders we reviewed did not contain sufficient provider-specific data to support approval and/or continuation of privileges. Further, the System's practice for collecting "low volume/no volume" data on providers who perform less than 12 procedures per year at the System or who otherwise have infrequent patient care responsibilities was inadequate.

CPRS Access. In FY 2016, 18 privileged attending physicians did not have CPRS access during a time when they had clinical care responsibilities. Staff we interviewed reported that VHA's stringent computer security requirements (periodic logons and password changes) could be difficult for providers whose responsibilities did not routinely require them to be in the System's main clinical building. Also, effective in FY 2016, users were required to use personal identity verification (PIV) cards to logon to network systems. We found that the System's equipment to create PIV cards was not always functional and the number of appropriately certified staff to process PIV credentials was inadequate. Further, it took three different appointments to secure a PIV card. Busy clinical staff with only periodic patient care responsibilities at the System did not always follow through with the difficult logistics of securing a PIV card.

We found that some service chiefs or their designees did not consistently respond to requests for certification of quarterly Network and biannual CPRS monitoring activities during FYs 2015–2016. Further, service chiefs did not consistently identify missing users (active providers not included on the CPRS monitoring list), and follow up with them to ensure they applied for and received appropriate authorization to access CPRS. The failure to match active, privileged providers with computer access and use data and certify that all CPRS users had valid CPRS access, resulted in several "work-arounds" where missing users obtained improper access to CPRS.

We confirmed several cases where the documentation clearly reflected improper access (using someone else's logon passwords), documentation (documenting on behalf of someone else), or "wet signatures" (signed by hand). While these activities do not comply with VHA guidance, we were informed the reason for these "work-arounds" existed to ensure continuity of patient care under the circumstances. Upon learning of the CPRS access issues, the new System Director took action to administratively suspend the privileges of providers without appropriate access.

Resident Supervision. Residents are physicians-in-training. As such, they require supervision from experienced physicians (attending or supervising physicians). External residency accrediting organizations and VHA policy require supervising physicians to document resident supervision in the EHR. Supervising physicians document resident supervision in CPRS in a variety of ways. If a supervising physician

does not have CPRS access and cannot document in patients' EHRs, the adequacy of resident supervision is called into question. We reviewed 212 visits to determine whether the supervising physician documented in the EHR or the resident referenced a discussion with the supervising physician about the patient's care. Four of the 212 EHRs did not contain documentation of resident supervision. We reviewed the care provided to these four patients and found no evidence of patient harm as a result of deficient resident supervision.

The System did not monitor resident supervision as required under VHA policy. The only documents the System provided to demonstrate monitoring of resident supervision were labelled "Medical Record Focused Review Surgical Services," which included data specific to inpatient admissions to the surgical service. These reviews were stopped following the Surgical Quality Improvement Coordinator's retirement in May 2016. No documents provided to OIG by the System reflected routine ongoing monitoring of resident supervision in other surgical service patient care settings. Further, the System did not maintain letters of agreement (with the affiliated institution), which outlined responsibilities for resident supervision in accordance with Accreditation Council for Graduate Medical Education requirements.

Staffing. A comparison of authorized full time equivalent (FTE) employees to actual FTE for FYs 2014–2016 for selected services reflected that the actual FTE was often below the authorized FTE. The System reportedly has difficulty recruiting employees, particularly nurses, hospitalists, gastroenterologists, and psychiatrists. The System uses several recruiting incentives and a Direct-Hire Authority to address staffing shortages and fill critical vacancies. System leaders prioritize job openings by reviewing all vacancies and meeting with the various service chiefs to determine hiring priorities. We noted that despite recruiting difficulties, the System had been successful in increasing clinical FTE during this time.

Clinic Access. Despite staffing challenges, the System has largely met access metrics for PC and MH. We did not independently verify VHA's access metrics. However, we identified that in 4 of 30 selected cases (13 percent), schedulers did not follow guidelines for scheduling MH appointments.

At the end of Q4 FY 2016, we found 637 of the 2,931 (22 percent) new patient appointments in SC clinics pending greater than 30 days. The System has implemented actions to improve SC access including recruitment of gastroenterologists and psychiatrists, converting other specialists from part-time to full-time positions, and increasing the use of the Veterans Choice Program.

SC clinic cancellations. Based on complaints we received about resident and attending physicians not consistently being present for clinic appointments, we reviewed clinic cancellations during FY 2016 in six specialty clinics. We found 1,288 clinic appointments were cancelled prior to the appointment time, reportedly due to provider absence. Of those, 852 appointments were rescheduled and completed within 30 days. However, 424 cancelled appointments were not addressed according to policy. We reviewed the EHRs of 22 (of the 424 patients) who either died or were hospitalized (for

a condition associated with the consult/appointment) subsequent to the clinic appointment cancellation. Based on our review of the 22 EHRs, we did not find evidence that the clinic cancellations contributed to clinically significant adverse outcomes.

We also found that the System's overall clinic cancellation rate in FY 2016 was comparable to other VHA facilities with the same complexity level (1a) and quality ranking (3-star).

Provider payments for cancelled clinics. We reviewed 504 (of the 1,288) clinic cancellations to determine if there were any potential improper payments caused by unauthorized part-time physician or resident absences. We determined that the System provided compensation for services that were not received, resulting in potential improper payments of approximately $5,191.

Call Center responsiveness. In Q4 FY 2016, Call Center responsiveness was improving but below performance targets; specifically, calls were answered in an average of 65 seconds (goal is 30 seconds) with an abandonment rate of 9 percent (goal is 5 percent). System managers have implemented improvement actions that are tracked through a performance improvement workgroup.

Veterans Choice and NVCC. Overall, the System was meeting timeliness goals for Veterans Choice and NVCC. At the end of Q2 FY 2016, the average appointment wait times were 30 and 34 days, respectively. At the end of Q3 FY 2016, both Veterans Choice and NVCC were scheduling appointments in an average of 28 days. In December 2015, the number of incomplete Veterans Choice and NVCC consults was 1,371. As of March 9, 2016, less than 400 incomplete consults were open greater than 90 days.

Quality of PC and Outpatient MH. We reviewed 674 EHRs of patients who had completed PC appointments from March 6 through March 12, 2016 with an associated primary or secondary diagnosis of hypertension, diabetes mellitus, or congestive heart failure. We found that providers consistently documented patients' relevant histories and presenting problems, treatment plans, follow-up, and medication reconciliation. While providers consistently documented in-house consult completion, the average time to complete some SC consults exceeded 30 days. Also, PC team members notified patients of selected abnormal laboratory test results within 7 days 85.6 percent of the time, and providers took actions to address clinically significant abnormal laboratory results 89.9 percent of the time. As of Q4 FY 2016, the System ranked in the lower half in the MH Domain (performance) measure for all VHA facilities.

ED. The System consistently met VHA's target measure of less than 12 minutes for nursing triage timeliness in the ED for the period we reviewed, with a median wait time of 7 minutes. The System did not meet VHA's performance goals for patients leaving the ED without being seen. In FY 2015, 7.5 percent of patients left without being seen and in FY 2016, 5.8 percent of patients left without being seen (threshold is 4 percent). Further, in FY 2015, the ED was on diversion an average of 18 percent of the time, and in FY 2016, the ED was on diversion an average of 15 percent of the time. While there

is no specific VHA target, the ED Chief told us that the recent diversion rate is less than ideal. System managers developed an ED workgroup, which met biweekly, and continued to implement several access improvement projects.

EOC. We inspected patient care areas including six inpatient units, the community living center, the ED, the Fast Track unit, and four outpatient clinics located at the Oklahoma City main healthcare facility. We also inspected the Ada, Altus, Ardmore, Blackwell, Enid, Lawton, North May, South Oklahoma City, and Wichita Falls community based outpatient clinics. We found no deficiencies during our infection prevention and life safety/emergency management reviews, but we identified compliance deficiencies with selected privacy, safety, security, and cleanliness requirements. We made 24 recommendations.

We recommended that the VISN Director:

- Review the former Chief of Surgery's performance in relation to issues discussed in this report, and confer with appropriate VA offices to determine the need for administrative action, if any.

We recommended that the System Director:

- Consult with the National Center for Organizational Development to facilitate organizational improvement following leadership changes and extensive inspections and investigations.
- Ensure use of the correct methodology to determine the severity assessment code for all reported patient safety events.
- Ensure compliance with the National Center for Patient Safety's guidelines on initiation and completion of Root Cause Analysis.
- Ensure that peer reviews are appropriately completed and address all relevant aspects of care provided by the reviewed clinician.
- Ensure a process is in place to identify and review cases where institutional disclosure may be indicated, and complete as appropriate.
- Ensure that the Quality, Safety and Value committee minutes include evidence of robust data analysis and action tracking to address performance opportunities, and monitor for compliance.
- Ensure adherence to all national peer review committee requirements, and monitor for compliance.
- Ensure that professional practice evaluations include performance data to support provider privileges and are conducted in accordance with Veterans Health Administration and System policy.
- Evaluate the current System policy and services provided by low volume/no volume providers to determine whether the System should continue to provide those services or seek community alternatives.

- Require service chiefs to assure that all providers within their purview secure and maintain appropriate computer access to ensure quality and continuity of patient care.
- Ensure availability of functional equipment, adequate staffing, and enhanced access for personal identity verification card completion.
- Ensure compliance in monitoring of resident supervision documentation in accordance with Veterans Health Administration and System policies, and take appropriate action when deficiencies are identified.
- Review letters of agreement between the University of Oklahoma's surgical residency program and the System to ensure compliance with Accreditation Council for Graduate Medical Education requirements.
- Continue efforts to recruit and hire for vacancies, and ensure that, until optimal staffing is attained, alternate methods are consistently available to meet patient care needs.
- Ensure timely completion of SC consults and monitor compliance.
- Implement a process to conduct routine scheduling audits to monitor compliance and identify ongoing training opportunities for all schedulers.
- Conduct an evaluation of the potential improper payments resulting from clinic cancellations, take appropriate corrective actions, and establish policies to mitigate improper payments related to clinic cancellations from occurring in the future.
- Continue efforts to improve call center timeliness.
- Continue efforts to improve timeliness of Care in the Community Program consult completion; enhance patient and community provider understanding of Veterans Choice and NVCC options; and continue to promote communication and coordination with TriWest Healthcare Alliance to assure appropriate, timely care for patients.
- Ensure Patient Aligned Care Team clinicians follow Veteran Health Administration requirements for patient notification and follow-up of clinically relevant abnormal laboratory results and document the actions in the EHR.
- Monitor consultation completion timeliness and identify process improvements for consults exceeding 30 days.
- Continue ED workgroup efforts to improve the timeliness of care, decrease the frequency of diversion status, and enhance customer service in the ED.
- Ensure that all patient care areas comply with environment of care requirements and that action plans specifically address deficient areas identified in this report.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes D and E, pages 66–78 for the Directors' comments.) Based on information provided, we considered Recommendations 4, 6, 9, 10, 11, 15, 16, 20, and 22 closed. For the remaining open recommendations, we will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

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Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to Senator James Inhofe's request to evaluate a range of clinical, supervisory, and administrative practices at the Oklahoma City VA Health Care System (System), Oklahoma, City, OK. We also evaluated several concerns reported to us by the System Director. We coordinated parts of this review with The Joint Commission (TJC).

Background

The System serves veterans in 48 counties in Oklahoma and 2 counties in north central Texas and is part of Veterans Integrated Service Network (VISN) 19. The System includes the Oklahoma City VA Medical Center, which offers a variety of primary and tertiary levels of inpatient medical and surgical care (192 inpatient beds) as well as long term care. The System has 8 operating rooms and completed 3,903 surgical cases in fiscal year (FY) 2016. The System performs complex procedures according to the Veterans Health Administration (VHA) surgical complexity designation.[1][2] The System also provides outpatient primary and consultative care in medicine, surgery, and mental health (MH) and oversees community based outpatient clinics (CBOC) and other clinics located in Ada, Altus, Ardmore, Blackwell, Enid, Lawton, Oklahoma City (two clinics), and Stillwater, OK, and Wichita Falls, TX.

Residency Programs

VHA plays an important role in the training of health care professionals throughout the United States. Sixty percent of physicians receive at least some of their training in a VA facility. VA permits physician trainees to work in VA facilities only if their residency programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME).

VA enters into two types of agreements with sponsoring institutions which permit their physician trainees to work at VA facilities. Affiliation agreements between the sponsoring institution and VA ensure compliance with accreditation requirements, while disbursement agreements allow VA to reimburse the institution sponsoring the trainees[3] for the cost of salaries and benefits for the period of time that a trainee serves in a VA

[1] VHA bases surgical complexity designations on a facility's infrastructure including physical capabilities, equipment, workload, and staffing. For example, hospitals assigned a "complex" rating require special facilities, equipment, and staff for difficult operations.
[2] VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010. This directive expired on May 31, 2015 and has not yet been updated.
[3] VHA Handbook 1400.05, *Disbursement Agreement Procedures for Physician and Dentist Residents*, August 14, 2015, p. 2. A sponsoring institution is the organization that assumes responsibility for the entirety of the resident's training program. VA must have an affiliation agreement with the sponsoring institution to ensure compliance with accreditation requirements.

facility. VA annually funds approximately 10,300 of these physician resident[4] positions[5] through disbursement agreements.

VA policy assigns responsibility for oversight of physician trainees working in a VHA facility to the Chief of Staff (COS) and to the Designated Education Officer (DEO), sometimes referred to as the Associate Chief of Staff for Education. The COS is responsible for assessing the quality of residency training programs, as well as the quality of the care provided by the residents and faculty in those programs. The DEO is responsible for ensuring that facility monitoring and reporting requirements regarding resident supervision are met, and for ensuring that a facility resident supervision policy is in place.

At the System and the University of Oklahoma (OU) Health Sciences Center, physicians who have dual appointments both at the VA and at OU see VA patients, supervise students and residents, and conduct research. In 2016, the System allotted 114.5 resident physician positions, with more than 400 resident physicians receiving some or all of their training at the System via clinical rotations.

Workload and Budget

Table 1. System Workload and Budget FYs 2014–2016

FY	Total Medical Care Full Time Equivalent Employees	Outpatient Visits	Medical Care Budget
2014	1,999	546,417	$431,040,787
2015	2,113	561,290	$463,212,296
2016	2,221	617,973	$509,594,802

Source: VHA Support Service Center Trip Pack Report II

Previous OIG Office of Healthcare Inspections Reviews

OIG conducted Combined Assessment Program (CAP) and CBOC reviews at the System and the Stillwater CBOC the week of September 14, 2015. These reviews are one element of OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. We made nine recommendations for improvement in our CAP report and eight recommendations for improvement in our CBOC report. System and VISN leaders implemented corrective actions and at the time of this publication, all recommendations were closed. OIG also conducted a hotline inspection with site visits

[4] VHA Handbook 1400.05, p. 6. VA defines a resident as a physician or dentist trainee engaged in post-graduate specialty or sub-specialty training programs, which includes both interns (those in their first year of training) and fellows (those who are pursuing sub-specialty training often after completion of an initial specialty residency program).
[5] VHA Handbook 1400.05, p.1.

in June 2014 and March 2015. We did not make any recommendations in our hotline report. Details of these reviews can be found in:

- *Combined Assessment Program Review of the Oklahoma City VA Health Care System, Oklahoma City, OK,* Report No. 15-00614-64, December 16, 2015
- *Review of Community Based Outpatient Clinic and Other Outpatient Clinics of Oklahoma City VA Healthcare System, Oklahoma City, OK,* Report No. 15-00157-39, December 3, 2015
- *Cardiothoracic Surgery Program and Cardiac Catheterization Laboratory Concerns, Oklahoma City VA Health Care System, Oklahoma City, OK.* Report No. 14-04361-348, August 4, 2016

Concerns

On March 24, 2016, Senator James Inhofe sent a letter to the VA OIG Deputy Inspector General that referenced some specific areas of concern and requested a review of clinical and administrative operations at the System. Subsequently, we learned that the new System Director (who started in late May 2016) had concerns about some leaders' actions related to an event that occurred in quarter (Q) 3 FY 2016[6] and about deficient provider-related practices involving computer access and resident supervision. In response to Senator Inhofe's request and the new System Director's concerns, we focused on:

a) Continuity of leadership and the System's responsiveness to specified deficient conditions requiring corrective action.

b) Performance measure data, including patient and employee satisfaction, and the System's follow-up of deficient conditions identified as "priority."

c) Patient safety practices including incident reporting, evaluation of patient safety events, peer reviews, institutional disclosures, and subordinate committee activities.

d) Provider privileging processes including data collection regarding low volume/no volume providers, supervisory and committee recommendations, and leadership approval of privileges.

e) Provider access to, and use of, the computerized patient record system (CPRS) to document patient care.

f) Selected residency program requirements and supervision practices.

g) Staffing in key clinical areas including primary care (PC), MH, specialty care (SC), Non-VA Care Coordination (NVCC), and nursing.

[6] In January 2016, the Chief of Staff reported two patients' deaths in the operating room. One of those cases is discussed further in this report.

h) Access to PC, MH, and SC clinics, and the System's management of cancelled clinic appointments.

i) Veterans Choice and NVCC program management and practices including availability of community providers and timeliness of appointment scheduling and consult completion.

j) Quality of clinical care as determined by documentation in the CPRS electronic health record (EHR) of assessment, care planning, and follow-up.

k) Timeliness of Emergency Department (ED) care, patient dispositions, and System diversion history.

l) Environment of care (EOC) including cleanliness and safety.

Invoice payment, disbursement agreement, and construction-related concerns will be addressed in a separate report. Several time and attendance irregularities were referred to a separate division of OIG for further investigation.

Scope and Methodology

We initiated this review in February 2016. The scope included an extensive review of System data, actions, and practices in FYs 2015–2016.

We visited the System March 7–9, May 16–20, October 18–21, October 24–28, November 7–10, December 1–2, and December 13–15, 2016. To assess the physical environments, we conducted EOC tours of the System and all 10 CBOCs.

We interviewed a former (retired) System Director, the interim System Director (during 2015 and early 2016), and the current System Director; the former Chief of Staff (COS), Associate Director for Patient Care Services (ADPCS), Associate Chief of Staff for Education (ACOS/E), and Chief of Surgery; the Chiefs of Medicine, SC, PC, the ED, and Pharmacy; the nurse managers for ED, MH, and PC; the acting Chiefs of Human Resource Management Service (HRMS), Medical Administration Service (MAS), Prosthetics, and MH; the Quality, Safety and Value (QSV) Chief; the Strategic Analytics for Improvement and Learning (SAIL) Coordinator, Infection Control Coordinator, Environmental Management Service supervisors, Business Office managers, and NVCC managers and staff; the Patient Safety Manager (PSM), Risk Manager, Nurse Staffing Coordinator, nurse recruiter, and lead Patient Advocate; clinical and administrative staff from all 10 CBOCs; and other staff knowledgeable about the issues. We also interviewed more than 120 attending and resident physicians, a majority in the presence of OU attorneys. We conducted more than 200 interviews.

