SPECIAL AUDIT

Oklahoma Department of Veterans Affairs

For the period July 1, 2014 through June 30, 2017

Oklahoma State
Auditor & Inspector
Gary A. Jones, CPA, CFE

Oklahoma Department of Veterans Affairs

Special Audit Report

For the Period
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Oklahoma State Auditor & Inspector

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August 1, 2018

TO THE HONORABLE MIKE HUNTER, OKLAHOMA ATTORNEY GENERAL

Pursuant to your request and in accordance with the requirements of 74 O.S. § 18(f), we performed an audit with respect to the Oklahoma Department of Veterans Affairs for the period July 1, 2014 through June 30, 2017.

The objectives of our audit primarily included, but were not limited to, concerns surrounding the control environment and communication breakdown at the agency, changes in the level of care for residents of the seven state veterans centers, various financial and operational questions, and events related to the Talihina center. The results of this audit are presented in the accompanying report.

Because the procedures performed do not constitute an audit conducted in accordance with generally accepted auditing standards, we do not express an opinion on the account balances or financial statements of the Oklahoma Department of Veterans Affairs for the period July 1, 2014 through June 30, 2017.

We also wish to take this opportunity to express our appreciation for the assistance and cooperation extended to our office during the course of our engagement.

Sincerely,

GARY A. JONES, CPA, CFE
OKLAHOMA STATE AUDITOR & INSPECTOR

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Oklahoma State Department of Veterans Affairs

Special Audit Report

Executive Summary

Background

We were engaged at the request of the Attorney General, pursuant to 74 O.S. § 18f, to address a wide variety of concerns expressed by legislators, citizens, and ODVA staff.

As a result of continual operational changes, removal of key financial staff, central management's interference in our communications, and growing reluctance of staff to be open with us due to a fear of retribution, we lost our ability to rely upon information provided by the agency. We then elected to cease detailed procedures, and focus on surveying employees and reporting the current circumstances at the agency, along with any completed information from our procedures.

What We Found

This report covers a wide variety of nuanced and interwoven topics. Here are the key findings related to three of the most significant areas.

Tone at the Top and Communication

A culture of fear and intimidation exists at ODVA. Employees across the state actively fear for their jobs and report experiencing dictatorial and aggressive leadership from the central office. They expressed that management makes changes without explanation, and ridicules those who offer input or disagree. Morale is reportedly at an all-time low, with staff left feeling unsupported, without adequate resources, and reminded regularly that they are replaceable.

A silo effect appears to be at work at the agency, with central management and varying divisions "cut off" from one another. Center management feels cut off from the Oklahoma Veterans Commission; centers feel cut off from one other. A lack of clear directives at both the central and veterans center levels obstructs the flow of information from the top down, hindering project implementation and aggravating employee concerns.

Staff are frustrated by perceived central office favoritism and bias in staffing and incentives. While the central office expands, center staff believe funds are being removed from veteran care for that purpose. Management argues that cuts to staffing and services are due to a decline in state appropriations, while staff are aware that state funds account for only a minor portion of the agency's overall revenues, which did not in fact decline over the audit period.

Overall, this toxic environment increases risk and lowers morale throughout the agency, no doubt impacting the quality of care and services provided.

Level of Care

Responses to our employee surveys and interview questions echoed one of the initial questions driving this audit with concerns that the level of care provided to residents of the state veterans centers is declining. In recent years, laboratory services at the centers have been outsourced, with reports that other services are soon to follow, as staffing shortages and turnover frustrate center employees. Access to medical providers is reportedly being restricted, and specialty diets have been limited while center menus were standardized. It is clear the historical level of in-house care at the centers is declining.

However, as the veterans centers are licensed as long-term care facilities, these changes do not appear to violate applicable regulations. Rather, they illustrate staff's concerns that the centers are being turned into nursing homes, that management is occupied with raising profits while meeting minimal regulatory requirements, and that central office does not share their respect and admiration for the residents in their care. These changes also contradict ODVA's mission of "providing to the Veterans residing in the state of Oklahoma the highest quality support and care available anywhere in the Nation."

Talihina Veterans Center

Management has presented varied reasons for wanting to relocate the Talihina Veterans Center, and staff there is convinced that central management has a vendetta against the center, fearing for their jobs and residents' wellbeing. Whether or not the center is eventually moved, there are residents living there and employees working there today, and by all appearances that will continue to be the case until a new facility can be made ready. Estimates for that time period have typically been in the range of five years. Providing quality care for the residents in the interim necessitates that the agency maintains the center at an acceptable level, staffs the facility adequately, and supports that staff in providing care and operating the center.