We reviewed VHA and System data related to the tenure of System leaders; quality and performance data and corrective actions; QSV reporting structure and patient safety operations; provider privileging processes; CPRS access and use; resident supervision; staffing and recruitment actions; scheduling, clinic access and cancellations, and consult management; utilization and management of the Veterans Choice and NVCC Programs; ED care, bed utilization, and hospital and ED diversion; select EOC

operations and practices; and select CBOC operations and practices. We reviewed VHA and System policies related to the areas noted above. We also reviewed other pertinent OIG and VHA reports to inform our inspection.

In addition to reviewing quality and performance metrics, we conducted an independent review of EHRs to determine if clinicians were providing and documenting selected patient care and follow-up.[7] We reviewed VA Corporate Data Warehouse data and identified 674 System patients who had completed PC appointments[8] during the period of March 6–March 12, 2016. We included all 674 patients in our quality of care EHR review.

We also reviewed employee responses to two OIG surveys:

- In January 2015, System employees responded to a survey that we distributed as part of a hotline complaint focusing primarily on cardiac-related care and services.[9] Some pharmacy and laboratory related concerns referenced in the 2015 survey were reconsidered during our 2016 site visit. Those complaints are included in Appendix A.
- In May 2016, 393 of about 2,050 System employees responded to a patient risk assessment survey we distributed in preparation for our site visit. Of those, 91 responded that they had identified a quality of care and/or patient safety issue in the past 12 months that placed a patient at risk or continued to place patients at risk. While 25 of those employees reported that managers had adequately addressed the conditions or concerns, 66 employees reported that managers had not. In some cases, the survey respondent did not provide sufficient details for us to adequately evaluate the issue(s). The remaining cases generally involved patient-specific quality of care concerns, and patient education, staffing, and environmental deficiencies. We either evaluated and dispositioned the issue(s) while onsite, or, in accordance with OIG guidance, we referred quality and safety concerns identified in the surveys to the OIG's Hotline Division for further review and possible disposition.

In addition to general privacy laws that govern the release of medical information, disclosure of certain veteran health or other private information may be prohibited by various Federal statutes including, but not limited to, 38 U.S. Code § 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, OIG adheres to the privacy and confidentiality laws and regulations protecting veteran health or other private information. In this report, we have generalized narratives and case scenarios, and we have de-identified protected patient and quality assurance information.

[7] Clinical providers included physicians, physician assistants, nurse practitioners, and clinical nurse specialists.
[8] Completed appointments were identified using stop codes within VHA's PC clinic group, including 322, 323, and 350.
[9] These concerns are discussed in VA OIG, *Cardiothoracic Surgery Program and Cardiac Catheterization Laboratory Concerns*, (Report No. 14-04361-348, August 4, 2016).

Eight policies cited in this report were expired or beyond the recertification date:

1. VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010 (expired May 31, 2015).
2. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (expired June 30, 2015).
3. VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel,* July 19, 2010 (expired July 31, 2015).
4. VHA Directive 2006-041, *Veterans Health Care Service Standards,* June 27, 2006 (expired June 30, 2011).
5. VHA Directive 2007-033, *Telephone Service for Clinical Care*, October 11, 2007 (expired October 31, 2012).
6. VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011 (expired March 31, 2016).
7. VHA Directive 2009-035, *Data Collection on Mislabeled Specimens for Pathology and Laboratory Medicine Service (P&LMS),* July 22, 2009 (expired July 31, 2014).
8. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (recertification due March 31, 2016).

We considered these policies to be in effect as they had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),[10] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[11] The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[12]

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

[10] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[11] VA Under Secretary for Health Memorandum, *Validity of VHA Policy Document,* June 29, 2016.
[12] Ibid.

Inspection Results

Issue 1: Leadership Stability and Responsiveness

The System has been plagued by instability in the Director's position from 2012–2016. This condition, along with a variety of leadership-related factors, influenced the System's culture and demeanor and "set the stage" for some of the deficient conditions described in this report.

Good leadership is central to the health and success of any organization. TJC devotes several chapters to leadership standards in the *2009 Comprehensive Accreditation Manual for Hospitals.* In the Federal government, "Leading Change" and "Leading People" are two of the five executive core qualifications[13] for senior executives.[14] Leaders establish the organization's culture through their words, expectations for action, and behavior.[15] For the purposes of this review, we defined senior leadership positions as the System Director, Associate Director, COS, and ADPCS (quadrad). To provide context for the reader, several service-level management positions including the Chiefs of Surgery, ACOS/E, and QSV Chief are also discussed in this report. A brief history and status of System leadership positions is as follows:

System Director. Between April 2012 and November 2014, the System had five acting or permanent directors. In December 2014, the Associate Director[16] was detailed for 90 days to be the interim System Director while VHA officials recruited a permanent director. At least two serious candidates declined the position and the Associate Director remained in the interim System Director role for about 18 months. The current System Director started on May 29, 2016.[17] He began evaluating System operations and holding appropriate leaders, managers, and employees accountable.

COS. The COS had been in his position for more than 5 years. He was reassigned to perform administrative functions in September 2016 and abruptly retired the following month.

ADPCS. The ADPCS had been in her role for more than 5 years, became the subject of an inquiry after the new System Director was installed, and resigned in August 2016.

[13] http://www.opm.gov/policy-data-oversight/senior-executive-service/executive-core-qualifications/. Accessed January 7, 2015.
[14] Most medical center/System directors and COSs are senior executives and must meet executive core qualification requirements.
[15] Leadership in Healthcare Organizations. A Guide to Joint Commission Leadership Standards. A Governance Institute White Paper, Winter 2009, p. 3.
[16] In about March 2014, the new Associate Director transferred to the System from a small VHA facility in a bordering state.
[17] The new System Director was detailed to the role effective May 29 with an official start date of June 12, 2016.

Chief of Surgery. The Chief of Surgery served in that role since 2011. He reportedly stepped down voluntarily in September 2016 after concerns about CPRS access and resident supervision arose.

Associate COS for Education. The Associate COS for Education (ACOS/E) had been half-time[18] in that role since 2013 and had responsibility for multiple functions related to the graduate medical education programs. The ACOS/E was reassigned to a clinical position in October 2016 after concerns arose about resident education and supervision. The ACOS/E retired in December 2016.

QSV Chief. The QSV Chief has been in her role for more than 5 years, and as of October 2017, continues in that position.

In general, strong, stable leadership correlates positively with the functional status of an organization. In this case, the lack of a stable, permanent System Director contributed to a weakened organizational environment, as did the leadership and management approaches of other senior leaders. While the System has performed well in some areas, several of the deficiencies outlined in subsequent sections of this report are largely attributable to leadership's failure to take appropriate actions and demand accountability from subordinates, from one another, and from external stakeholders. During our interviews with key leaders and our review of documents, we identified instances where leaders' actions did not appear to comport with policy or expectation, consistent with interviewees' perceptions. For example:

- The interim System Director stated that he only expected to be in this interim role for 90 days, which kept getting extended. He reported that his primary goal during his tenure was to "build [relationships in] the [leadership] team" and that he relied on the other quadrad members to make appropriate decisions and follow-through on issues in their areas. We found, however, that he did not consistently follow up on some important issues to understand how they were addressed, nor did he take an effective stance on emerging issues involving provider computer access and certification and OU relations. The interim System Director told us that he was seeking employment in other VHA facilities during at least some of the 18 months he was in the role.

- The COS either knew, or should have known, about the lack of surgery-related privileging data but approved privileges anyway. (See Issue 4, *Provider Privileging*.)
- The COS did not consistently comply with VHA requirements on how to evaluate adverse patient events. (See Issue 3, *Patient Safety and Related Committee Activities*.)

[18] The ACOS/E had a 7/8 VA appointment (4/8 as ACOS/E and 3/8 clinical); the remaining 1/8 was a faculty appointment at OU.

- The ADPCS' testimony in at least one Administrative Board of Investigation did not reflect full disclosure of the necessary details.
- The COS and Chief of Surgery both appeared reluctant to consistently address physician-related problems (such as clinic coverage) or otherwise arouse a negative confrontation with OU for fear that OU would discontinue certain residency programs and/or decline to provide subspecialty support.
- The Chief of Surgery admitted to writing a progress note on behalf of another attending physician because that provider did not have CPRS access. While this may have been done to ensure patient care, it did not comply with policy. (See Issue 5, *CPRS*.)
- The Chief of Surgery told us he was aware that a particular attending surgeon often did not attend clinic as scheduled or called off at the last minute for non-emergent issues, thus requiring patient appointments to be rescheduled. The Chief of Surgery told us that he "got the impression over the years that HR [MS] rules were difficult" and did not bother "spinning [his] wheels" to deal with problem employees.
- The ACOS/E did not perform many of the functions required of the position. (See Issue 6, *Resident Supervision*.) While we agree that the ACOS/E's office was under-resourced, we were not told about, nor did we identify, ongoing efforts on the part of the ACOS/E to improve staffing and other functions.

Further, the QSV Chief's role in relation to the quadrad and service chiefs was one of persuasion rather than authority. We found the QSV Chief to be knowledgeable about QSV policies but appeared limited in her ability to get others, such as service chiefs, to be responsive to data requests and to follow through on corrective actions.

During the course of interviews with staff, we found almost universal support for the new System Director. Staff commended his efforts to be transparent in communications and his willingness to make unpopular decisions and take long-overdue actions to correct deficiencies. One interviewee described the new System Director's tendency to "get his information from the ground up."

As of January 30, 2017, the COS, ADPCS, Associate Director, ACOS/E, and Chief of Surgery positions were all being recruited.

Recommendation 1: We recommended that the Veterans Integrated Service Network Director review the former Chief of Surgery's performance in relation to issues discussed in this report, and confer with appropriate VA offices to determine the need for administrative action, if any.

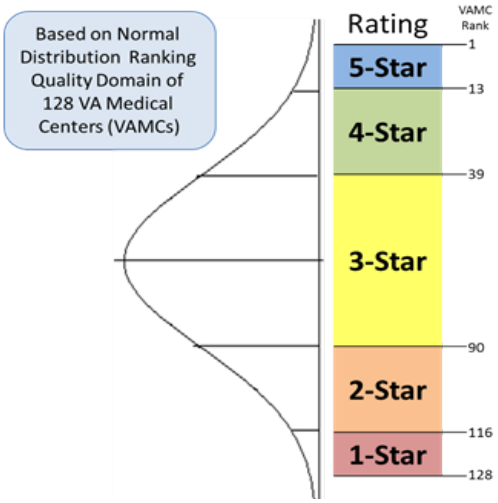
Recommendation 2: We recommended the System Director consult with the National Center for Organizational Development to facilitate organizational improvement following leadership changes and extensive inspections and investigations.

Issue 2: Performance Measure Data

The System underperformed in several quality domains; however, corrective actions implemented in FYs 2015–2016 have improved many of the System's individual performance measure scores and resulted in an increased star ranking.

VHA's Office of Operational Analytics and Reporting developed the SAIL model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL comprise multiple composite measures, and the resulting scores permit comparison of facilities within a VISN or across VHA. The SAIL model uses a "star" ranking system to designate a facility's performance in individual measures, domains, and overall quality. As Figure 1 illustrates, SAIL "estimates the 10th, 30th, 70th and 90th percentile cut-offs of overall Quality and assigns facilities 1- and 5-Star if their scores fall in the bottom and top 10th percentile, respectively. Facilities in the next bottom and top 20 percent of the distribution are assigned 2- and 4-Star. The remaining 40 percent of facilities are assigned 3-Star."[19]

Figure 1. VHA SAIL Star Rating



Source: VHA SAIL website, accessed May 12, 2016

In most measures, the SAIL model reflects the facility's performance over a rolling 12-month period. SAIL offers a variety of tools and reports to assist facilities in identifying lower-performing areas and opportunities for improvement. A summarized list of the SAIL domains and supporting measures can be found in Appendix B.

[19] SAIL website data definitions section, accessed May 12, 2016.

Because some SAIL data and reports may be protected by 38 U.S. Code § 5705, *Confidentiality of Medical Quality Assurance Records,* this report focuses on how a facility has been performing in key domains and measures, and whether: (a) the facility has a process for identifying and prioritizing quality deficiencies, and (b) corrective actions have been implemented and are being tracked to ensure that they have the desired effect(s).

Overall SAIL Performance as of Q4 FY 2016

In August 2014, System leaders met with a representative from the VHA Office of Analytics and Reporting to review the System's performance data. From that meeting, System leaders identified key measures for priority attention and assigned champions for each measure. Service chiefs and measure champions continued to review SAIL data, identified opportunities for improvement, and implemented corrective actions. Action plan updates were reported during the weekly SAIL Workgroup meetings. Also, the SAIL Coordinator used SAIL tools and trigger reports, which permit goal setting and real-time evaluation of cases. Cases that met internal guidelines, as determined by clinical leaders, were reviewed at a monthly Clinical Complication Committee meeting chaired by the COS.

After 5 years ranked as a "1-star in quality" through Q4 FY 2015, the System achieved an overall "3-star in quality" ranking amongst all VHA medical facilities in Q3 FY 2016. We found that the key measures selected for priority evaluation and intervention were reasonable and appropriate given the performance deficits in those areas. Further, continued System leadership efforts have been effective as performance measure scores have generally moved in a positive direction.

Senator Inhofe's letter referenced concerns about mortality rates, feedback to veterans and family members, and employees' work environments. Therefore, we are specifically reporting on the System's performance in Acute Care Mortality, Patient Satisfaction, and Employee Satisfaction. Additional performance measure data are also reported under Issue 3, *Patient Safety and Related Committee Activities*; Issue 8, *Clinic Access*; and Issue 10, *Quality of Primary Care and Outpatient Mental Health Care.*

The Acute Care Mortality domain is a composite measure comprising an in-hospital standardized mortality ratio (SMR),[20] a 30-day SMR,[21] and 30-day risk SMR (RSMR) for patients with acute myocardial infarction (AMI), congestive heart failure (CHF), or

[20] VHA SAIL Model Data Definitions link, accessed May 3, 2016. "SMR is the actual number of deaths within 1 day of hospital discharge for patients who were admitted to acute care wards divided by the sum of the expected deaths determined using the risk adjusted mortality model for patients admitted to acute care wards."
[21] VHA SAIL Model Data Definitions link, accessed May 3, 2016. "The 30-day SMR is the actual number of patients admitted to acute care wards who died within 30 days of hospital admission divided by the sum of the expected deaths of all acute care ward patients using the risk adjusted mortality model that predicts death at 30 days."

pneumonia (PN).[22] In general, the System's composite acute care mortality scores were comparable to or slightly better than the average facility ending Q4 FY 2016. However, while the AMI RSMR score has been favorable (substantially better than average), the System underperformed in the CHF and PN RSMR measures for the past 5 years.

System leaders have taken several actions to improve the CHF and PN RSMR scores including hiring two CHF providers;[23] opening Pulmonary Rehabilitation, CHF, and Palliative Care clinics; improving antibiotic prescribing practices; and enhancing the quality and completeness of EHR documentation. CHF and PN RSMR measures continue to be tracked and reported internally.

The Patient Satisfaction domain is a composite measure comprised of patient survey responses related to both inpatient and outpatient care encounters. Survey questions relate to access, communication, and care coordination. The System consistently underperformed in the patient satisfaction domain from FY 2013 through FY 2015 despite multiple ongoing actions to improve scores. These efforts coalesced in FY 2016 and patient satisfaction scores significantly improved.[24] At the direction of the incoming System Director, responsible managers and process champions implemented a comprehensive "stoplight dashboard" that included all of the customer service measures, sorted by System/CBOC location, to track the status of each measure and determine whether corrective actions were having the desired effect.

Employee Satisfaction is reported, in part, through the Best Places to Work (BPTW) measure. On an annual basis, the VA AES is distributed to VA employees and includes questions about job satisfaction, psychological safety, work/life balance, and recognition, among others. Employee feedback gained through the AES results are used to calculate a BPTW composite score ranging from 0–100 points. The BPTW is based on the annual ranking of U.S. government agencies by the Partnership for Public Service using Federal Employee Viewpoint Survey data. Data reflected that the System underperformed in the BPTW measure in FYs 2013–2014. However, when comparing AES measures and scores from FY 2014 to FY 2015, the System consistently achieved a higher percentage of positive change than other facilities within the VISN.[25] When comparing AES measures and scores from FY 2015 to FY 2016, we noted slippage in several areas, including overall satisfaction, burnout, and workload.

[22] VHA SAIL Model Data Definitions link, accessed May 3, 2016. "The Centers for Medicare and Medicaid Services measures RSMR as the ratio of the number of predicted deaths within 30 days of hospital admission in AMI, CHF, or PN patients to the expected number of deaths within 30-days of hospital admission in AMI, CHF, or PN patients, multiplied by the national unadjusted 30-day mortality rate."
[23] The System lost both physicians in Q1 FY 2016; however, the System has hired another full time physician who currently works with a mid-level provider in the clinic.
[24] Corrective actions included patient advocates conducting rounds on the wards and updating the patient complaint and feedback process, among other activities.
[25] The System was part of VISN 16 during FY 2014 and 2015.

While the System's performance data did not compare favorably to other VHA facilities in some areas, we determined that the System had a process in place to correct deficiencies. The System demonstrated success in improving its performance relative to other facilities; therefore, we did not make recommendations in this area.

Issue 3: Patient Safety and Related Committee Activities

While most of the System's QSV programs appeared to be superficially functional, deeper review revealed that basic elements of the patient safety program continuum were not consistently completed as required.

VHA requires implementation of a QSV program to ensure compliance with VHA standards, regulations, and policies; integration under an organizational structure that promotes the exchange and flow of quality information; and avoidance of organizational silos.[26] Patient safety is at the core of all QSV functions, and VHA Handbook 1050.01 delineates what types of events are to be considered within the patient safety program and how events need to be addressed. Identifying patient safety-related incidents, broadly evaluating the actual and potential contributory factors, and analyzing, trending, and reporting near misses and actual incidents are keys to preventing future occurrences of similar events.[27]

The case examples below illustrate deficiencies across the patient safety spectrum.

- Patient A underwent a procedure during which his colon was perforated. The perforation was a known complication of the procedure and surgeons decided to admit the patient to the surgical intensive care unit (SICU) for observation and intravenous antibiotics. While in the SICU, the patient's developing sepsis and deteriorating condition were not adequately documented or consistently communicated amongst the care providers. Surgeons brought the patient back to the OR where he died.[28]
- Patient B was undergoing a procedure for which there was consent. However, Patient B did not consent to another non-emergent procedure completed during the same episode of care. The second procedure could have resulted in long-term negative health effects.

[26] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value,* August 2, 2013.
[27] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook,* March 4, 2011. This handbook was scheduled for recertification on or before the last working date of March 2016; it has not yet been recertified.
[28] Because OR deaths at the System are unusual, the former COS reported this case and another OR death that occurred in the same month. We did not find OR-related quality of care issues in either case; however, we did identify perioperative care issues in the case of Patient A.

We found that the System did not consistently comply with VHA requirements, thus weakening the QSV program as follows:

Accuracy of Severity Assessment Code (SAC) Scoring

Patient safety events are assigned scores 1–3 with ascending levels of severity using a standardized scale called a Severity Assessment Code (SAC). System leaders use an event's SAC score to determine if they need to perform a root cause analysis (RCA). The more severe/frequent the event, the higher the SAC score and the greater need for review. An RCA is a critical tool in the process of improving patient safety. Multidisciplinary RCA teams investigate matters ranging from medication errors, to suicides, to wrong site surgeries. These teams formulate solutions, test the solutions, implement needed actions, and measure outcomes. To be effective, the RCA process must be supported by the organization's leadership.

The PSM is responsible for the evaluation of patient safety events using the SAC methodology and recording the results for further trending and analysis.[29] System managers must address patient safety events with an actual and potential SAC score of 1 or 2[30] and perform an RCA[31] for all patient safety events with an actual or potential SAC score of 3. The following table provides the methodology used to determine the SAC score.

Table 2. SAC Scoring Methodology

		SEVERITY			
		Catastrophic	Major	Moderate	Minor
PROBABILITY	Frequent	3	3	2	1
	Occasional	3	2	1	1
	Uncommon	3	2	1	1
	Remote	3	2	1	1

Source: VHA Handbook 1050.01

We determined that prior to the installation of the new System Director, the PSM did not consistently score events to reflect the severity and/or probability of the event, and System managers did not have a secondary review process to validate SAC scoring of those events.[32,33,34] As a result, System managers did not conduct RCAs on all

[29] CM-Office of QSV-2, *Patient Safety Improvement*, March 2, 2015.
[30] Actions can include no action or, if indicated, an RCA.
[31] RCA is a process used to identify the basic or contributing factors associated with a patient safety event.
[32] Neither VHA policy nor the System's process required a secondary review to assure accurate SAC scoring of events; however, other national QSV programs such as peer review and utilization management both include validation of a percentage of specified cases to ensure consistent and accurate rating determinations.
[33] VHA Directive 1117, *Utilization Management Program,* July 9, 2014.

triggering events. The following cases are examples of inconsistency in SAC scoring for the two previously identified cases.

Patient A: The PSM assigned an actual SAC score of 1 to Patient A's adverse event. Per VHA guidelines, a perforation resulting in death should require a score of 3. Further, the former COS told us that a debriefing was conducted with the staff directly involved in caring for Patient A the morning after the patient's OR death and that the debriefing resulted in a list of potential systems issues. The former COS further stated that since the debriefing was completed, System managers did not initiate an RCA because the COS did not believe an RCA would discover anything new beyond what had been identified during the debriefing. System managers conducted an RCA of the event; however, the RCA was essentially a replica of the debriefing and did not include a detailed evaluation of processes, communication, or documentation during the perioperative period of care.

Patient B: The PSM assigned an actual SAC score of 1 to Patient B's adverse event and System managers did not conduct an RCA of this case. Per VHA guidelines, removal of a body part under non-emergent circumstances without consent would generally require a score of 3.

We reviewed the patient safety event logs for FYs 2015 and 2016 (retrieved from the System database) to determine the accuracy of SAC scoring.[35] We identified 15 events where management assigned a lower score to the severity and/or probability of the event,[36] resulting in the failure to conduct required System reviews. We specifically noted that:

- Three of 15 events reflected a SAC score of "0" which was not consistent with VHA scoring methodology.[37][38]
- Six of 15 events had the potential for serious negative outcomes and should have prompted clinicians involved in the care of these patients to report the events and follow up on patient safety concerns, regardless of the SAC score.

The current Director started in late May 2016 and by the end of June had chartered four RCAs related to events that occurred prior to his arrival. Further, patient safety events are now a standing agenda item for discussion in the Director's morning report.

[34] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. This directive expired June 30, 2015 and had not yet been updated.
[35] VHA Handbook 1050.01.
[36] Six of the 15 events did not clearly reflect the potential for serious negative outcome.
[37] During the course of this review, we found that VHA does not mandate a specific reporting process or system; therefore, healthcare facilities use multiple patient safety event data capture systems. At the System, this has resulted in inconsistent data capture and reporting. We discussed this concern with the System Director for evaluation and follow-up, as needed.
[38] We noted that, upon further review, the PSM changed the SAC score from a "0" to a "1" in one of the three cases.

Peer Review

Peer Review (PR) is one means of evaluating health care provider performance in the delivery of patient care with a goal of improving quality. VHA policy identifies clinical events requiring PR, including lack of documentation of a patient's clinical deterioration during the 48 hours preceding death; a significant change in a patient's clinical condition without evidence of appropriate intervention; and patient deaths that appear related to a hospital-incurred incident or a complication of treatment.

Patient A: While the System conducted separate PRs for the event involving Patient A, the PRs did not address post-procedure care.

Patient B: As of March 6, 2017, System managers had not conducted a PR of this case.

We found that System managers conducted PRs for 3 of the 15 patient safety events. To comply with VHA policy, System managers should have completed PRs on nine[39] additional events to determine whether clinical care and services were properly delivered.

Institutional Disclosure

System leaders did not have processes in place to ensure consideration of institutional disclosure in cases involving unanticipated outcomes. VHA and TJC require that patients, and when appropriate, their families, be informed of unanticipated outcomes related to an adverse event that occurred during care.[40,41,42] The intent of institutional disclosure is to inform patients and their families about substantive issues related to their care and options for redress, when appropriate.

Patient A: We found no evidence that the System attempted disclosure prior to June 2016.

Patient B: As of March 6, 2017, we found no evidence of consideration of institutional disclosure for this patient's case. Upon our review of the 15 patient safety events, we found that an additional 10 events should have been considered for institutional disclosure; however, we found no documented evidence of this consideration.

QSV-related Committee Activities

QSV-related committees generally provided a broad review and longitudinal perspective of quality of care and patient safety activities, but did not have effective systems in place to review aggregate data and identify trends or patterns. To help determine the

[39] Three of the 15 patient safety events did not require a peer review based on the type of event.
[40] Includes those events that resulted in, or reasonably expected to result in, death or serious injury; prolonged hospitalization; or life-sustaining intervention or intervention to prevent impairment or damage.
[41] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012 (Corrected October 12, 2012).
[42] http://vaww.oqsv.med.va.gov/functions/integrity/accred/jointcommission.aspx. Accessed July 26, 2016.

effectiveness of the System's QSV program, we reviewed VHA and System policies related to selected QSV functions and corresponding FY 2015 and FY 2016 meeting minutes.[43]

The basic QSV committee structure, including the incorporation of VHA and System policies and communication processes, appeared functional. However, subordinate committee meeting minutes contained inconsistent documentation of data collection, analysis, action identification, and tracking. We identified deficiencies in the following areas:

- *Data Collection and Analysis.* Committee minutes did not include collection, aggregation, or critical analysis of data to support committee members' decision-making as required.[44][45] Presented data consisted of "raw" numbers and informational summaries. We found minimal evidence of robust data evaluation, discussion, or identification of emerging trends and/or patterns.
- *Action Identification and Tracking*. Committee minutes did not consistently include identification of measurable actions or assignment of responsibility. For example, we noted documentation of a "closed" status for action items with future due dates. We noted committee minutes contained statements such as "continue to monitor" while there were clear indications that additional actions were expected, and instances where attachments included recommendations, which were not carried forward in the meeting minutes for action.

We also found that the PR Committee (PRC) attendance and follow-through of actions were inadequate. VHA policy requires healthcare facilities to establish and maintain a PR process for quality management purposes that include activities of the PRC.[46] We reviewed the Level 3[47] PRs assigned by the PRC during FYs 2015 through 2016 and found the following activities were not aligned with VHA requirements:

- *Opportunity for provider under review to attend PRC*. VHA policy requires the PRC to invite the provider under review to submit written comments or appear before the PRC prior to the final determination of a PR level assignment.[48] We found that the PRC did not consistently permit providers with Level 3 PR assignments to present information to the PRC, as required.

[43] The functions included in our review included QSV committees and processes, patient safety events, peer review, institutional disclosure, operative and other procedure review, resuscitation and its outcomes, medical record reviews, blood and blood usage review, restraints and seclusion, mortality and morbidity review, reusable medical equipment, and infection control.
[44] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value,* August 2, 2013.
[45] Center Memorandum (CM) Office of Performance and Quality (OPQ)-1, *Enterprise Framework for Quality, Safety, and Value,* March 28, 2014.
[46] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[47] Level 1- the most experienced, competent practitioners would have managed the case in a similar manner;
Level 2- the most experienced, competent practitioners might have managed the case differently; and
Level 3- the most experienced, competent practitioners would have managed the case differently.
[48] VHA Directive 2010-025.

- *Follow-through on recommended actions*. VHA and System policy required the PRC to recommend and track corrective actions to completion.[4950] The supervisor of the provider under review is responsible for completing the PRC's recommended actions and notifying the PRC when actions are completed. We found that PRC minutes did not consistently include documentation showing actions had been taken and completed for the applicable Level 3 PR cases included in our review.

Since starting in May 2016, the new System Director took several actions to improve elements of the QSV program. He hired additional QSV staff and PSM (started in January 2017); reviewed patient safety incident reports daily in morning meeting; initiated second-level reviews of RCAs; strengthened PR processes; and established improved systems for review and consideration of institutional disclosures.

Recommendation 3: We recommended that the System Director ensure use of the correct methodology to determine the severity assessment code for all reported patient safety events.

Recommendation 4: We recommended that the System Director ensure compliance with the National Center for Patient Safety's guidelines on initiation and completion of Root Cause Analysis.

Recommendation 5: We recommended that the System Director ensure that peer reviews are appropriately completed and address all relevant aspects of care provided by the reviewed clinician.

Recommendation 6: We recommended that the System Director ensure a process is in place to identify and review cases where institutional disclosure may be indicated, and complete as appropriate.

Recommendation 7: We recommended the System Director ensure that the Quality, Safety and Value committee minutes include evidence of robust data analysis and action tracking to address performance deficiencies, and monitor for compliance.

Recommendation 8: We recommended that the System Director ensure adherence to all Veterans Health Administration peer review committee requirements, and monitor for compliance.

Issue 4: Provider Privileging

The System substantially failed to follow VHA policy when completing provider practice evaluations during the privileging process,[51] and as a result, some physicians were

[49] VHA Directive 2010-025, *Peer Review for Quality Management,* June 3, 2010.
[50] CM OPQ-20, *Peer Review for Quality Management,* September 12, 2014.
[51] VHA Handbook 1100.19, *Credentialing and Privileging,* October 15, 2012.

re-privileged to provide care to veterans despite inadequate documentation of their competency to do so.

VHA policy defines clinical privileging as the method by which the System grants a provider privileges to perform specified medical procedures or other patient care within the scope of the provider's license. Clinical privileges must be based on evidence of an individual's current competence. Documentation of clinical activity (for example, evidence that a practitioner[52] has performed a procedure) is one component of the competency equation. The second component is whether or not the practitioner has had good outcomes in practice or when performing a procedure. Clinical privilege requests must be initiated by the practitioner. The applicant has the responsibility to provide evidence or establish possession of the appropriate credentials, qualifications, and the clinical competency to justify the clinical privileges requested.

To determine whether a provider is competent to perform an action or a procedure, VHA facility managers conduct two types of evaluations: a Focused Professional Practice Evaluation (FPPE) and an Ongoing Professional Practice Evaluation (OPPE). An FPPE is a time-limited oversight period allowing the credentialed provider[53] to independently practice during performance evaluation of the requested privileges.[54] FPPE is frequently used for providers new to the VA system who have not established sufficient performance data and for providers whose practice has been "triggered" for further evaluation. According to System policy, a provider must perform a minimum of three procedures during FPPE in order to determine competency.[55]

OPPE is dependent upon the successful completion of the FPPE. In order to determine the provider's level of competence and evaluate the outcomes of care, the System managers must collect and maintain relevant provider-specific data. The re-privileging process needs to include consideration of such factors as the number of procedures performed or major diagnoses treated, rates of complications compared with those of others doing similar procedures, and adverse results indicating patterns or trends in a practitioner's clinical practice.

In order to evaluate the System's FPPE and OPPE practices, we selected a sample of 75 medicine and surgery service-level privileging folders of providers who were privileged for patient care during some portion of FY 2016. We found that 10 of 14 FPPE folders and 55 of 61 OPPE folders did not contain sufficient provider-specific data to support approval and/or continuation of privileges. For example, we found limited volume data without evidence of quality of care information. In addition, the folders did not contain the required 6-month interval reporting. We also found

[52] Practitioner, physician, and provider are equivalent terms used interchangeably in this report.
[53] Credentials include a combination of the provider's licensure, education, training, experience, competence, and health status.
[54] VHA Handbook 1100.19.
[55] CM 11-35, *Credentialing and Privileging of Health Care Providers*, July 23, 2013.

documented statements by the service chief, including "on-call only" or "does not have CPRS" written on the report by the service chief.

Table 3 illustrates additional breakdowns in the System's privileging process.

Table 3. Provider Privileging Requirements and OIG Findings

VHA/System Requirement	OIG Findings
Providers undergo FPPE (as a new provider to the facility), a period of focused evaluation, as defined at the time of privilege approval. Providers can be converted to OPPE upon evaluation of the data collected during the time of FPPE.	Ten FPPE's were documented as completed, 3 of which were converted to OPPE, without evidence of evaluation of quality of care.
The timeframe for on-going monitoring is to be defined at the facility level. It is suggested that, at a minimum, service chiefs must be able to demonstrate that relevant practitioner data is reviewed on a regular basis (at a minimum of every 6 months). System policy identified the timeframe for on-going monitor to be semi-annually.	None of the 61 OPPE folders reviewed included the required semi-annual practitioner data reviews.
The service chief must review all privileging information and must document (list documents reviewed and the rationale for conclusions reached) that the results of quality of care activities have been considered in recommending individual privileges.	None of the 61 OPPE folders reviewed included the list of documents reviewed or the rationale for conclusions reached or evidence that quality of care was considered.
In those instances where a practitioner does not meet established criteria (or does not have data supporting renewal of privileges), the service chief has the responsibility to document these facts. These situations can occur for a number of reasons and do not preclude a service chief recommending the renewal of privileges, but the service chief must clearly document the basis for the recommendation of renewal of privileges.	None of the records reviewed included evidence of service chief reasoning or supportive data for recommending approval of continuation of privileges. The service chief may have noted "call only."
The Executive Committee of the Medical Staff must consider all information available, including the service chief's recommendation and reasons for renewal when criteria have not been met, prior to making their recommendation for the granting of privileges to the Director. This deliberation must be clearly documented in the minutes.	We reviewed 321 Professional Standards Board (PSB) meeting minutes for FYs 13–16. We found that the minutes did not document deliberations of low volume/no volume providers or others without data supporting approval or continuation of privileges.
The System Director must weigh all information available, as well as the recommendations, in the determination of whether or not to approve the renewal of privileges and document this consideration.	We determined that previous System leaders did not have adequate or supporting information available to make an informed decision on the approval or renewal of privileges. In addition, there was no evidence of documented consideration of data and the PSB minutes reflected a "rubber stamp" of approval.

Source: VA OIG Analysis

Low Volume/No Volume

According to System policy, "Low volume/no volume" providers, described as providers who perform less than 12 procedures (such as bronchoscopies)[56] per year at the System, must undergo further evaluation to renew privileges.[57] To determine

[56] Bronchoscopies are performed using a lighted, flexible tube (called a bronchoscope) that is passed through the mouth or nose into the lungs.
[57] CM 11-35, *Credentialing and Privileging of Health Care Providers*, July 23, 2013.

competency of low volume/no volume providers, System managers may consider volume and outcome data from procedures performed at other VA and non-VA health care facilities. In addition, System policy requires that if providers undergoing FPPE are unable to perform enough procedures to meet the minimum requirement to determine competency, data from other VA and non-VA health care facilities must be collected and reviewed. If the provider fails to provide appropriate evidence-based data to complete the FPPE, they are deemed to have voluntarily relinquished clinical privileges. We found that the System's method for requesting outside data was inadequate, as follows:

- Low volume/no volume providers' privileges were renewed, or in the case of FPPE were converted to OPPE, without supporting data from providers' outside practices or other evidence of ongoing competencies.
- Low volume/no volume letters sent to OU for completion were in a YES/NO format and did not require OU to provide information regarding providers' actual quality or volume of procedures and outcomes.
- Low volume/no volume letters were not routinely completed and returned by OU for inclusion in providers' credentialing and privileging folders.

We also found that because some low volume/no volume providers were subspecialists with infrequent patient care responsibilities, System staff paid for these services in the community. Paying for services as needed helped to ensure that VHA was paying providers only for the services actually rendered, and avoided potential patient care events resulting from unfamiliarity with VHA processes or an inability to access VHA's EHR to obtain patient history, laboratory tests, or other important information. In addition, the System would need only enough staff to credential and privilege providers who regularly provided care at the System, rather than maintaining staff to credential and privilege providers who intermittently or infrequently provided care to veterans.

Based on interviews and our review of individual privileging data, PSB minutes, and final approvals, we concluded that responsible managers and leaders had not been attentive to provider privileging requirements as outlined in VHA and System policy for many years; specifically, some providers had been serially re-privileged for more than 2 years without sufficient supporting data. One interviewee described leaders as being "unconcerned" about the lack of supporting data when this issue was brought forward.

Our EHR reviews did not identify any negative patient care events resulting from the systemic breakdown of various aspects of the privileging process. However, the lack of a functional privileging process left patients and other providers vulnerable to adverse outcomes.

Recommendation 9: We recommended that the System Director ensure that professional practice evaluations include performance data to support provider privileges and are conducted in accordance with Veterans Health Administration and System policy.

Recommendation 10: We recommended that the System Director evaluate the current System policy and services provided by low volume/no volume providers to determine whether the System should continue to provide those services or seek community alternatives.

Issue 5: CPRS

Some physicians did not have access to EHRs during times when they had patient care and/or clinical oversight responsibilities. However, we determined that VA's rigid administrative processes and lack of controls contributed to this condition.

VHA uses CPRS to document and maintain clinically pertinent and readily accessible EHRs. Authorized personnel use CPRS to document clinical information; enter notes and orders; and review images and test results, among other functions. CPRS has been integral to patient care in VHA facilities for more than 20 years. In general, users must have a VA network account, which is a gateway to a variety of VA computer systems. Users access CPRS through the secured VA network. If providers with patient care responsibilities cannot access CPRS to review patients' clinical data or document assessments and interventions, patient care may be compromised. Further, attending providers are required to document resident supervision using various methods in CPRS. (See Issue 6, *Resident Supervision.*)

In FY 2016, 18 privileged attending providers did not have CPRS access during the time when they had clinical care responsibilities. Some of these attending physicians, whose primary responsibilities were at OU, had only periodic clinical responsibilities (4 days per year) or only "on call" responsibilities that did not routinely require them to be in the System's main clinical building. Further, some of these physicians provided specialized services not typically available at the System. These physicians were the providers most likely to not have CPRS access or a personal identity verification (PIV) card.

Computer Access Requirements

VA requires all individuals with access to VA information and information systems to:

- Complete VA approved Privacy and Information Security Awareness Rules of Behavior training before being given access and annually thereafter. This training outlines expectations regarding the secure use of passwords.[58]
- Log on to network and CPRS accounts using their own complex, secure passwords at required intervals to avoid account deactivation or expiration.[59]

[58] The VA requires trainees and residents to complete the mandatory trainee training (MTT). MTT incorporates a variety of VA trainings into a single training.
[59] For residents, the Academic Affiliation Waiver must be set to "Yes" so that 90-day rule, rather than a 30-day logon rule, is applied.