What We Recommend

1. The Commission should evaluate and address the negative control environment and communication breakdown in the most efficient and positive manner possible. The Commission should also recognize its authority and responsibility in appointing the director, as outlined in 72 O.S. § 63.3.
2. Management should establish a system of clear communication that relays information from the bottom of the organization to the top and vice versa.
3. The Commission should seek an independent evaluation of cost effectiveness and impacts to services prior to relocating any veterans center.
4. Management should ensure policies and procedures are standardized or customized to the extent that best ensures the agency meets its mission and complies with appropriate requirements. Staff should receive adequate review time and training when policy changes occur.
5. Management should ensure appropriate cost-benefit analyses are performed prior to outsourcing key services or making other significant operational changes.
6. Management should pursue an independent examination of current financial controls and other significant operational areas as outlined at the end of this report, as well as any other areas that have undergone substantial changes.

This Engagement: Background

As a result of concerns about the Oklahoma Department of Veterans Affairs (ODVA or the agency) expressed by legislators and citizens, the Attorney General requested the assistance of the State Auditor and Inspector (SAI) in an engagement pursuant to 74 O.S. § 18f.

The various questions and concerns that initially prompted the engagement were compounded by stories regarding ODVA in the media, upcoming legislation impacting the agency, and worries shared by administrators and staff once we began interviews. This resulted in nearly 30 topics being addressed in our original planned procedures, varying from budgeting and financial issues to staffing, capital projects, center operations and resident care, and to overall issues of management attitude and communication within the agency.

During the engagement, some aspects of operations at ODVA appeared to deteriorate. We were contacted frequently by staff and citizens, including those with a vested interest in the Talihina center, and these discussions became more serious and urgent. The business offices at the veterans centers were dismantled and their main responsibilities consolidated into the central office in Oklahoma City; five of the seven business managers were terminated and the other two transferred to central office. The agency's chief financial officer, who had previously served as our main contact, took leave for an extended period of time and subsequently, other long-time central office staff either took extended leave or separated from the agency. Management's operational changes and centralization of certain duties continued, sometimes inappropriately using unrelated recommendations from SAI's past audits as justification for the changes. They also made uninformed statements about the progress and impending results of *this* engagement to staff and outside parties.

We experienced increasing difficulty in obtaining information from the veterans centers, due in part to the removal of the business managers, but also because central office began intervening in questions we had directed to the centers, insisting on fulfilling some requests centrally and instructing center staff on which questions they were permitted to answer.

From the time of our first meetings at the centers, it was clear that we were observed entering and leaving the facilities; and we were later informed that administrators were contacted by central management as soon as we left with inquiries as to what we had discussed. Throughout our procedures we continued to receive warnings and concerns that any contact between our office and ODVA staff was monitored, and that most employees could not be open with us due to fear of retribution. (These concerns were later further validated by responses to our employee survey, which included many comments to the effect that respondents feared being fired or other retaliation, that they would need protection to

come forward, that we were being watched, or that they would try to reach out using separate channels or in the future.)

It soon became clear that we no longer had willing, independent sources of information regarding the individual veterans centers, and further determined we could not rely upon, or in some cases verify, information provided by central office. It was clear center personnel feared for their jobs and did not feel comfortable contacting us. This situation resulted in what is referred to as a "scope impairment" in a typical performance audit, meaning a constraint imposed on the audit approach by limited access to reliable evidence, or certain records or individuals.[1] It also put us in a position of potentially putting further jobs at risk if we insisted upon direct contact with staff.

We discussed the situation with the Attorney General's office and agreed to alter our planned procedures as necessary and to perform an anonymous employee survey of ODVA staff across the state. Survey recipients included most financial and administrative staff at the central office and veterans centers, as well as a random sample of staff from throughout the rest of the agency. Recipients were instructed that they could provide the electronic survey link or auditors' contact information to other interested employees, including past employees who had been present during the audit period. In total, 254 responses were received, including several dozen sent by fax and by mail.

In order to bring to light our serious concerns about the negative control environment and damaging tone at the top of ODVA, which we consider to be one of the most pressing overall issues currently impacting agency staff, finances, and the level of care provided at the veterans' centers, it was important to cease detailed procedures focusing on the past so we could provide this information about the current environment to decision makers as soon as possible.

This report includes the results of procedures we were able to perform, with the level of detail or support that was available and appropriate, as well as a list of topics that bear further consideration. For issues we noted that were not applicable to the contents of the report or not supported by sufficient information to be considered significant to the report, we have listed additional issues and allegations for the Attorney General's consideration in a separate memo and provided that, along with supporting documents, to his office.

[1] Performance audit scopes and related limitations are discussed in the Government Accountability Office's *Government Auditing Standards*, 2011 revision, Chapter 7. Section 7.11 specifically states auditors should report any significant constraints imposed on the audit approach by information limitations or scope impairments, including denials or excessive delays of access to certain records or individuals. While an engagement under 74 O.S. § 18f is not statutorily bound to auditing standards, this standard illustrates why an auditor cannot in good conscience perform procedures or report results based upon what he or she believes to be insufficient or unreliable evidence.

For general procedures, we focused on the period of July 1, 2014 through June 30, 2017. However, as events and changes continued to unfold at ODVA, we extended this period as needed to report as fully as possible. The responses to the employee surveys referred to throughout this report were received in March 2018 and offer the most immediate information about the current agency environment. However, even after the close of that survey, staff has continued to reach out to us with questions and concerns.

ODVA Background

The Oklahoma Department of Veterans Affairs was created by the Oklahoma Legislature in 1947 and is responsible for the administration of the general duties of the Oklahoma Veterans Commission (Commission), including assistance to veterans and their dependents in obtaining benefits.

ODVA provides benefits, services, and care to veterans living in Oklahoma through claims and benefits assistance and residential care. Just over 1,300 veterans reside in its seven long-term care centers located in Norman, Clinton, Ardmore, Sulphur, Claremore, Talihina, and Lawton. Each center has its own administrator and limited administrative staff, in addition to its medical and food service functions. The central office houses the executive director and central business staff and provides support services and oversight for the seven veterans centers and other divisions.

The agency's stated mission is that, "In partnership with the Secretary of Veterans Affairs, the Oklahoma Department of Veterans Affairs, state and local agencies, and veterans services organizations, the state of Oklahoma will facilitate in providing to the veterans residing in the state of Oklahoma the highest quality support and care available anywhere in the nation."

The Commission is the controlling board for the agency and each veterans center. It is responsible to the Governor for carrying out the laws enacted by the Oklahoma Legislature and for administering the veterans program in Oklahoma. The Commission consists of nine members appointed by the Governor, with the advice and consent of the Senate, from lists of five names submitted by the American Legion, the Veterans of Foreign wars, the Disabled American Veterans, the Paralyzed Veterans of America, the Military Order of the Purple Heart, and the National Guard Association of Oklahoma. One member is selected from each of these groups and three members are at large, one of whom may be a nonveteran with a family member residing in a state veteran center. Commissioners serve a term of three years.

The Commission has authorized and charged the director with the responsibility of administering its programs. The director active during

our official audit period retired in January 2018, and the audit period deputy director was appointed director at that time.

Commission members as of June 2018 are:

Tom Richey ..... Chairman/Paralyzed Veterans of America
Larry Van Schuyver..... Vice-Chair/Military Order of the Purple Heart
Jon Arthur .....Disabled American Veterans
Jerry Ball .....America Legion
Paul Costilow..... At-Large Member
Pat Fite ..... At-Large Member
Gary Secor ..... Veterans of Foreign Wars
Lloyd Smithson .....National Guard Association
Gaylord "Z" Thomas ..... At-Large Member

CONTROL ENVIRONMENT & TONE AT THE TOP

Hostile Tone at the Top

Management's ethics, integrity, attitude, and operating style are the foundation of all other internal control components that help an entity achieve its objectives and minimize risk. According to government internal control standards produced by the federal Government Accountability Office (GAO standards)[2], an effective internal control system has in place policies and procedures that reduce the risk of errors, fraud, and professional misconduct within the organization. Key factors in this system are the environment established by management, and effective information and communication to achieve the agency's objectives.

The agency-wide control environment has a pervasive influence that affects all activities of the organization. The governing board, executive director, and entire management team must all contribute to creating a positive control environment or "tone at the top." The governing board sets the proper tone for the control environment when it establishes and communicates a code of ethics, requires ethical and honest behavior from all employees, observes the same rules it expects others to follow, and requires appropriate conduct from everyone in the organization. Management's philosophy and methods of employee direction and development also greatly influence this environment. Management demonstrates the importance of integrity and ethical values through their directives, attitudes, and behavior.