Effective in FY 2016, users were required to use PIV cards to logon to VA network systems. In 2004, Homeland Security Presidential Directive 12 (HSPD-12) mandated a government-wide standard for secure and reliable identity credentials for government workers, contractors, and affiliates to access federal buildings and computer networks. PIV is required if access is needed for a period of more than 6 months or more than 180 consecutive or aggregate days in a 365-day period. VA began a phased implementation of PIV cards in 2007. The System started "rolling-out" use of PIV cards around September 2015. As of August 15, 2016, all employees, contractors, and affiliates were to use their PIV cards to logon on to the network. The user must establish a minimum 6-character personal identification number. Use of the PIV card obviates the need for the 12-character username and 8-character password previously required for network access, but CPRS passwords are still required. PIV cards must be renewed every 3 years.

Provider Challenges in Securing and Maintaining Computer Access

We interviewed more than 70 clinical providers, a clinical applications coordinator (CAC), HRMS staff, and other staff knowledgeable about the computer access issues and challenges in securing and maintaining PIV cards. We also reviewed compliance-related documents and interviewed the System's Information Security Officer (ISO) to determine the effectiveness of internal control efforts. Overall, clinicians we interviewed did not report training requirements to be unduly burdensome or a barrier to securing or maintaining computer access. However, interviewees did identify the following issues:

- *Passwords – the length and complexity of passwords, coupled with the requirement to change them at specified intervals, makes it difficult for periodic users (such as contract staff who moonlight once per month) to remember their codes.*
- *Log-on Requirements – users must logon at specified intervals. For users with infrequent patient care or resident supervision responsibilities (such as contract physicians who perform intermittent on-call duties) the requirement to logon from a VA-based computer to maintain the account is arduous.*
- *PIV Card – virtually every interviewee that we asked about PIV cards reported a cumbersome, "broken" process.* To secure a PIV card, employees are required to make three separate appointments, as follows:
    - ✓ Fingerprinting: Fingerprint results are generally returned within 24 hours and are good for 120 days.
    - ✓ Photo/Registration: This step should be completed within the first 2 weeks of entering on duty at the System and takes approximately 10–15 minutes.

- ✓ Badge Pick-Up: This step should occur 2–3 days after the photograph is taken and takes approximately 45 minutes.[60]

Busy clinical staff who only have periodic patient care responsibilities at the System (such as contractors and without compensation (WOC) subspecialists) may reasonably elect to not complete three different appointments for a PIV card that they may only need a few times per year. As of March 2017, the System was endeavoring to reduce the number of appointments required from three to two.

For PIV renewals, cardholders receive daily notices starting 60 days out advising that they need to update their PIV badge. If cardholders delay starting the renewal process, the possibility of a PIV card lapse increases. Cardholders can receive a 2-week exemption via the Help Desk to use a manual logon process (passwords).

System Challenges in Monitoring Computer Access and Creating PIV Cards

Monitoring Computer Access

To determine whether user accounts are still needed, the ISO sends notification to the service chiefs to review all users assigned to their service.

Service chiefs or designees can obtain the list of their employees, including account information with last logon and user "keys," by printing these lists from select menu options. The service chief or designee is to annotate and digitally sign the form, thereby certifying that his/her employees have the correct menu options and accounts are still needed. If an active provider is not included on the ISO's list (referred to as "missing" users in the ISO's notification e-mail), then this information should be annotated as well. Accounts that have not been used and are no longer needed are generally terminated, such as when an employee retires.

We reviewed quarterly network and biannual CPRS monitoring activities for FYs 2015–2016 and found that some clinical services did not consistently respond to requests for certification. Further, service chiefs did not consistently identify and follow up on missing users, which may have been another opportunity to match active, privileged providers with computer access and use data.

Creating PIV Accounts and Cards

The System has two PIV card printers, neither of which was functional in the 2 weeks prior to our October 24 site visit. We were told that when the printers were operational, the System could print about 20–25 PIV badges per day; however, HRMS had about 150 cards pending because the printers were not functional. Reportedly, the printers

[60] During activation, the **Issuer** scans the fingerprints and makes sure they match the information on the card; validates the cardholder's identity; and loads the electronic credentials (certificates) onto the card's chip. The **Issuer** then officially releases the card to the credential holder, who sets a 6-digit PIN and accepts responsibility for the card.

jam, fail to laminate, or otherwise do not print properly on occasion. New printers and cameras were ordered on October 24, 2016.

Reportedly, three staff members were able to process PIV badges; however, not all of them were able to complete all elements of the PIV account creation and badge processing steps. There was a 9-month backlog with the Office of Personnel Management for security assistants to get moderate risk background investigation–Tier 2 (non-sensitive) access. The System's PIV coordinator was only recently granted this access after waiting almost 2 years. Another system-level security assistant in HRMS was in the process of obtaining this access, but at the time of our interview with him, he was only able to check backgrounds over the phone, not via internet, and he was unable to initiate a new account.

Nation-wide issues related to PIV server capacity and the Card Management System (PIV portal) contract expiration were beyond the scope of this review.

Managing Patient Care Without CPRS Access

Several employees we interviewed, including the Chief of Surgery and the ACOS/E, had knowledge of providers, including residents, who entered information into a patient's EHR on behalf of another provider who did not have access to CPRS. Providers we interviewed also reported they conferred extensively with residents about clinical information and documented this discussion in the patient's EHR.

We confirmed several cases where the documentation clearly reflected improper access (used someone else's logon passwords) or documentation (documented on behalf of someone else). In addition, Health Information Management Service (HIMS) staff got "wet signatures" (signed by hand) on printed copies of certain notes, such as operative reports, and then scanned and uploaded those documents to CPRS. While we do not condone these activities as they do not comply with VHA guidance, we acknowledge these "work-arounds" existed to ensure continuity of patient care.

Upon learning of the CPRS access issues, the new System Director took action to administratively suspend the privileges of providers without appropriate access.

Recommendation 11: We recommended that the System Director require service chiefs to assure that all providers within their purview secure and maintain appropriate computer access to ensure quality and continuity of patient care.

Recommendation 12: We recommended that the System Director ensure availability of functional equipment, adequate staffing, and enhanced access for personal identity verification card completion.

Issue 6: Resident Supervision

While some patients' EHRs did not contain evidence of adequate resident supervision, we did not identify patients who were harmed as a result of deficient resident supervision. System managers did not adequately monitor resident supervision and did not maintain letters of agreement which outlined responsibilities for resident supervision in accordance with ACGME requirements.

Resident Supervision Documentation

Through interviews, we determined that System staff were concerned about resident supervision in the orthopedics, neurosurgery, cardiology, and otolaryngology (ear, nose, and throat (ENT) clinics). To assess resident supervision in these areas, we generated a list of all patients admitted to one of the System's hospital units in calendar year 2016 with high risk conditions that required consultation with cardiology, orthopedics, neurosurgery, or ENT services. These health conditions included admissions for heart attacks, hemorrhagic strokes, hip fractures, amputations, brain tumors, or head and neck tumors. We determined there were 185 unique patients who had a total of 212 visits from one of these four services during their hospitalization.

For inpatient settings, VA policy requires that the supervising physician "must physically meet, examine and evaluate the patient within 24 hours of admission, including weekends and holidays."[61] Documentation of the supervising physician's initial examination of an inpatient must be in the form of a separate note in the EHR, or an addendum to a resident's note. In other situations, documentation of the supervising physician's involvement can be in the form of a separate note, an addendum to a resident note, co-signature of a progress note, or a resident note documenting the name of the supervising physician and their discussion of the case.[62]

We applied these resident supervision rules to the 212 visits we reviewed to determine whether the supervising physician saw the patient within 24 hours of admission or consultation. In 200 of the 212 visits we reviewed, the supervising physician saw the patient within 24 hours of admission or consultation. Eight additional EHRs contained evidence of resident supervision, but not within 24 hours of the consultation or admission. Our review determined that 4 of 212 visits contained no documentation of resident supervision.

While the EHRs for these patients did not contain required documentation of resident supervision, we did not find evidence that patient harm occurred during these episodes of care.

Despite finding deficiencies in the documentation of resident supervision, we could not substantiate an actual lack of resident supervision. Specifically:

[61] VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
[62] VHA Handbook 1400.01.

- We interviewed 31 resident physicians. None of them reported any deficiencies in supervision.
- We reviewed documentation from OU of Neurosurgery Program Evaluation Committee Minutes, dated July 25, 2014; July 31, 2015; and June 24, 2016. These minutes stated that the program scored above the national mean among exiting neurosurgical residents in the sufficiency of resident supervision. Other meeting minutes, provided by OU in response to our request included Clinical Competency Committee and Program Evaluation Committee meetings in I'2014–2016, did not contain documentation of deficiencies in resident supervision.
- We reviewed incident reports, peer reviews, and other documentation for FYs 2015–2016. While issues regarding documentation of resident supervision appeared sporadically in these documents, none described evidence of actual deficits in residents' supervision.

Monitoring of Resident Supervision

System managers did not monitor resident supervision as required under VHA policy. The monitoring process must include, at a minimum, a facility policy titled "Monitoring of Resident Supervision;" reviews of patient safety, risk management, and quality improvement data, including record reviews describing patient care involving residents; analysis of reports by external accrediting and certifying bodies; and residents' comments regarding their VA experience. Each facility must also complete an annual report on its resident training program; to include actions taken by accrediting or certifying bodies, changes in status of affiliations, and a specific analysis of resident supervision issues.

VHA policy assigns responsibility for monitoring resident supervision to the DEO. The DEO is responsible for ensuring that facility monitoring and reporting requirements regarding resident supervision are met, and for ensuring that a facility resident supervision policy is in place. The program director, who usually holds a position at the sponsoring institution, is responsible for ensuring that the policy complies with accreditation requirements. The site director is responsible for "ensuring that supervising physicians are appropriately fulfilling their responsibilities to provide supervision to residents and that ongoing evaluation of supervisors, residents, and the VA site are conducted."[63]

We determined that System managers' monitoring of surgery resident supervision did not comply with the System policy. Medical Center Memorandum 11-84 states that facility monitoring of resident supervision occurs in a variety of patient care settings, including inpatient, outpatient, procedural, emergency, consultative, and surgical care. Further, the System policy states that monitoring resident supervision should also include residents' comments about their rotations at VA; opportunities for improvement

[63] VHA Handbook 1400.01, p. 18.

in resident supervision and creation of action plans; and completion of an annual report on residency training programs. The only documents System managers provided us to demonstrate monitoring of surgery resident supervision were labelled "Medical Record Focused Review Surgical Services" and contained data specific to inpatient admissions to the surgical service. Monthly compliance rates ranged from 70 to 93 percent between June 2014 and March 2016. These reviews were stopped following the Surgical Quality Improvement Coordinator's retirement in May 2016. None of the documents we received documented routine ongoing monitoring of resident supervision in other surgical service patient care settings.

VHA provided a consultative site visit report, in which the results of an audit of 14 EHRs by the Compliance and Business Integrity Office (CBI) determined that one record did not contain documentation of appropriate medical supervision. The CBI site visit team recommended that the Compliance officer conduct a 100 percent review of all surgical episodes, and a statistically valid sample of all outpatient episodes of care, which involved supervising physicians who did not have access to CPRS at a time when they were responsible for residents' supervision. The site visit team also recommended a number of improvements in the monitoring of resident supervision, which included the use of standardized templates and designating one service to be responsible for tracking resident supervision.

Surgical Service's Letter of Agreement

We also found that OU's Surgical Residency Program's letter of agreement with the System did not contain required information defining faculty/staff responsibilities for resident supervision.

ACGME sets quality standards for graduate medical education programs in the United States and the institutions that sponsor residents. By policy, VA follows ACGME institutional requirements, which include requirements for participating sites. ACGME requires that a program letter of agreement be in place between the program and each participating site. This agreement must be renewed at least every 5 years, identify faculty who will assume both educational and supervisory responsibilities for residents; specify responsibilities for teaching, supervision and evaluation of residents; specify the duration and content of the educational experience; and state the policies and procedures that govern resident education.

The System entered into a letter of agreement with OU's surgical residency program director on February 24, 2014. This agreement did not specify beyond the residency program director any faculty responsible for the teaching, supervision, and evaluation of residents. It also did not state the policies and procedures that govern resident education, but instead stated that the System would inform the resident physicians of those policies. We therefore determined the agreement did not meet ACGME requirements as required by VHA policy.

Since our December 2016 site visit, the System Director added staff to oversee resident training and time and attendance; established new processes for OU invoice review and tracking of resident activities; and established site directors for applicable clinical areas.

Recommendation 13: We recommended that the System Director ensure compliance in monitoring of resident supervision documentation in accordance with Veterans Health Administration and System policies, and take appropriate action when deficiencies are identified.

Recommendation 14: We recommended that the System Director review letters of agreement between the University of Oklahoma's surgical residency program and the System to ensure compliance with Accreditation Council for Graduate Medical Education requirements.

Issue 7: Staffing

Some areas are chronically understaffed; however, System leaders utilize hiring incentives and prioritize clinical hiring positions to meet patient care needs.

Adequate staffing levels are a key component to meeting the demands for patient care and services. A comparison of authorized full time equivalent (FTE) employees to actual FTE for FYs 2014–2016 for the selected services reflected that the actual FTE was often below the authorized FTE as shown in Table 4. We noted, however, that the System had been successful hiring clinical staff during this time.

Table 4. Comparison of Authorized Versus Actual FTEs FYs 2014–2016

	FY 2014		FY 2015		FY 2016	
Service	Authorized FTE	Actual FTE	Authorized FTE	Actual FTE	Authorized FTE	Actual FTE
Nursing	689.9	616	758.9	638.7	779	680.4
PC (providers)	32	26	36	31	38	36
SC (providers)[64]	128.5	81.9	141.6	100.9	192.1	161.2
MH[65]	140.1	128.4	151.3	134.3	159.5	140.1

Source: VHA System Data

We reviewed staffing status and hiring plans for Nursing Service, PC, SC, and MH. We also reviewed System policies, VHA guidelines, and interviewed key staff. We confirmed that the System had multiple vacancies in the selected clinical services. However, we received conflicting information from different sources, making it difficult to determine with certainty the precise number of actual vacancies.

[64] SC Service consists of providers in Anesthesiology, Surgery, Medicine, Radiology, Pathology and Laboratory, Neurology and Rehabilitation, Geriatrics, and Nuclear Medicine.
[65] MH is comprised of Psychiatry, Psychology, and Social Work Services; each of which reports to the COS.

We were told repeatedly by System, HRMS, and clinical leaders that System managers have difficulty recruiting and retaining some specialists because they compete with private-sector health care organizations for qualified clinical professionals. System managers use several recruiting incentives and a Direct-Hire Authority[66] to address staffing shortages and fill critical vacancies. System leaders prioritized job openings by reviewing all vacancies and meeting with the various service chiefs to determine hiring priorities.

Staffing Status and Hiring Plans

Nursing Service: System Nursing Service leaders told us that they have difficulty recruiting and retaining nurses because, like providers, they also must compete with the private-sector for qualified nurses. Nursing leaders implemented several registered nurse (RN) recruitment and retention strategies including a nurse residency, an extern program,[67] education debt reduction programs, VA scholarships, community pay parity, local newspaper advertisements, and flexible schedules. System managers redesigned their nurse onboarding[68] process, and for FY 2016, the average nurse onboarding time was 21 days.

During FY 2016, Nursing Service gained 140 employees and lost 93 employees. However, as shown in Table 5, the percentage of authorized RN FTE positions filled increased in FY 2016.

Table 5. RN Staffing by Fiscal Year

Fiscal Year	Authorized FTE	Actual FTE	Percentage of Authorized RN Positions Filled
FY 2014	404.1	358.7	88.7
FY 2015	436.1	379.0	86.9
FY 2016	476.6	415.4	87

Source: VHA System data

Nursing Service leaders implemented VHA's nationally standardized nurse staffing methodology in 2011.[69] Nursing leaders reported that the System has progressively improved in meeting the nurse staffing levels identified per the staffing methodology. We reviewed the April and May 2016 staffing levels for one intensive care and two medicine units and determined that each unit met required minimum staffing as

[66] A Direct-Hire Authority is an appointing (hiring) authority that the Office of Personnel Management can give to Federal agencies for filling vacancies when a critical hiring need or severe shortage of candidates exists.
[67] The extern program focuses on providing a transition from nursing student to registered nurse.
[68] Onboarding is a process that includes completion of required paperwork such as security clearance, federal application for nurses and nurse anesthetists, employment eligibility verification, and medical history.
[69] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel,* July 19, 2010. This directive expired July 31, 2015 and has not yet been updated.

outlined in the nurse staffing methodology. To support staffing needs, Nursing Service uses a float pool consisting of 10 RNs, some of whom can work in the medical/surgical and intensive care units, as well as the ED.

The System's senior leaders approved the FY 2015–2016 Nurse Staffing Methodology. In accordance with the approved methodology, System leaders approved Nursing Service leaders to fill vacant RN positions and to convert vacant licensed practical nurse positions to RN positions to facilitate timely patient care and meet documentation requirements.

We also evaluated ED RN staffing levels. Nurse leaders told us that the ED is authorized for 28.5 RN FTEs, but as of September 30, 2016, had 20.1 RN FTEs. The ED used budgeted overtime to ensure adequate coverage, and RNs from the intensive care unit floated to the ED when needed. ED nurse leaders and RNs reported that they were always able to meet the minimum staffing level. We reviewed the ED nurse staffing sheets for May and early June 2016 and found that the ED met minimal RN staffing levels and used the float pool and overtime to cover ED nurse absences. As of November 16, 2016, ED nurse leaders reported that five new RNs were in the onboarding process, and candidates were being interviewed for a sixth position.

PC: PC consisted of 33 Patient-Aligned Care Teams (PACTs) that included a physician, an RN, and 2 licensed practical nurses. PC managers hired two physicians and three nurse practitioners as float providers to cover during PC providers' absences. PC managers anticipated three vacancies over the next few months, and interviews were in progress to fill these positions. We were told that the CBOCs were fully staffed as of September 30, 2016.[70]

SC: System leaders reported that the biggest SC deficits were for hospitalists[71] and GI physicians:

- The System had 6.0 FTE vacancies for hospitalists. The System acknowledged high turnover in this area and difficulty in recruiting. They used contract providers, inpatient fee basis and contract locum tenens[72] providers when needed for coverage.
- GI Clinic was authorized 9.625 FTE (6.625 physicians and 3.0 nurse practitioners). As of November 2016, the System had 1.625 FTE physician vacancies, both of which had been approved for recruitment.

[70] There were eight providers at the Lawton CBOC and three providers at the Wichita Falls CBOC with one provider floating between the two sites. The Stillwater CBOC had one physician and one mid-level provider. The physician recently departed, but there was a new hire in process with floating staff providing interim coverage.
[71] Hospitalists are physician and non-physician providers who engage in clinical care, teaching, research, or leadership in the field of general hospital medicine.
[72] Locum tenens is a Latin phrase that means "to hold the place of, to substitute for," https://www.locumtenens.com/about-us/what-we-do/what-is-locum-tenens/. Accessed June 14, 2016.