It was made clear to us immediately upon beginning interviews and regularly throughout our contact with staff statewide that a culture of fear and intimidation exists at ODVA. Employees across the state reported fearing for their jobs and experiencing dictatorial and aggressive leadership from the central office. This top level of the agency was described as generating a "toxic environment," having a "very strong barrier of intimidation," as being, in employees' words, dictatorial, totalitarian, and vengeful, and it was remarked of central management that "when they say jump, you ask how high." Most reports we received credited the audit period deputy director (now director) and the director of clinical compliance with creating and sustaining this negative agency-wide environment.

Of 144 survey respondents with an opinion[3], 60% believe central office management "Seldom" or "Never" demonstrates high ethical standards.

[2] Unless otherwise stated, references to GAO standards throughout this report refer to the United States Government Accountability Office's (GAO) *Standards for Internal Control in the Federal Government*. While this publication addresses controls in the federal government, the criteria it contains can be treated as best practices. The theory of controls applies uniformly to federal or state government.

[3] Some survey respondents elected not to answer all survey questions, or were not provided certain questions based upon their position and location. "No opinion" and blank responses are excluded from survey figures in this report.

The concerns and perspectives expressed most frequently in survey responses, and supported by our discussions with staff throughout our procedures, included the following:

- Central office management often sends directives without explanation, and without gathering input or feedback. Frequently these are knee-jerk decisions that are later changed or retracted.
- Management lacks relevant experience in long-term care and health care, and does not seek input from experienced staff; this reportedly leads to bad decisions and staff feeling their knowledge and experience is being ignored.
    - One respondent explained it as follows: "Central office staff that make decisions directly involving patient care have never taken part in actuality seeing or doing what is done by front line staff. Central office tells us how to do our job with no concept or concern of how their directives effect the care of our residents, staff, or resident families."
    - Staff are concerned central management doesn't understand the impact of their actions on patient care.
    - Lower level staff who consider themselves the "backbone" of the agency also feel ignored and expendable.
- When staff asks for an explanation or tries to give input, they're belittled, degraded, or met with sarcasm and rudeness.
- Staff and center management are intimidated and threatened with termination or demotion. Administrators are rendered powerless and not treated as equals.
- Most central office staff is condescending and rude in conversation and correspondence.
- The overall agency environment is stressful and anxiety-producing. Numerous employees relayed that they and their coworkers are terrified of losing their jobs.
- Central office cares primarily about politics and generating revenue, and derives enjoyment and satisfaction from controlling and threatening others.
- The central office essentially manages by fear, as illustrated in the following comments:
    - "I have heard more than once words to the effect of 'Get on board or get off the boat.' when reasonable questions have been asked about changes."
    - "It is futile to resist any changes or bring up any concerns."
    - Central office leaders "intimidate, harass, bully and threaten staff."
    - "The employees at Central Office appear to be riding the wave of a power trip. They employ the 'rule with an iron fist' mentality yet deny attempting to micro-manage our homes."

- "Our central office is a 'Toxic leadership' installing fear in most every employee."

Two other comments stood out as summarizing many of the feelings that resonated in our survey results:

> "This is the most punitive, negative, secretive, dysfunctional environment I have ever worked in. I feel my job is in jeopardy every day that I go to work. The ODVA is run from central office by lies, deceit, and secrets. The Center administration tries to communicate to the staff, but is often unable to due to the lack of communication and/or threats from central office. Everyone I know is constantly looking for a new job and keeping resumes updated because of the fear of being the next department to be shut down and outsourced."

> "Our leadership is comparable to a dictatorship. Our management, a puppet regime. The result is that staff are left without proper resources and reminded daily how replaceable and unimportant they are."

Employees did express repeatedly that there is still effective teamwork within their center or local department and that they love having the opportunity to serve the veterans. Indeed, at all levels, center staff's passion for their work appears to only increase their frustration at having that work impacted by unexplained staff cuts and policy changes. They clarified that the pressure and uncertainty they are now experiencing is diminishing any positive aspects left in their work.