While hospitalists and GI physicians represent the System's biggest physician staffing deficits, ongoing efforts were underway to recruit for other specialties including pulmonology and cardiology. As of September 30, 2016, there were no vacancies in nephrology.

MH: At the System, MH includes Psychiatry, Psychology, and Social Work Services. These services work collaboratively under the MH Executive Board, but they all report independently to the COS.

The January 6, 2016 Executive Resource Board minutes noted "Our facility staffing for Mental Health Services is 26.6 FTE below VACO [VA Central Office] recommended staffing levels. Our outpatient Mental Health staffing level is currently the lowest within the VISN." According to the acting Chief of Psychiatry, the System has difficulty hiring prescribing providers due to salary limitations and, more recently, due to the System's budget constraints.[73] As of September 30, 2016, the System had 7.0 prescribing provider vacancies (providers who can prescribe medications and order tests and treatments), with 3.5 of those positions approved for recruitment. Additionally, MH was approved to hire five clinicians and an administrative support employee to staff a new MH intake clinic; however, this effort was "on hold" pending the availability of funding. MH managers had made selections of four prescribing providers; however, all declined the positions due to salary not being competitive enough.

System and MH leaders told us that recruiting psychiatrists had also been a longstanding problem at the Lawton CBOC. MH leadership reported that they recently selected a psychiatrist and a psychologist for the Lawton CBOC. To ensure patient access in the interim, the System provided tele-MH to the Lawton CBOC patients.

Despite MH staffing vacancies, patients were generally able to access MH care in a timely manner. (See Issue 8, *Clinic Access.*)

Recommendation 15: We recommended that the System Director continue efforts to recruit and hire for vacancies, and ensure that, until optimal staffing is attained, alternate methods are consistently available to meet patient care needs.

Issue 8: Clinic Access

The System is not meeting several access measures. Inadequate staffing and inconsistent scheduling practices appear to be contributors affecting clinic access.

VHA requires that patients be able to schedule a routine (non-urgent) care appointment with their PC provider or a specialist within 30 days.[74] Further, System policy requires that when a clinic is cancelled, staff will contact the patient to inform them of the cancellation and reschedule the appointment to an earlier date. Those patients who

[73] Reportedly, the System generally does not have difficulty recruiting and hiring psychologists and social workers.
[74] VHA Directive 2006-041, *Veterans Health Care Service Standards,* June 27, 2006. This directive expired June 30, 2011 and has not yet been updated.

cannot be scheduled to an earlier date will be given an appointment within one month and provided sufficient medication to last until 2 weeks beyond their new scheduled appointment.

For new patients (those who do not have established relationships with specified clinics or providers), initial appointments are typically requested through consults to specialists or to the specialty clinics. Consults remain open until appointments are completed and the results are available in the patients' EHRs. One of VHA's access-related performance measures is the number of consults open greater than 30 days. VHA staff report consults open greater than 90 days on the VHA consult switchboard.[75]

VHA staff use the Scheduling Trigger Tool to identify scheduling-related issues. The Data Compliance score identifies potentially erroneous scheduling practices used to increase performance, and the Scheduling Compliance score indicates possible non-compliance with scheduling policies and the need for staff training.

Clinical Care Timeliness Measures

SC Access. In general, the System completed routine SC appointments within the 30-day timeframe, as required. However, timely completion of SC appointments declined when comparing Q1 FY 2015 (97 percent) to Q1 FY 2016 (92 percent). At the end of Q4 FY 2016, the following SC clinics exceeded the 30-day timeframe to complete new patient appointments:

- Renal Clinic – average of 41 days
- Gastroenterology – average of 43 days

Across all SC clinics, we found 637 of the 2,931 (22 percent) new patient appointments were pending greater than 30 days.[76]

SC Clinic Cancellations

Based on complaints we received about resident and attending physicians not consistently being present for clinic, we reviewed clinic cancellations during FY 2016 for ENT, orthopedics, rheumatology, neurosurgery, cardiology, and ophthalmology clinics. We found 1,288 clinic appointments were cancelled prior to the appointment time, reportedly due to provider absences.

Rescheduling. Of the 1,288 cancelled appointments under review, 852 appointments were rescheduled and completed within 30 days. However, 424 cancelled appointments were not addressed according to policy, as follows:

[75] The consult switchboard is a central location for new consult business rule information and for users to access documentation, tasks, reporting, and help.
[76] An appointment is considered pending when there is an appointment date entered, but no checkout, no-show, or cancel date; deceased patients are excluded. These appointments were scheduled for in-house services.

- 135 cancelled appointments were not subsequently rescheduled and completed.
- 289 cancelled appointments were completed, but not within 30 days of the original appointment date.[77]

Twenty-two of the 424 patients noted above either died or were hospitalized (for a condition associated with the consult/appointment) subsequent to the clinic appointment cancellation. Based on our review of the 22 EHRs, we did not find evidence that the clinic cancellations contributed to clinically significant adverse outcomes.

The System's overall clinic cancellation rate in FY 2016 was comparable to other VHA facilities with the same complexity level (1a) and quality ranking (3-star).

Payment for services. Of the 1,288 clinic cancellations, 784 involved either full-time physicians or non-provider issues such as scheduling errors (that were improperly coded as provider absences). We reviewed the remaining 504 clinic cancellations to determine if there were any potential improper payments caused by possible unauthorized physician absences.[78]

For 169 of the 504 clinic cancellations, we found no documented evidence in EHRs (such as progress notes and surgery logs) to support that the physicians were on duty during the times of the clinic cancellations. Moreover, we found no evidence that the absent physicians were in an authorized leave status.

Example 1:

> The System cancelled four ENT clinic appointments on June 15, 2016 because a part-time physician was not on duty as scheduled. We found no documented evidence to support the accomplishment of any VA duties for the part-time physician on the day of the cancelled appointments. We also verified that the physician was not on leave.

Example 2:

> The System cancelled 16 ophthalmology clinic appointments on May 5, 2016 because a resident was not on duty as scheduled. Although the System was billed 28 days for this resident's services in May 2016, medical documentation only supported that the resident performed VA work on 18 days during the month of May. Further, the medical documentation did not show that the resident worked on the day of the cancelled appointments.

The System made potentially improper payments because of insufficient time and attendance monitoring of part-time and resident physicians. Service and section chiefs did not adequately monitor time and attendance for both part-time and resident

[77] There were 12 appointments where the patient declined to reschedule or the appointment was no longer needed.
[78] FT providers are salaried VA employees and were therefore excluded from this review.

physicians throughout FY 2016. Further, the DEO did not establish adequate procedures for resident educational activity record keeping or for reconciling the educational activity records with OU's invoices for the time residents spent performing VA work, which may have increased the risk of these types of errors going undetected.

As a result, System managers provided compensation for part-time and resident physician services that were not received resulting in potential improper payments of approximately $5,191 as denoted in Table 6.

Table 6: Potential Improper Payments Summary

		Part-Time Physicians		Residents/Fellows	
Service	**Total Clinic Cancellations**	**Cancellations Due to Unauthorized Absences**	**Potential Improper Payments**	**Cancellations Due to Unauthorized Absences**	**Potential Improper Payments**
Ophthalmology[79]	325	0	$ 0	114	$2,977
Rheumatology	100	6	$159	41	$1,329
Cardiology	23	0	$ 0	3	$400
ENT	47	5	$326	0	$ 0
Orthopedics	9	0	$ 0	0	$ 0
Total	504	11	$485	158	$4,706

Source: VA OIG Audit and Evaluations staff

We found that SC had multiple consult types open greater than 90 days, meaning that these consults were incomplete (pending, active, scheduled, or seen without documented consult results). At the end of Q4 FY 2016, the following areas had the highest number of open consults greater than 90 days:

- Gastroenterology - 146 open consults
- Cardiology - 53 open consults
- Sleep Medicine - 52 open consults
- Neurology - 48 open consults

Reportedly, System managers were recruiting for gastroenterologists. Beginning in April 2016, the System extended GI clinic hours on Tuesday evening and Saturday to help increase access; however, we found that the System held only one Saturday clinic between April and June 2016. To increase Sleep Medicine Clinic access, System managers increased the number of referrals to Veterans Choice and converted a

[79] Ophthalmology contained 86 clinic cancellations that were the result of contract or fee-basis provider absences that did not contain any potential improper payments.

pulmonary physician from part-time to full-time. System managers were also considering the purchase of equipment for home sleep studies. To improve Pain Clinic access, System managers converted a provider's FTE from 0.25 to 0.375, and increased the number of referrals to Veterans Choice.

We found that the System's Q2 FY 2016 Scheduling Trigger Tool data were in the bottom 20th percentile of the overall Scheduling Compliance score for SC clinics across VHA; however, by the end of Q4 FY 2016, SC clinics achieved compliance in the overall Scheduling Compliance score.[80]

MH Access. Routine MH appointments were generally completed within the 30-day timeframe. As of the end of Q4 FY 2016, we found 12 of the 167 (7 percent) new patient appointments were pending greater than 30 days.

During our review of MH data; however, we identified an unusually high rate (compared to SC and PC) of new patients being scheduled on the same day as their desired date, which is reflected as a 0-day waiting time and may be an indication of improper scheduling practices.[81] We reviewed 30 randomly selected EHRs of patient appointments that had 0-day wait times. Of those, we found that 4 (13 percent) did not comply with VHA scheduling policy. The acting Chief of MAS reviewed the four scheduling instances in question and confirmed that the scheduling clerks may have erred. He told us that since his entry on duty in late April 2016, System managers have undertaken multiple efforts to train schedulers in MAS, which included developing a new training module and instituting ongoing refresher training.

We determined that while MH generally provided timely care, opportunities exist to improve timeliness. The System had multiple psychiatrist vacancies. The System identified staffing deficits as a continuing priority and was working to develop an MH intake clinic to improve access.

PC Access. The System typically completed routine PC appointments within the 30-day timeframe.[82] As of the end of Q4 FY 2016, we found 7 of the 414 (2 percent) new patient appointments pending greater than 30 days. We did not find indications of improper scheduling practices.

Call Center (Medical Advice Line) Responsiveness

VHA established call centers to provide access to telephone care 24-hours-a-day, 7-days-a-week.[83] The call center's performance is measured by a call answer speed

[80] Facilities that fall within the bottom 20th percentile of composite scores for overall Data Compliance or Scheduling Compliance are identified as having potential access issues.
[81] If scheduling clerks used the next available appointment slot as the desired appointment date for new patients, a 0-day wait would "improve" wait time performance scores.
[82] VHA Directive 2006-041.
[83] VHA Directive 2007-033, *Telephone Service for Clinical Care*, October 11, 2007. This directive expired October 31, 2012, and has not yet been updated.

within 30 seconds and a call abandonment rate no greater than 5 percent.[8485] In Q1 FY 2016, calls were answered in an average of 135 seconds with an abandonment rate of 17 percent; those numbers improved in Q4 FY 2016 to 65 seconds and 9 percent, respectively. System managers implemented improvement actions tracked through the SAIL workgroup.

Recommendation 16: We recommended that the System Director ensure timely completion of specialty care consults and monitor compliance.

Recommendation 17: We recommended that the System Director implement a process to conduct routine scheduling audits to monitor compliance and identify ongoing training opportunities for all schedulers.

Recommendation 18: We recommended that the System Director conduct an evaluation of the potential improper payments resulting from clinic cancellations, take appropriate corrective actions, and establish policies to mitigate improper payments related to clinic cancellations from occurring in the future.

Recommendation 19: We recommended that the System Director continue efforts to improve call center timeliness.

Issue 9: Veterans Choice and NVCC

Overall, the System is meeting timeliness goals for Veterans Choice and NVCC care; however, opportunities for continued improvement exist.

When a VA facility cannot provide needed medical care due to a lack of a service or specialists, high demand for care, geographic inaccessibility, or other limiting factors; eligible patients may use non-VA care.[86] At the System, Veterans Choice and NVCC are organizationally aligned under the Care in the Community Program (CCP) and are the primary avenues to provide non-VA care. CCP currently has 18 employees with 4 additional employees approved and pending hire.[87] CCP employees provide administrative and clinical coordination of Veterans Choice and NVCC services.

Veterans Choice is a program initiated in August 2014 through the Veterans Access, Choice, and Accountability Act. Veterans Choice offers several options including Choice First (when the service is not available at the System, such as mammograms) and Choice 30 (when the patient cannot be scheduled with System providers within

[84] The abandonment rate is the percentage of calls that are terminated by the persons originating the call before being answered.
85 The speed of answer is the average delay that inbound telephone calls wait in the telephone queue before being answered.
[86] VHA Directive 1601, *Non-VA Medical Care Program*, January 23, 2013; *Choice First Standard Operating Procedure (SOP): Non-VA Medical Care Referral Process for Services Unavailable and 30-Day Wait Time*, November 2, 2015 (Version 15); and VHA Consult Management Business Rules.
[87] CCP staff currently includes 12 nursing employees and 6 program assistants. Three additional nursing employees and a program assistant are in various stages of recruitment and/or hiring.

30 days).[88] TriWest Healthcare Alliance (TriWest) is the VA-contracted third-party administrator with responsibility for recruitment and maintenance of a "network" of providers to meet specialty, geographic, or other care needs for patients served by the System.

NVCC may be used if services cannot be delivered by VA providers; if Veterans Choice does not cover the care or specialty services (such as hospice, chronic dialysis treatments, or dental care); or if the patient declines to use Veterans Choice.

After a System provider initiates a non-VA care consult, CCP staff review the case to determine administrative eligibility and clinical appropriateness. After staff secure authorization for care, they contact the patient to determine whether he or she wants to "opt in" to Veterans Choice.

If the patient chooses to use Veterans Choice, CCP staff uploads the consult to the TriWest portal[89] for further action. TriWest contacts the patient to schedule the appointment with a community provider and notifies CCP staff once the patient is scheduled. CCP staff track the consult to ensure that the patient was scheduled with the clinically appropriate provider; the patient attended the appointment; and the consult results have been received, scanned, and linked in the patient's EHR.

If the patient declines Veterans Choice,[90] NVCC may be used. CCP staff send the consult, authorization, and supporting documents to a community provider or a medical practice for completion of the consultation and/or evaluation. For NVCC services, CCP staff coordinate the scheduling and follow-up process.

Consult Volume and Timeliness

The goal of CCP is for patients to be scheduled an appointment within 30 days of their provider's clinically indicated date. At the end of Q2 FY 2016, the average appointment wait times were down to 30 and 34 days, for Veterans Choice and NVCC respectively. At the end of Q3 FY 2016, both Veterans Choice and NVCC were scheduling appointments in an average of 28 days.

Another CCP goal is for consults to be completed (results received, scanned, and linked in the EHR) within 90 days of the consult request. According to data collected by the CCP Coordinator, the System "peaked" in December 2015 with a high number of consults open (incomplete) greater than 90 days. The CCP Coordinator told us that

[88] Choice 40 can be used when patients reside greater than 40 miles from a VA facility that can provide the needed care. Choice 40 permits patients to coordinate their care directly through TriWest. Patients can still elect to be seen at the System even if they live outside the 40-mile radius from the nearest VA medical facility. Choice 40 consults were not evaluated as part of our review.
[89] The TriWest portal is a secure portal, which enables providers and staff to access patient referrals that contain pertinent information such as referral number, referral date range, and authorized Current Procedural Terminology/Healthcare Common Procedure codes.
[90] Reportedly, about 30 percent of patients "opt-out" of using Veterans Choice.

while patients had often completed their appointments, CCP staff sometimes had difficulty retrieving clinical results from community providers in order to close the consult. On a weekly basis, the CCP Coordinator monitors the list of consults older than 90 days and follows up on consults where delays could be clinically or otherwise concerning.

A quarterly snapshot for FY 2016 of incomplete consults greater than 90 days old reflects the following:

- 1,371 on December 29, 2015
- 677 on March 29, 2016
- 693 on June 21, 2016
- More than 800 as of September 30, 2016

While the number of CCP consults increased in Qs 3 and 4 FY 2016, data indicates improvement in FY 2017. As of March 9, there were less than 400 incomplete CCP consults open greater than 90 days.[91]

CCP Challenges

We found the CCP to be adequately staffed with tenured, knowledgeable, and proactive employees who were able to overcome many of the obstacles that continue to challenge other VA health care facilities. The CCP Coordinator and other interviewees told us that adding TriWest to manage all Veterans Choice consults complicated processes and possibly delayed care. Specifically, they said:

- Patients, System staff, community providers, and TriWest staff get confused with the different processes and terms (such as Choice First, Choice 30, Choice 40), and community providers and patients do not always understand the difference between, and the differing responsibilities of, VA versus TriWest.
- TriWest sometimes schedules patients with community specialists who cannot provide the care that is needed and/or requested (such as the patient is scheduled with a cardiologist[92] when he/she needs to see a cardiothoracic surgeon).[93]
- To ensure timely availability of clinical documentation for continuity of care, CCP staff contacted community providers for consult results within 14 days of the appointment/treatment date. The VA-TriWest contract stated that TriWest had

[91] As of March 13, 2017, VHA's consult switchboard documented that 364 (13 percent) of the System's 2,716 incomplete CCP consults were in an active (154) or scheduled (210) status greater than 90 days. On July 7, 2016, 665 (17 percent) of the System's 3,943 CCP consults were incomplete greater than 90 days.
[92] A cardiologist is a medical doctor with special training and skill in finding, treating, and preventing diseases of the heart and blood vessels.
[93] A cardiothoracic surgeon is a medical doctor who specializes in surgical procedures of the heart, lungs, esophagus, and other organs in the chest.

75 days to obtain the consult results and upload them to the portal. However, CCP staff worked to ensure these documents were available to VA providers sooner.

- Some non-VA providers declined to see VA patients because TriWest had not paid prior bills. Patients were reportedly filing complaints because these unpaid medical bills were sent to collection agencies.

We reviewed 30 randomly selected Veterans Choice consults from Q2 FY 2016 and confirmed that, in spite of the reported challenges, appointments were scheduled and completed in a timely manner. Of the records reviewed, it took, on average, one day to complete the clinical and administrative reviews; 3 days to upload the Veterans Choice consult to the TriWest portal; and 29 days (range 0–77 days) for the patient to be seen for care.

Recommendation 20: We recommended that the System Director continue efforts to improve timeliness of Care in the Community Program consult completion; enhance patient and community provider understanding of Veterans Choice and Non-VA Care Coordination options; and continue to promote communication and coordination with TriWest Healthcare Alliance to assure appropriate, timely care for patients.

Issue 10: Quality of PC and Outpatient MH Care

Outpatient care needs improvement in the areas of abnormal laboratory result notification and interventions and consultation completion timeliness.

PC is the foundation of VHA health care; it is in this outpatient setting that many enrolled veterans have their first contact with a VA clinical provider.[94] VHA providers must maintain complete, accurate, timely, clinically pertinent, and readily accessible EHRs that contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses and treatment, and measure outcomes.[95]

To determine if PACT teams were providing and documenting specified care and follow-up, we identified 674 patients who had completed PC appointments[96] from March 6 through March 12, 2016, with an associated primary or secondary diagnosis of hypertension, diabetes mellitus, or congestive heart failure.[97]

[94] VHA Directive 2012-011, *Primary Care Standards*, April 11, 2012. This directive was rescinded and replaced by VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, on March 26, 2015, that contains the same or similar language (see p. 1).
[95] VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2015.
[96] Completed appointments were identified using stop codes within VHA's PC clinic group, including 322, 323, and 350.
[97] We chose to focus our review on these chronic conditions because of their high prevalence within the veteran population and because of the availability of nationally recognized guidelines for treating these conditions. Primary or secondary diagnoses were identified using selected International Classification of Diseases, Tenth Edition (ICD-10) codes that went into effect October 1, 2015.

We evaluated:

- Clinical care documentation and medication reconciliation during the PC appointments
- Compliance with abnormal laboratory result notifications and interventions
- Consultation completions
- Medical advice line call responses

We also evaluated outpatient MH care quality by examining the System's SAIL metrics.

Clinical Care Documentation. The EHR is a tool for communication and continuity of care for the health care team.[98] EHR documentation allows providers and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor the patient's health over time. In the outpatient setting, the provider must document a pertinent progress note at the time of each outpatient care visit.[99]

We reviewed EHRs to determine if required components of care[100] were documented. We found high compliance in the following areas:

- Presenting problem(s) – 100.0 percent
- History and objective data relevant to presenting problem(s) – 99.4 percent
- Assessment of problem(s) – 99.9 percent
- Treatment plan for problem(s) – 99.6 percent
- Diagnosis(es) treated or that required further treatment – 97.9 percent

Medication Reconciliation. Medication reconciliation is the process by which clinicians maintain and communicate accurate patient medication information through identifying, addressing, and documenting medication discrepancies found in the EHR as compared to the medication information given by the patient.[101] We found that PACT team members performed and documented medication reconciliation in 667 of the 674 (99.0 percent) EHRs reviewed.

Abnormal Laboratory Result Follow-ups. In the delivery of high quality patient-centered care, all VA medical facilities are expected to have appropriate systems and processes in place to ensure timely communication and follow-up of test results. To do this, VHA

[98] VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2015.
[99] Ibid.
[100] Ibid.
[101] VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011. This directive expired March 31, 2016 and has not yet been updated.

requires that all test results requiring action be communicated to patients no later than 7 calendar days from the date on which the results are available.[102]

We reviewed EHRs for evidence of patient notification of, and interventions taken for,[103] abnormal laboratory results that were clinically significant.[104] For our selected patient population with diagnosis(es) of hypertension, diabetes mellitus, or heart failure; we evaluated selected diagnostically relevant laboratory results associated with each patient's March 2016 encounter.[105]

Patient Notification of Abnormal Lab Results. PACT team members notified patients of 920 of the 1,075 (85.6 percent) abnormal results of the selected laboratory tests within 7 days of the availability of the results.[106] PACT team members used a variety of ways to notify patients, including face-to-face visits, letters, and phone calls. (See Table 7 for details; notification counts in Table 7 may not sum to the totals due to rounding.)

Table 7. Patient Notification of Selected Abnormal Lab Results by System Location for Patients with Completed Appointments March 6–March 12, 2016

Clinical Site	Patient Notification				Total Count	Total Percent
	YES		NO			
	Count	Percent	Count	Percent		
OK City VA Medical Center Clinics	565	52.6	70	6.5	635	59.1
South OK City VA Clinic	115	10.7	44	4.1	159	14.8
Lawton VA Clinic	88	8.2	16	1.5	104	9.7
Wichita Falls VA Clinic	55	5.1	0	0.0	55	5.1
Ardmore VA Clinic	33	3.1	4	0.4	37	3.4
Ada VA Clinic	20	1.9	13	1.2	33	3.1
Stillwater VA Clinic	16	1.5	2	0.2	18	1.7
Blackwell VA Clinic	15	1.4	2	0.2	17	1.6
Enid VA Clinic	9	0.8	4	0.4	13	1.2
Altus VA Clinic	4	0.4	0	0.0	4	0.4
Total	**920**	**85.6**	**155**	**14.4**	**1075**	**100.0**

Source: VA OIG EHR review

[102] VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.
[103] Interventions might include medication or diet change or other actions.
[104] Clinically significant laboratory results are those that required action (interventions) by the ordering providers.
[105] Diagnostically-relevant laboratory tests included Creatinine, Hemoglobin A1c, Low Density Lipoprotein, Cholesterol, Urine Microalbumin, Potassium, Triglyceride, Urine Glucose, Urine Ketones, and Urine Protein.
[106] Patients could have more than one abnormal laboratory result reported.

Interventions Taken for Abnormal Results. PACT providers took actions to address 873 of the 971 (89.9 percent) clinically significant abnormal laboratory results. (See Table 8 for details; intervention counts in Table 8 may not sum to the totals due to rounding.)

Table 8. Interventions Taken for Selected Abnormal Lab Results by System Location for Patients with Completed Appointments March 6–March 12, 2016

Station	Interventions Taken				Total Count	Total Percent
	YES		NO			
	Count	Percent	Count	Percent		
OK City VA Medical Center Clinics	513	52.8	36	3.7	549	56.5
South OK City VA Clinic	121	12.5	36	3.7	157	16.2
Lawton VA Clinic	89	9.2	9	0.9	98	10.1
Wichita Falls VA Clinic	55	5.7	0	0.0	55	5.7
Ardmore VA Clinic	27	2.8	7	0.7	34	3.5
Ada VA Clinic	28	2.9	4	0.4	32	3.3
Stillwater VA Clinic	16	1.6	1	0.1	17	1.8
Blackwell VA Clinic	13	1.3	1	0.1	14	1.4
Enid VA Clinic	7	0.7	4	0.4	11	1.1
Altus VA Clinic	4	0.4	0	0.0	4	0.4
Total	**873**	**89.9**	**98**	**10.1**	**971**	**100.0**

Source: VA OIG EHR review and analysis

Consultation Completions. In the provision of comprehensive care, clinical consultations for SC are sometimes required to meet the needs of outpatients. The requesting provider coordinates his/her patients' care and communicates with VHA and private-sector specialists.[107] SC consults are considered complete after consultation results are entered and linked to the consult request in the patients' EHRs.[108]

We reviewed 562 consultation requests for patients who had PC visits from March 6 through March 12, 2016. Thirty-three of these consults were subsequently discontinued or cancelled. We found 502 of the remaining 529 (94.9 percent) clinical consults[109] had a completed status by June 9, 2016.[110] We noted that 27 consults (5.1 percent) were open; these either had scheduled appointments that were on future dates beyond

[107] VHA Directive 2012-011, *Primary Care Standards*, April 11, 2012. This directive was rescinded and replaced by VHA Handbook 1101.10 that continues to place a strong emphasis on the provider's/team's coordination of care duties.
[108] Medical Center Memorandum 11-16, *Consultation Policy*, May 14, 2015.
[109] We excluded inpatient consults as well as prosthetic and home oxygen consults because these involved the procurement of equipment.
[110] We validated all completed, discontinued, and cancelled consults, and then re-reviewed all consult requests with a "pending" status after June 9 to determine if consultations were completed during our review period.

June 9, 2016 or lacked EHR documentation by the PC and/or SC providers (or services) to indicate care had been rendered.

We also identified 15 categories that exceeded 35 days for consult completion[111] and affected more than one patient. (See Table 9 for details.)

Table 9. Completed Consultations by Title and Average Timeliness for Patients with Completed Appointments March 6–March 12, 2016

Completed Consultations by Title	Average Days to Completion	Number of Patients Involved[112]
RENAL CLINIC OUTPT [outpatient]	**83**	**2**
GASTROINTESTINAL CLINIC OUTPT	**73**	**4**
SLEEP (HOME STUDY) OUTPT	**66**	**4**
REHAB POWER MOBILITY OUTPT	**51**	**3**
GI PROCEDURE CONSULT OUTPT	**49**	**3**
OPHTHALMOLOGY OUTPATIENT	**47**	**36**
DIABETES EDUCATION OUTPT	**45**	**7**
THERAPEUTIC REC/CREATIVE ART THERAPY (OUTPT)	**42**	**4**
CP [cardiopulmonary] PULMONARY FUNCTION TEST	**40**	**17**
AUDIOLOGY OUTPT CONSULT	**39**	**27**
DENTAL/ORAL SURGERY OUTPATIENT	**38**	**3**
GYNECOLOGY OUTPATIENT	**37**	**2**
PHYSICAL THERAPY OUTPATIENT CONSULT	**37**	**12**
CARDIOLOGY CLINIC (OUTPATIENT) CONSULT	**36**	**4**
NEUROLOGY OUTPATIENT CONSULT	**36**	**4**

Source: VA OIG EHR review and analysis

Medical Advice Line Call Responses. To promote accessibility and timeliness, patients must be able to obtain medical advice when they seek it, whether for urgent, minor, acute, or chronic conditions.[113] The System's medical advice line staff provide patients

[111] VHA consults are to be completed within 30 days. We selected the 35-day timeframe to allow for potential patient delay circumstances.
[112] Small denominators mean that the average can be easily skewed by outliers and should therefore be considered in that context.
[113] VHA Directive 2012-011, *Primary Care Standards*, April 11, 2012. This directive was rescinded and replaced by VHA Handbook 1101.10 that contains the same or similar requirements related to access (see p. 59).

with medical advice, answer questions about medications, and assist callers with scheduling non-urgent (routine) appointments.[114]

In our review of the March 6–March 12, 2016 EHRs, described above, we found that 65 of the 674 patients contacted the Medical Advice Line for clinical advice. We found that PACT clinicians responded to patients' calls within 24 hours for 64 (98.5 percent) of these calls.

MH Outpatient Care. In SAIL metrics, the MH Domain includes composites of Population Coverage, Continuity of Care, and Experience of Care. In general, the Population Coverage composite includes the percentages of certain patients receiving MH care and of patients with certain MH diagnoses receiving specified care. The Continuity of Care composite generally includes the percentage of patients receiving follow-up care after discharge from an inpatient or residential treatment setting and the percentage of patients receiving diagnosis-specific treatment and therapies. The Experience of Care composite includes the survey results of both patients and MH providers regarding their perceptions of, and satisfaction with, MH care. As of Q4 FY 2016, the System ranked in the lower half in the MH Domain measure for all VHA facilities. For more than 18 months, the System tracked MH-related performance and implemented corrective actions to target deficient conditions. Process champions routinely reported on MH performance measures to the Health Care Delivery Committee.[115] The System identified staffing deficits, patient and employee satisfaction, and management of at-risk patients as continuing priorities. We noted the System's ranking improved slightly from the previous year.

Recommendation 21: We recommended that the System Director ensure Patient Aligned Care Team clinicians follow Veteran Health Administration requirements for patient notification and follow-up of clinically relevant abnormal laboratory results and document the actions in the electronic health record.

Recommendation 22: We recommended that the System Director monitor consultation completion timeliness and identify process improvements for consults exceeding 30 days.

Issue 11: ED

The ED was not meeting several performance measures including timeliness of care and patients leaving without being seen; however, System leaders developed an ED workgroup to identify opportunities for improvement and have begun implementing corrective actions.

The ED has 10 patient exam rooms, a MH observation room, and a MH seclusion room. Each patient who presents to the ED is checked-in and then triaged using the 5-level

[114] System's Internet Contact Page, http://www.muskogee.va.gov/contact/. Accessed June 22, 2016.
[115] We verified that the Q2 FY 2016 MH domain scores showed improvement.

Emergency Severity Index (ESI).[116] After triage, a provider assesses the patient, orders laboratory and other tests as needed, enters consults, and determines the patient's disposition (such as admission to a unit or discharge home with PC follow-up). During the work week, the ED uses a 4-bed Fast Track unit that provides care and treatment for patients with ESI scores of 4 or 5.[117][118] In FY 2015–FY 2016, the ED treated approximately 21,000 patients.

Timeliness of Care

In order to evaluate timeliness of care, we reviewed Emergency Department Integrated Software (EDIS) data for patients seen in the ED in FY 2015–FY 2016. EDIS reports provide performance data for timeliness of patient care within the ED and collects, tracks, and trends the data. A designated System employee reviews, monitors, and reports on the data to the Director's morning meeting and the Healthcare Delivery Committee. The three ED timeliness of care metrics we reviewed were triage, patients leaving without being seen, and length of stay (LOS).

Triage. The System consistently met VHA's target measure of less than 12 minutes for nursing triage[119] timeliness for the 24 months we reviewed; the median wait time was 7 minutes.

Patients Leaving [the ED] Without Being Seen. The System did not meet VHA's performance goals in this measure for the 24-month review period. The VHA target is less than 2 percent but no greater than 4 percent. In FY 2015, 7.5 percent of patients left without being seen and in FY 2016, 5.8 percent of patients left without being seen.

LOS. The System LOS metrics have improved, but as of the end of FY 2016, the System continued to fall short of performance goals for this measure. (See Table 10.) LOS is the elapsed time from when the patient checks in to the ED to the time of disposition.

[116] ESI levels range from level 1 (requires immediate life-saving interventions) to level 5 (no resources needed).
[117] The Fast Track unit, located one floor above the ED, operates Monday–Friday from 10 a.m.–6 p.m. Staffing includes a physician, a nurse, and a transporter.
[118] The Fast Track unit provides care for patients with an acute medical or psychiatric illness or minor injuries for which there is a pressing need for treatment to prevent deterioration of the condition or impair possible recovery. Patients that have been triaged as level 4 or 5 may be seen in the Fast Track unit.
[119] Triage is from patient check-in until the triage nurse assesses the patient and determines the ESI level.

Table 10. LOS Performance Measures

LOS Measure	Performance Goal	FY 2015	FY 2016
Overall Median Time from Door to Disposition	< 200 minutes	**244 minutes**	**229 minutes**
• Median Time from Door to *Admission*	< 240 minutes	**368 minutes**	**303 minutes**
• Median Time from Door to *Discharge*	< 150 minutes	**225 minutes**	**200 minutes**

Source: VHA Support Service Center data downloaded November 7, 2016

The ED workgroup meets biweekly and has implemented several access improvement projects including opening the Fast Track unit and allowing the ED providers to write admission orders to improve LOS.

Diversion

VHA defines diversion as any situation where patients arriving to the System from another VA or non-VA facility (who would normally be transferred to the receiving System for their particular care need) are not accepted for care, services, or beds because they are not available. For example, staffing may not be adequate or normal operations could be interrupted by a disaster. In these situations, patients are diverted to another facility for care and treatment.[120]

The ED attending provider, along with the charge nurse and COS, determine when to divert. Once on diversion, ED leadership reviews the need to continue in that status on an hourly basis. ED leaders and staff told us that the ED does not divert patients due to nurse staffing levels because the System reportedly maintains minimum nurse staffing levels, and nurses float from other units to assist in the ED as needed. ED staff reported that they are on diversion about 2 to 3 times a week, usually because of the volume of patients,[121] patients' ESI levels, or lack of space.[122] When on diversion, ambulances are routed to community hospitals, and transfers to the ED are delayed. However, we were told by ED leaders that patients who walk in to the ED receive care.

In FY 2015, the ED was on diversion an average of 18 percent of the time, and in FY 2016, the ED was on diversion an average of 15 percent of the time. The ED Chief noted that the recent diversion rate is less than ideal and noted that a larger ED would help to decrease the need for diversion.

[120] VHA Directive 2009-069, *VHA Medical Facility Emergency Department Diversion Policy*, December 16, 2009, pg. 3. This directive was rescinded and replaced by VHA Directive 1101.05(2), *Emergency Medicine*, September, 2, 2016 (amended March 7, 2017). Both directives have the same or similar language regarding ED Diversion.
[121] The ED provides care to 60–70 patients per day.
[122] Due to renovations in other parts of the facility, the ED space decreased to its current size. ED staff and leadership noted that the current space is insufficient to meet demand.

Patient Complaints

The ED Chief stated that the number of complaints he received decreased from one to three per day in FY 2015, to about two to three per week in FY 2016. We reviewed the System's Patient Advocate Tracking System[123] data and found that the number of ED complaints increased from 83 in FY 2015 to 91 in FY 2016. The most frequent complaints were waiting times, decision preference,[124] and staff courtesy.

Recommendation 23: We recommended that the System Director continue Emergency Department workgroup efforts to improve the timeliness of care, decrease the frequency of diversion status, and enhance customer service in the Emergency Department.

Issue 12: EOC

Actions are needed to ensure that the System maintains a clean and safe health care environment in accordance with VHA and other applicable requirements.

VHA requires facilities to maintain a clean and safe health care environment in accordance with applicable requirements.[125] VHA facilities must comply with requirements, standards, and recommendations from VHA, Occupational Safety and Health Administration (OSHA), National Fire Protection Association (NFPA), Centers for Disease Control and Prevention (CDC), and TJC to ensure a safe environment, reduce infection risks, and facilitate optimal patient care outcomes. We reviewed System documents and inspected patient care areas focusing on selected elements of medication safety and security, information technology (IT) security, environmental safety, infection prevention, fire prevention, work place violence, the Women Veterans Program, and privacy. A summary of the review topics is in Appendix C.

We inspected six inpatient units,[126] the community living center (CLC), the ED, the Fast Track unit, and four outpatient clinics located at the Oklahoma City main health care facility.[127] We also inspected the Ada, Altus, Ardmore, Blackwell, Enid, Lawton, North May, South Oklahoma City, and Wichita Falls CBOCs.[128]

We found no deficiencies in our EOC-related reviews of the acute MH unit, 7 East, medical intensive care unit, surgical intensive care unit, CLC, audiology and surgery

[123] The Patient Advocate Tracking System is used to document, track, and report patient-related issues including patient complaints.
[124] Decision preference includes a patient disagreeing with the ED provider's decision(s).
[125] VHA Directive 1608, *Comprehensive Environment of Care Program*, February 1, 2016.
[126] The inpatient units included the acute MH unit, 7 East, 6 North, 5 North, medical intensive care unit, and surgical intensive care unit.
[127] The outpatient clinics included PC, women's health, surgery, and audiology.
[128] We did not review the Stillwater CBOC because OIG recently inspected the Stillwater CBOC and published a report with eight recommendations. *Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Oklahoma City VA Health Care System, Oklahoma City, Oklahoma*, (Report No. 15-00157-39, December 3, 2015).

clinics, and the Ada CBOC. The furnishings and equipment throughout were safe and in good repair. The Infection Prevention and the Life Safety and Emergency Management programs were in compliance.

We found the following deficiencies:

- Medication Safety and Security
  - (5 North and 6 North): Medications were expired.
  - (Enid CBOC): Medications were not secured.
- IT Security
  - (Enid CBOC): The IT network room did not restrict access to only authorized personnel. This was a repeat finding from a 2013 OIG CBOC report.
  - (Altus, Ardmore, Blackwell, Enid, Lawton, North May, South Oklahoma City, and Wichita Falls CBOCs): The IT network rooms did not contain sign-in/sign-out access documentation.[129]
- Environmental Safety:
  - Cleanliness
    - (Enid CBOC): The carpet was heavily soiled with large stains in multiple areas, and ceiling tiles were stained throughout.
    - (Lawton CBOC): We noted moisture under plastic kick plates and deterioration of the wood under the plates.
  - Hazardous Chemicals Management
    - (Altus, Ardmore, Enid, Lawton, North May, South Oklahoma City, and Wichita Falls CBOCs; and the ED, Fast Track unit, PC and women's health clinics): Inventories of hazardous materials and waste were not reviewed for accuracy twice within the prior 12 months as required.
    - (Ardmore, Enid, and South Oklahoma City CBOCs): Safety data sheets for chemicals were not readily available to staff.
- Workplace Violence Prevention
  - (Enid CBOC): Managers did not control access to and from areas identified as security-sensitive.
  - (Altus, Ardmore, Enid, South Oklahoma City, and Wichita Falls CBOCs): Managers did not install alarm systems in high-risk areas.

[129] The Altus CBOC is a contracted facility. At the time of the site visit, staff present did not have access to the IT network rooms and could not produce evidence of the list of authorized individuals with access or the sign-in/sign-out sheets.

- Women Veterans Program (Blackwell and Enid CBOCs): Feminine hygiene products were not available in examination rooms where pelvic examinations were performed.
- Privacy
  - (Altus and Enid CBOCs): Exam rooms did not contain either an electronic or manual door lock.
  - (Enid and South Oklahoma City CBOCs): Privacy signs were not posted to indicate that telehealth visits were in progress.
  - (Blackwell and Enid CBOCs): Documents containing patient-identifiable information were visible and unsecured.

Recommendation 24: We recommended that the System Director ensure that all patient care areas comply with environment of care requirements and that action plans specifically address deficient areas identified in this report.

Conclusions

Our comprehensive review identified multiple program areas, processes and operations needing improvement. The root cause for many of these issues was the result of poor and unstable leadership at a number of levels, most notably at the Director position. Without strong and effective leadership, an inattentive and apathetic organizational culture evolved that allowed problems to arise and persist. Only after new leadership was installed in May 2016 did the culture improve and necessary changes take place.

Leadership. Between April 2012 and November 2014, the System had five acting or permanent directors. In December 2014, the Associate Director was detailed to be the acting System Director where he remained for about 18 months. We found that the lack of a stable, permanent System Director contributed to a weakened organizational environment, as did the leadership and management approaches of other senior leaders. Several of the deficiencies outlined in this report are largely attributable to leadership's failure to take appropriate actions and demand accountability from subordinates, from one another, and from external stakeholders. A permanent System Director started on May 29, 2016, and staff we interviewed commended his efforts to take actions and be transparent.

Performance Data. Despite some leadership failures and other deficiencies, in FYs 2015–2016, the System's performance in multiple quality measures improved. After 5 years ranked as a "1-star in quality" through Q4 FY 2015, the System achieved an overall "3-star in quality" ranking in Q3 FY 2016. The System implemented workgroups and corrective actions to enhance performance in multiple areas, including acute care mortality, patient satisfaction, and employee satisfaction.

Patient Safety. VHA facility managers assess and respond to patient safety concerns in a variety of ways. They evaluate patient safety incidents, conduct RCAs to retrospectively identify factors that contributed to a poor outcome, and complete PRs of care provided by credentialed and privileged practitioners. While most of the System's QSV programs appeared to be superficially functional, deeper review revealed that basic elements of the patient safety program continuum were not consistently completed as required. We found that:

- SAC scoring of unanticipated events, RCAs, and PRs did not consistently comply with VHA requirements.
- Processes were not in place to ensure consideration of institutional disclosure in cases involving unanticipated outcomes. Institutional disclosure is indicated when poor outcomes occur as a result of System or provider error and involves notifying the patient or the patient's family when the care is less than optimal.
- Subordinate committees' meeting minutes did not include information needed to evaluate and correct deficient patient care processes.
- The PR Committee did not consistently comply with guidelines regarding Level 3 PR assignments.

Provider Privileging. System managers failed to follow VHA policy when completing provider practice evaluations during the privileging process, and as a result, some physicians were re-privileged to provide care to veterans despite inadequate documentation of their competency to do so. We did not identify negative patient care events resulting from the systemic breakdown of various aspects of the privileging process. However, the lack of a functional privileging process left patients and other providers vulnerable to adverse outcomes. We found that 65 of 75 professional practice evaluation folders we reviewed did not contain sufficient provider-specific data to support approval and/or continuation of privileges. Further, the System's practice was inadequate for collecting data on "low volume/no volume" providers who perform less than 12 procedures per year at the System or who otherwise have infrequent patient care responsibilities.

CPRS Access. In FY 2016, 18 privileged attending physicians did not have CPRS access during a time when they had clinical care responsibilities. Staff we interviewed reported that VHA's stringent computer security requirements (periodic logons and password changes), could be difficult for providers whose responsibilities did not routinely require them to be in the System's main clinical building. Also, effective in FY 2016, users were required to use PIV cards to logon to network systems. We found that the System's equipment to create PIV cards was not always functional and there was an inadequate number of appropriately certified staff to process PIV credentials. Further, it took three different appointments to secure a PIV card. Busy clinical staff with only periodic patient care responsibilities at the System did not always follow through with the difficult logistics of securing a PIV card.

We found that some clinical service chiefs or their designees did not consistently respond to requests for certification of quarterly network and biannual CPRS monitoring activities during FYs 2015–2016. Further, service chiefs did not consistently identify and follow up on missing users (active providers who are not included on the monitoring list), which may have been another opportunity to match active, privileged providers with computer access and use data.

We confirmed several cases where the documentation clearly reflected improper access (using someone else's logon passwords), documentation (documenting on behalf of someone else), or "wet signatures" (signed by hand). While these activities do not comply with VHA guidance, we acknowledge these "work-arounds" existed to ensure continuity of patient care. Upon learning of the CPRS access issues, the new System Director took action to administratively suspend the privileges of providers without appropriate access.

Resident Supervision. We reviewed 212 visits for documentation reflecting that the supervising physician documented in the EHR or the resident referenced a discussion with the supervising physician about the patient's care. Four of the 212 EHRs did not contain any documentation of resident supervision. We reviewed the care provided to these four patients but found no evidence of patient harm as a result of deficient resident supervision.

The System did not monitor resident supervision as required under VHA policy. The only documents the System provided to demonstrate monitoring of resident supervision were labelled "Medical Record Focused Review Surgical Services," which included data specific to inpatient admissions to the surgical service. These reviews were stopped following the Surgical Quality Improvement Coordinator's retirement in May 2016. None of the documents provided to OIG reflected routine ongoing monitoring of resident supervision in other surgical service patient care settings. Further, the System did not maintain letters of agreement with the affiliated institution, which outlined responsibilities for resident supervision in accordance with ACGME requirements.

Staffing. For FYs 2014–2016, we compared authorized FTE to actual FTE employees for selected services and found that the actual FTE was often below the authorized FTE. System managers reportedly had difficulty recruiting employees, particularly nurses, hospitalists, gastroenterologists, and psychiatrists. System managers used several recruiting incentives and a Direct-Hire Authority to address staffing shortages and fill critical vacancies. System leaders prioritized job openings by reviewing all vacancies and meeting with the various service chiefs to determine hiring priorities. We noted that despite recruiting difficulties, the System had been successful in increasing clinical FTE during this time.

Clinic Access. Despite staffing challenges, the System has largely met access metrics for PC and MH. We did not independently verify VHA's access metrics. However, at the end of Q4 FY 2016, we found 637 of the 2,931 (22 percent) new patient appointments in SC clinics were pending greater than 30 days. System leaders implemented actions to improve SC access including recruitment of gastroenterologists and psychiatrists, converting other specialists from part-time to full-time positions, and increasing the use of Veterans Choice.

SC clinic cancellations. Based on complaints we received about resident and attending physicians not consistently being present for clinic, we reviewed clinic cancellations during FY 2016 in six specific specialty clinics. We found 1,288 clinic appointments were cancelled prior to the appointment time, reportedly due to provider absences. Of those, 852 appointments were rescheduled and completed within 30 days. However, 424 cancelled appointments were not addressed according to policy. We reviewed the EHRs of 22 (of the 424 patients) who either died or were hospitalized (for a condition associated with the consult/appointment) subsequent to the clinic appointment cancellation. Based on our review of the 22 EHRs, we did not find evidence that the clinic cancellations contributed to clinically significant adverse outcomes.

We also found that the System's overall clinic cancellation rate in FY 2016 was comparable to other VHA facilities with the same complexity level (1a) and quality ranking (3-star).

Provider payments for cancelled clinics. We reviewed 504 (of the 1,288) clinic cancellations to determine if there were any potential improper payments caused by unauthorized part-time physician or resident absences. We determined that the System

provided compensation for services that were not received, which resulted in potential improper payments of approximately $5,191.

Call Center responsiveness. In Q4 FY 2016, Call Center responsiveness was improving but below performance targets; specifically, calls were answered in an average of 65 seconds (goal is 30 seconds) with a caller abandonment rate of 9 percent (goal is 5 percent). System managers implemented improvement actions that were tracked through a performance improvement workgroup. We identified that in 4 of 30 selected cases (13 percent) schedulers did not follow guidelines for scheduling MH appointments.

Veterans Choice and NVCC. Overall, the System met timeliness goals for Veterans Choice and NVCC. At the end of Q2 FY 2016, the average appointment wait times were 30 and 34 days, for Veterans Choice and NVCC respectively. At the end of Q3 FY 2016, both Veterans Choice and NVCC were scheduling appointments in an average of 28 days. In December 2015, the number of incomplete Veterans Choice and NVCC consults was 1,371. As of March 9, there were fewer than 400 incomplete consults open greater than 90 days.

Quality of PC and Outpatient MH. We reviewed 674 EHRs of patients who had completed PC appointments from March 6 through March 12, 2016 with an associated primary or secondary diagnosis of hypertension, diabetes mellitus, or congestive heart failure. We found that providers consistently documented patients' relevant histories and presenting problems, treatment plans, and follow-up; and providers documented medication reconciliation. While providers consistently documented in-house consult completion, the average time to complete some SC consults exceeded 30 days. Also, PC team members notified patients of selected abnormal laboratory test results within 7 days 85.6 percent of the time, and providers took actions to address clinically significant abnormal laboratory results 89.9 percent of the time. As of Q4 FY 2016, the System ranked in the lower half in the MH Domain (performance) measure for all VHA facilities.

ED. The System consistently met VHA's ED target measure of less than 12 minutes for nursing triage timeliness for FY 2015 and FY 2016, with a median wait time of 7 minutes. The System did not meet VHA's performance goals for patients leaving the ED without being seen. In FY 2015, 7.5 percent of patients left without being seen and in FY 2016, 5.8 percent of patients left without being seen (threshold is 4 percent). Further, in FY 2015, the ED was on diversion an average of 18 percent of the time, and in FY 2016, the ED was on diversion an average of 15 percent of the time. While there is no specific VHA diversion target, the ED Chief told us that the recent diversion rate is less than ideal. System managers developed an ED workgroup, which meets biweekly, and continues to implement several access improvement projects.

EOC. We inspected patient care areas including six inpatient units, the CLC, the ED, the Fast Track unit, and four outpatient clinics located at the Oklahoma City main healthcare facility. We also inspected the Ada, Altus, Ardmore, Blackwell, Enid, Lawton, North May, South Oklahoma City, and Wichita Falls CBOC. We found no deficiencies

during our infection prevention and life safety/emergency management reviews; however, we identified compliance deficiencies with selected privacy, safety, security, and cleanliness requirements.

We made 24 recommendations.

Recommendations

1. We recommended that the Veterans Integrated Service Network Director review the former Chief of Surgery's performance in relation to issues discussed in this report, and confer with appropriate VA offices to determine the need for administrative action, if any.

2. We recommended the System Director consult with the National Center for Organizational Development to facilitate organizational improvement following leadership changes and extensive inspections and investigations.

3. We recommended that the System Director ensure use of the correct methodology to determine the severity assessment code for all reported patient safety events.

4. We recommended that the System Director ensure compliance with the National Center for Patient Safety's guidelines on initiation and completion of Root Cause Analysis.

5. We recommended that the System Director ensure that peer reviews are appropriately completed and address all relevant aspects of care provided by the reviewed clinician.

6. We recommended that the System Director ensure a process is in place to identify and review cases where institutional disclosure may be indicated, and complete as appropriate.

7. We recommended the System Director ensure that the Quality, Safety and Value committee minutes include evidence of robust data analysis and action tracking to address performance deficiencies, and monitor for compliance.

8. We recommended that the System Director ensure adherence to all Veterans Health Administration peer review committee requirements, and monitor for compliance.

9. We recommended that the System Director ensure that professional practice evaluations include performance data to support provider privileges and are conducted in accordance with Veterans Health Administration and System policy.

10. We recommended that the System Director evaluate the current System policy and services provided by low volume/no volume providers to determine whether the System should continue to provide those services or seek community alternatives.

11. We recommended that the System Director require service chiefs to assure that all providers within their purview secure and maintain appropriate computer access to ensure quality and continuity of patient care.

12. We recommended that the System Director ensure availability of functional equipment, adequate staffing, and enhanced access for personal identity verification card completion.

13. We recommended that the System Director ensure compliance in monitoring of resident supervision documentation in accordance with Veterans Health Administration and System policies, and take appropriate action when deficiencies are identified.

14. We recommended that the System Director review letters of agreement between the University of Oklahoma's surgical residency program and the System to ensure compliance with Accreditation Council for Graduate Medical Education requirements.

15. We recommended that the System Director continue efforts to recruit and hire for vacancies, and ensure that, until optimal staffing is attained, alternate methods are consistently available to meet patient care needs.

16. We recommended that the System Director ensure timely completion of specialty care consults and monitor compliance.

17. We recommended that the System Director implement a process to conduct routine scheduling audits to monitor compliance and identify ongoing training opportunities for all schedulers.

18. We recommended that the System Director conduct an evaluation of the potential improper payments resulting from clinic cancellations, take appropriate corrective actions, and establish policies to mitigate improper payments related to clinic cancellations from occurring in the future.

19. We recommended that the System Director continue efforts to improve call center timeliness.

20. We recommended that the System Director continue efforts to improve timeliness of Care in the Community Program consult completion; enhance patient and community provider understanding of Veterans Choice and Non-VA Care Coordination options; and continue to promote communication and coordination with TriWest Healthcare Alliance to assure appropriate, timely care for patients.

21. We recommended that the System Director ensure Patient Aligned Care Team clinicians follow Veteran Health Administration requirements for patient notification and follow-up of clinically relevant abnormal laboratory results and document the actions in the electronic health record.

22. We recommended that the System Director monitor consultation completion timeliness and identify process improvements for consults exceeding 30 days.

23. We recommended that the System Director continue Emergency Department workgroup efforts to improve the timeliness of care, decrease the frequency of diversion status, and enhance customer service in the Emergency Department.

24. We recommended that the System Director ensure that all patient care areas comply with environment of care requirements and that action plans specifically address deficient areas identified in this report.

Appendix A

2015 OIG Survey Responses

Allegations Lacking Adequate Detail To Permit a Full Review

The allegations listed below were identified through the 2015 OIG survey comments. These complaints lacked sufficient detail for us to fully or reasonably evaluate the issues. In these instances, we attempted to determine whether: (1) the System had policies or procedures governing the area in question; (2) System leaders were aware of the concerns cited; and/or (3) actions had been taken to address those concerns. The following comments reflect our review.

Delays Related to Lab Specimens

Survey respondent comments concerning laboratory specimens were related to delays in notifying providers of critical laboratory values and ordering, collecting, and mislabeling of specimens. Upon notification of these concerns in January 2015, the acting System Director provided a written response.

Delay in Provider Notification. The acting System Director outlined the System's practice that was current at the time of our review. Managers monitored all critical labs to ensure the ordering provider was called with the results as required. The acting System Director reported no knowledge of issues with notifying providers of critical laboratory values.

Ordering, Collecting, and Labeling Specimens. The acting System Director reported that clinical staff entered orders into patients' EHRs for laboratory tests. The acting System Director also reported that the timeliness of routine inpatient laboratory specimen collection was monitored monthly, and that, during the months of October 2014 through February 2015, the data reflected that specimens were collected within 4 hours of being ordered at least 97 percent of the time.

The acting System Director reported that mislabeled specimens were tracked as required by VHA[130] and the System's incidence of mislabeled specimens was lower than the VHA national average.[131] The acting System Director reported monitoring these rates each month and taking actions as needed.

[130] VHA Directive 2009-035, *Data Collection on Mislabeled Specimens for Pathology and Laboratory Medicine Service (P&LMS),* July 22, 2009. This directive expired July 31, 2014 and has not yet been updated.
[131] For FY 2014, the System-reported incidence of mislabeled specimens was 0.26 per 1000 specimens compared to the national average of 0.94 per 1000 specimens: in November 2014, System and national averages were 0.99 per 1000 specimens; in December 2014, System averages were reported as 0.25 per 1000 specimens and national averages as 0.54 per 1000 specimens. Compliance of critical laboratory values called to providers was 98–100 percent for June 2014 through December 2014.

Pharmacy

Survey respondent comments concerning Pharmacy Service included:

- Staff had to leave the unit to obtain medication stock items because items were not available and no pharmacy staff were on duty to deliver the needed medications.
- There were too many missing medication doses on the units.
- Two nurses did not check high-alert non-intravenous medications before administering them, resulting in medication errors.

Stock Medications. According to the Chief of Pharmacy, stock medications were, and continued to be, available in Omnicell® devices. When stock medications were not in the Omnicell®, the pharmacist on duty could send non-narcotic medications from the pharmacy to the unit via a pneumatic tube system. In that circumstance, staff were not required to leave the unit to retrieve stock medications. Further, a pharmacist was available 24 hours each day, and in the event the pneumatic tube system was not functional, pharmacy staff were expected to deliver the medications to the units.

Medication Doses. The anonymous survey respondent did not provide sufficient information for a thorough review of the issue. We interpreted the comments to indicate either (a) that medications were not available on the unit for nurses to administer within the prescribed timeframe, or (b) that patients were not receiving all their prescribed medications as ordered, implying that patients were "missing" medication doses.

Regarding possible concern (a) above, we found that because medications were available during all hours, missing doses should not occur. Further, a "missing dose" reported through the Bar Code Medication Administration system would not necessarily mean the medication was not available. The dose could be in the Omnicell® or in the pneumatic tube waiting to be picked up and therefore would not be considered a missing dose in this context. Pharmacy leaders denied knowledge of missed doses due to the unavailability of medications.

Regarding possible concern (b) above, we could not determine with certainty whether patients did or did not receive medications at some point in the past. In some instances, nurses may not have been able to administer medications because the patient was not on the unit or the patient refused the medication. As noted previously, nursing documentation of missed doses through the Bar Code Medication Administration system does not reliably capture the reason for a missed dose of medication.

High-Alert Medications. The System has no requirement for high-alert non-intravenous medications, or any medications, to be checked by two nurses prior to administration. A System manager reviews all medication errors through the incident reporting system daily and actions are taken as appropriate to prevent future occurrences. The acting Director informed us that the System reported 26 medication errors involving high-alert medications between February 2014 and January 2015. The acting Director further stated that, had a policy been in place that required a check by two nurses, a two-person check would not have prevented any of the errors.

Appendix B

Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
Mental Health Wait Time	Mental health care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	Mental health continuity of care (FY14Q3 and later)	MH Continuity Care
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	Inpatient performance measure (ORYX)	A higher value is better than a lower value
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC Provider	Rating of primary care providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care module)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cadiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hopsital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value

Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions
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Appendix C

EOC Review Topics

Review Topic	Requirement Standards	OHI Evaluation Process
Medication Safety and Security	TJC: ▪ MM.03.01.01, EP 4, 8	Verifying that medications were not expired and were secured from unauthorized access.
IT Security	VHA Handbook 6500	Verifying that IT network rooms were locked, restricted to authorized personnel only, and documentation of who accessed the room and when was available.
Environmental Safety	TJC: ▪ EC.02.06.01, EP 20, 26, ▪ EC.02.02.01, EP 1 VA Directive 0059 OSHA: 29 CFR 1910.1200(g)(8)	Ensuring that the facility was clean and well maintained; furnishings were safe and in good repair; EOC inspection rounds occurred and that EOC Committee meeting minutes documented issues and those issues were addressed timely; inventory of hazardous chemicals and wastes were reviewed twice over the past 12 months; and safety data sheets for chemicals were readily available.
Infection Prevention	OSHA: ▪ 29 CFR 1910.1030(d)(2)(iii) ▪ 29 CFR 1910.1030(d)(3)(iii) ▪ 29 CFR 1910.1030(d)(4)(iii) ▪ 29 CFR 1910.1030(d)(2) VHA Directive 2011-007 International Association of Healthcare Central Services Material Management, Central Service Technical Manual, 7th edition TJC: IC.02.01.01, EP 6	Verifying availability and accessibility of hand hygiene facilities and products, personal protective equipment, and sharps containers; food and drinks were kept separate from blood and other potentially infectious materials; sterile supplies were not expired; and staff minimized the risk when storing or disposing of medical (infectious) waste.
Fire Safety (Life Safety and Emergency Management)	NFPA 101 (2015 edition) ▪ 9.6.2.7, Life Safety Code ▪ 7.10.1.2 NFPA 10 (2013 edition) ▪ 6.1.3.1 ▪ 6.1.3 ▪ 6.1.3.3.2 ▪ A.6.1.3.3.2 TJC: EC.02.03.01, EP 4	Ensuring accessibility and visibility of fire alarms, pull stations, fire extinguishers, exit signs, and exit routes.

Work Place Violence	TJC: ▪ EC.02.01.01, EP 7, 8 VA Handbook 6500 VHA Directive 2012-026	Ensuring that all staff wore VA-issued identification badges; was controlled access to areas identified as security sensitive; and alarm systems were installed in high-risk areas.
Women Veterans Program	VHA Handbook 1330.01 TJC: ▪ RI.01.01.01, EP 7	Ensuring privacy in examination rooms and access to feminine hygiene products both where pelvic examinations occur as well as in women's public restrooms.
Privacy	HIPAA Privacy Rule TJC: ▪ RI.01.01.01, EP 7 VHA Handbook 1101.10 VHA Handbook 1907.01 VHA Handbook 6500 VHA Telehealth Services, VHA Clinic Based Telehealth Operations Manual	Ensuring visual and auditory privacy at check-in and in the interview/examination areas; were locks on examination rooms; privacy signs were posted when Telehealth visits occurred; and protected patient information was secured and not visible to the public.

Legend:

- MM – Medication Management
- EP – Element of Performance
- EC – Environment of Care
- CFR – Code of Federal Regulations
- IC – Infection Prevention and Control
- RI – Rights and Responsibilities of the Individual
- HIPAA – Health Insurance Portability and Accountability Act of 1996

Appendix D

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: August 17, 2017

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

Subj: Healthcare Inspection—Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma

To: Director, Rapid Response (54RR)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to review and comment on the draft report, Healthcare Inspection—Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma.

2. I concur with the findings, provide the attached action plan to address recommendation 1 at the VISN level, and agree with the attached action plan submitted by Oklahoma City VA Health Care System to address the remaining recommendations.

Ralph T. Gigliotti, FACHE
Director, VA Rocky Mountain Network (10N19)

Comments to OIG Report

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

OIG Recommendations

Recommendation 1. We recommended that the Veterans Integrated Service Network Director review the former Chief of Surgery's performance in relation to issues discussed in this report, and confer with appropriate VA offices to determine the need for administrative action, if any.

Concur

Target date for completion: October 31, 2017

VISN response: The Oklahoma City VA Health Care System is reviewing the former Chief of Surgery's performance as outlined in the report. The VISN Director will review findings where indicated and employ action at the VISN level as appropriate

Appendix E

System Director Comments

Department of Veterans Affairs

Memorandum

Date: August 17, 2017

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

Subj: Healthcare Inspection—Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma

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

1. I have reviewed the findings within the report of the Healthcare Inspection—Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma. I agree with the findings of the inspection.

2. The plan for corrective actions has been established.

Wade Vlosich
Director, Oklahoma City VA Health Care System

Comments to OIG Report

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

OIG Recommendations

Recommendation 2. We recommended the System Director consult with the National Center for Organizational Development to facilitate organizational improvement following leadership changes and extensive inspections and investigations.

Concur

Target date for completion: March 30, 2018

System response: The OKCVAHCS System Director has coordinated with the National Center for Organizational Development (NCOD) to help facilitate organizational improvement due to leadership changes. NCOD staff will work first with Senior Leadership and then Service Leadership to help improve the overall organizational culture. NCOD staff has agreed to work with departments in the event interventions are needed in the future.

Recommendation 3. We recommended that the System Director ensure use of the correct methodology to determine the severity assessment code for all reported patient safety events.

Concur

Target date for completion: Completed

System response: The OKCVAHCS Patient Safety Coordinator (PSC) completed "Patient Safety Improvement 101: RCA & Healthcare Failure and Effect Analysis" presented by the VA National Center for Patient Safety August 30–September 1, 2016. The PSC attended the "Patient Safety 201: Developing Leaders in Patient Safety Training" the week of August 7, 2017.

A second Patient Safety Coordinator was hired with a start date of May 29, 2017 and attended the "Patient Safety Improvement 101: RCA & Healthcare Failure and Effect Analysis" the week of August 7, 2017.

On October 3–6, 2016, the VA National Center for Patient Safety conducted a review of the OKCVAHCS Patient Safety Program. In addition, a VISN 19 PSM site visit was conducted June 20-22, 2017 to review Patient Safety Program activities.

OIG Comment: We do not consider this recommendation closed and will follow up on the recently implemented actions provided by the System Director to ensure that corrective actions have been effective and sustained.

Recommendation 4. We recommended that the System Director ensure compliance with the National Center for Patient Safety's guidelines on initiation and completion of Root Cause Analysis.

Concur

Target date for completion: Completed

System response: Incident reports are discussed in the System Director's morning report each morning. In addition, the System Director reviews all incident reports to ensure adequate follow-up occurs, and RCAs are initiated, as required.

OIG Comment: The System provided sufficient supporting documentation, and we consider this recommendation closed.

Recommendation 5. We recommended that the System Director ensure that peer reviews are appropriately completed and address all relevant aspects of care provided by the reviewed clinician.

Concur

Target date for completion: Completed

System response: Peer reviews are generated, as appropriate. PRC (Peer Review Committee), chaired by the Chief of Staff, conducts evaluation of peer reviews, to include robust discussions of care provided by the reviewed clinician. Peer Reviewers complete training prior to completion of a peer review, and PRC members complete peer review training every 2 years. When concerns are identified regarding review of all relevant aspects of care, the peer review is returned to the initial peer reviewer with a request for further information.

OIG Comment: We do not consider this recommendation closed and will follow up on the recently implemented actions provided by the System Director to ensure that corrective actions have been effective and sustained.

Recommendation 6. We recommended that the System Director ensure a process is in place to identify and review cases where institutional disclosure may be indicated, and complete as appropriate.

Concur

Target date for completion: Completed

System response: The Patient Safety Coordinators and Risk Management identify events through a variety of avenues including incident reports, staff phone calls/emails, etc. In addition, reported events are discussed at the System Director's morning report. Significant events are discussed with the System Director, the Chief of Staff, and Regional Counsel to determine appropriateness of institutional disclosure.

OIG Comment: The System provided sufficient supporting documentation, and we consider this recommendation closed.

Recommendation 7. We recommended the System Director ensure that the Quality, Safety and Value committee minutes include evidence of robust data analysis and action tracking to address performance deficiencies, and monitor for compliance.

Concur

Target date for completion: March 30, 2018

System response: The OKCVAHCS System Director is currently reorganizing the entire committee structure within the organization to ensure robust data analysis and tracking is occurring. The Director presented the proposed structure to the Quality, Safety, and Value Committee on August 10, 2017. The new structure will ensure that all requirements are met.

Recommendation 8. We recommended that the System Director ensure adherence to all Veterans Health Administration peer review committee requirements, and monitor for compliance.

Concur

Target date for completion: Completed

System response: All providers with a Level 2 or Level 3 Peer Review (PR) assignment are offered the opportunity to provide information to the Peer Review Committee (PRC). In addition, PRC minutes consistently include documentation showing actions have been taken and completed for Level 2 or Level 3 PR cases. Tracking occurs utilizing a Peer Review Log to ensure all follow-up is received.

OIG Comment: We do not consider this recommendation closed and will follow up on the recently implemented actions provided by the System Director to ensure that corrective actions have been effective and sustained.

Recommendation 9. We recommended that the System Director ensure that professional practice evaluations include performance data to support provider privileges and are conducted in accordance with Veterans Health Administration and System policy.

Concur

Target date for completion: Completed

System response: OPPE/FPPE forms were updated in January 2017. Credentialing and Privileging is conducting random audits of 10 percent of OPPE to ensure the professional practice evaluations are completed in accordance with Veterans Health Administration and System policy. Results of the audits are given to the Chief of Staff

for appropriate follow-up. The Professional Standards Board and Credentialing Committee reviews all completed OPPE/FPPE documents at re-credentialing.

OIG Comment: The System provided sufficient supporting documentation, and we consider this recommendation closed.

Recommendation 10. We recommended that the System Director evaluate the current System policy and services provided by low volume/no volume providers to determine whether the System should continue to provide those services or seek community alternatives.

Concur

Target date for completion: Completed

System response: The Professional Standards Board – Credentialing Committee, chaired by the facility Chief of Staff, evaluates low volume/no volume providers at the time of credentialing and re-credentialing.

OIG Comment: The System provided sufficient supporting documentation, and we consider this recommendation closed.

Recommendation 11. We recommended that the System Director require service chiefs to assure that all providers within their purview secure and maintain appropriate computer access to ensure quality and continuity of patient care.

Concur

Target date for completion: Completed

System response: The OKCVAHCS System Director mandated all providers maintain appropriate computer access. Providers who do not maintain appropriate computer access will have their privileges administratively suspended and will receive appropriate disciplinary action. The Compliance Office performs routine audits to ensure appropriate computer access is maintained.

OIG Comment: The System provided sufficient supporting documentation, and we consider this recommendation closed.

Recommendation 12. We recommended that the System Director ensure availability of functional equipment, adequate staffing, and enhanced access for personal identity verification card completion.

Concur

Target date for completion: December 29, 2017

System response: The OKCVAHCS System Director has ensured that two personal identification verification printers, two registration stations, and one portable registration station were procured and placed into operation. The System Director has approved for recruitment two new Security Specialist employees. The positions are expected to be onboard and fully functioning with Office of Personnel Management approval by December 29, 2017.

Recommendation 13. We recommended that the System Director ensure compliance in monitoring of resident supervision documentation in accordance with Veterans Health Administration and System policies, and take appropriate action when deficiencies are identified.

Concur

Target date for completion: March 30, 2018

System response: Compliance with resident supervision is being monitored through OQSV with results reported to the applicable service chief, Designated Education Officer (DEO), and Medical Records Committee. DEO will review audit data with VA site directors on a regular basis and VA site directors will also be tasked with auditing their programs. Action plans are to be developed by services and VA site directors, as needed, to address any identified deficiencies.

Recommendation 14. We recommended that the System Director review letters of agreement between the University of Oklahoma's surgical residency program and the System to ensure compliance with Accreditation Council for Graduate Medical Education requirements.

Concur

Target date for completion: March 30, 2018

System response: An affiliation agreement with Oklahoma University (OU) Health Science Center is in place. Planned Learning Agreements (PLAs) are complete for Ophthalmology and Urology. The OKCVAHCS is awaiting final signatures for Gynecology, Orthopedics, and Plastic Surgery. The OKCVAHCS is currently pending agreements that needed to be forwarded from OU to the VA for Otolaryngology, General Surgery and Neurosurgery.

Recommendation 15. We recommended that the System Director continue efforts to recruit and hire for vacancies, and ensure that, until optimal staffing is attained, alternate methods are consistently available to meet patient care needs.

Concur

Target date for completion: Completed

System response: The OKCVAHCS System Director has established a process for automatic vacancy recruitment and hire for such positions as Nursing, Physician, and Medical Support Assistants. Staffing is monitored bi-weekly with Human Resources to ensure staffing levels are maintained. When needed, alternate methods of providing staff are obtained through contract, fee-basis, and with-out-compensation staff.

OIG Comment: The System provided sufficient supporting documentation, and we consider this recommendation closed.

Recommendation 16. We recommended that the System Director ensure timely completion of specialty care consults and monitor compliance.

Concur

Target date for completion: Completed

System response: The System Director has established a process to monitor consult timeliness and completion at the Director's Morning Report. Tasks are assigned to those services who fall outside of the timely completion standards. Additionally, consult audits from the Compliance Officer are monitored quarterly as another check and balance for compliance with VHA directives.

OIG Comment: The System provided sufficient supporting documentation, and we consider this recommendation closed.

Recommendation 17. We recommended that the System Director implement a process to conduct routine scheduling audits to monitor compliance and identify ongoing training opportunities for all schedulers.

Concur

Target date for completion: December 29, 2017

System response: The Compliance Office will conduct routine scheduling audits, 3 appointments per scheduler per month. The information will be provided to Medical Administration Service (MAS); staff that are not scheduling per policy will be receive further training by MAS.

The internal MAS process for auditing appointments has recently changed. MAS Supervisory staff has been equipped with the new software and the training for conducting audits of staff that schedule appointments. In addition, a new Scheduling Trainer position is being recruited to serve as a subject matter expert for all employees with scheduling access. This employee will take over the Onboarding and Refresher Training for all schedulers to ensure that consistency with directives are maintained. Currently, all scheduling staff are receiving refresher training. Those employees who do not complete the training will have their scheduling keys removed on October 1, 2017.

Recommendation 18. We recommended that the System Director conduct an evaluation of the potential improper payments resulting from clinic cancellations, take appropriate corrective actions, and establish policies to mitigate improper payments related to clinic cancellations from occurring in the future.

Concur

Target date for completion: December 29, 2017

System response: For medical residents, the Compliance Office will review documentation and audits completed by the Learning Organization staff. Documentation from Site Directors will be reviewed and specialty clinics identified that have cancelled appointments. This will be compared to invoices received from the affiliate. If any cancellations occurred which caused overpayment, then this will be provided to the Learning Organization and to the affiliate to request a refund.

For attending physician staff, the Compliance Office will request a list of cancelled clinics monthly that were cancelled within 45 days of the date of clinic to audit for appropriateness.

Recommendation 19. We recommended that the System Director continue efforts to improve call center timeliness.

Concur

Target date for completion: December 29, 2017

System response: The System Director holds a weekly meeting to discuss the timeliness of the call center. Based upon data, plans of action are implemented to address any deficits for the week. During FY 2017, the System Director also added additional staff to the call center, which include 1 Pharmacy Technician, 10 Medical Support Assistants, and 7 Registered Nurses.

Side-by-side monitoring will be implemented more consistently. Phone line splitters have been ordered for the supervisors and trainers to provide monitoring and training. This will allow the supervisors and trainers to listen to the patient calls, which should help improve timeliness. From our current efforts, we have seen a decline of our abandonment rate from 23.1 percent in December 2016 to 13.5 percent in July 2017.

Recommendation 20. We recommended that the System Director continue efforts to improve timeliness of Care in the Community Program consult completion, enhance patient and community provider understanding of Veterans Choice and Non-VA Care Coordination options, and continue to promote communication and coordination with TriWest Healthcare Alliance to assure appropriate, timely care for patients.

Concur

Target date for completion: Completed

System response: Care in the Community Consults are monitored daily for timeliness and tasks are assigned to improve timeliness as needed. There is a weekly meeting during the Director's Morning Report with the all senior level staff that discusses both Non-VA Care and Choice workload to ensure timeliness standards are met. During FY 2017, additional TriWest (Choice Contractor) staff have been imbedded in the Medical Center of the OKCVAHCS to answer questions and resolve issues as they arise to promote communication and coordination.

OIG Comment: The System provided sufficient supporting documentation, and we consider this recommendation closed.

Recommendation 21. We recommended that the System Director ensure Patient Aligned Care Team clinicians follow Veteran Health Administration requirements for patient notification and follow-up of clinically relevant abnormal laboratory results and document the actions in the electronic health record.

Concur

Target date for completion: March 30, 2018

System response: Compliance with test result reporting requirements is being monitored through OQSV with results reported to the applicable service chief and Medical Records Committee. Action plans are to be developed by services, as needed, to address any identified deficiencies. This will be monitored for compliance of 90 percent or greater for 3 consecutive months.

Recommendation 22. We recommended that the System Director monitor consultation completion timeliness and identify process improvements for consults exceeding 30 days.

Concur

Target date for completion: Completed

System response: The System Director has established a process to monitor consult timeliness and completion. Tasks are assigned to those services who fall outside of the timely completion standards. Additionally, consult audits from the Compliance Officer are monitored bi-annually as another check and balance for compliance with VHA directives.

OIG Comment: The System provided sufficient supporting documentation, and we consider this recommendation closed.

Recommendation 23. We recommended that the System Director continue Emergency Department workgroup efforts to improve the timeliness of care, decrease the frequency of diversion status, and enhance customer service in the Emergency Department.

Concur

Target date for completion: March 30, 2018

System response: The System Director continues to make improvements to the Emergency Department. A functioning X-Ray unit was added to the Emergency Department in July 2017, along with a process for blood draws to occur in the actual Emergency Department instead of going to the 4th Floor. Station level construction is on-going to add 4 Fast Track rooms to the Emergency Department to enhance timeliness. The OKCVAHCS will also be adding Urgent Care Clinics during FY 2017–2018. To reduce diversion, the Chief of Staff must approve all diversion statuses to assist with identification of alternatives to diversion.

Recommendation 24. We recommended that the System Director ensure that all patient care areas comply with environment of care requirements and that action plans specifically address deficient areas identified in this report.

Concur

Target date for completion: March 30, 2018

System response: Action Plans are being developed by the Points of Contacts for the deficiencies found within the inspection. The action plans will be tracked by the Environment of Committee to ensure completion of the plans. Environment of Care rounds are being conducted by the Assistant Director routinely in compliance with VHA Directives and policies.

Appendix F

OIG Contact and Staff Acknowledgments

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