Low Employee Morale

The fact that management's philosophy and methods of direction greatly influence the agency's control environment is evident in the low morale currently articulated by employees throughout ODVA. Numerous survey respondents included comments such as, "I have never seen the morale of staff this low before," and, "The satisfaction amongst workers is at an all-time low." Veterans center staff members at all levels reported fearing for their jobs, feeling unsupported and replaceable, and specifically feeling that the central administration of the past few years is at fault. They conveyed that central office staff is cut off and decisions impacting center jobs are made in a vacuum. Multiple employees remarked that morale is low while turnover is high, and many expressed disgust and disheartenment at the change in environment and declining level of care for the veterans.

Several final survey comments illustrate this experience:

- "I have been discouraged by the lack of understanding towards the effect on resident care when business/financial decisions are made, as well as the personal effect to the employees and their families."

- "Morale and unity suffer as a result of poor leadership and lack of communication. When problems arise within our organization, there is no 'safe ground' or support to assist w/the problem."
- "Everyone feels as if we are walking on a tightrope and could fall off at any moment. We have been told everyone except nurses are expendable. The quality of care at our centers is not as good as it was previously because of the cuts that have been made. We have lost several key staff members."
- "There is no job security here. We work with an axe over our heads knowing any day our position could be eliminated. Morale is understandably low."

Staffing, Turnover, and Salary Concerns

Employees responding to our survey voiced numerous concerns specific to the staffing levels at the centers, turnover rates, and having worked as much as two decades without receiving a raise.

- Complaints about high turnover rates came from centers across the state. Employees voiced related concerns about the agency losing valuable employees while less competent employees remain employed and are "moved around" rather than disciplined.
- Many employees reported difficulties due to understaffing, particularly in direct care, including
    - Employees working unpaid overtime
    - Not enough staff on the floor to care for veterans with multi-system diseases and many medications
    - Multiple complaints about having only two to three people on the floor at night to care for as many as 50 veterans
    - Not enough time to complete charts and new forms
    - One employee describing the understaffing as operating in "continuous gap fill mode"
- Nursing departments have reports regularly added to their workload, and a nursing schedule implemented by central office has allegedly caused long-time nurses to quit.
- Many comments discussed not having received a raise in as much as one to two decades. Staff don't feel valued or supported – not only financially, but functionally and emotionally. As two respondents put it:
    - "It's no secret we go years without a raise. This contributes to anxiety and affects every area of care for our vets and our family's welfare."
    - "They make it harder and harder until your mental and physical health suffer."
- Concerns were repeatedly expressed about the effectiveness of employees hired through the Galt Foundation staffing service, as

well as the Galt hiring process, and Galt employees' segregation from standard state employees.

We were recently informed that central management has revoked a promise previously made to patient care assistants (PCA) hired through Galt that they would have the option of becoming ODVA employees after one year of employment. Employees who had been hired with this promise in place during the past year no longer have this option. We were also informed that food service employees hired through Galt had the option to become state employees, whereas nursing staff did not.

Communication

GAO standards also provide best practices for an entity such as ODVA in the area of communication:

> Management should communicate the necessary quality information to achieve the entity's objectives, both internally and externally.
>
> Management communicates quality information throughout the entity using established reporting lines. Quality information is communicated down, across, up, and around reporting lines to all levels of the entity.
>
> As part of establishing an organizational structure, management considers how units interact in order to fulfill their overall responsibilities. Management establishes reporting lines within an organizational structure so that units can communicate the quality information necessary for each unit to fulfill its overall responsibilities.

As these standards emphasize, accurate and timely communication is essential within the organization, at all levels, as well as with outside parties. Methods of communication should be designed to flow effectively through all levels of the entity.

ODVA employees are experiencing a culture of change, fear, and intimidation, and a serious breakdown in internal communication appears to be a key cause of that challenging environment. Of 146 survey respondents with an opinion, 70% believe central office management "Seldom" or "Never" provides a clear sense of purpose and direction. Countless comments referred to management, varying divisions, and centers as "cut off" or "isolated." They discussed central leadership being secretive, lying, and purposefully fostering division, and complained of a lack of staff meetings and clear directives at both the central and veterans center levels, hindering the flow of information from the top down. Many staff members do not understand the reasoning behind decisions that impact their work, and receive information second and third hand, with

opinions and possible misinformation attached, or learn about agency news through the newspaper or TV.

Administrators feel they are not allowed to talk to commissioners, and related that they have been threatened or scolded for doing so. In the past, commission meetings were held at the veterans centers, and some commissioners reportedly made it a point to regularly visit the centers most accessible to them. The administrators and other center staff valued these opportunities to connect with the commissioners and appreciated their interest in center operations, and their interaction with the veterans. Commission meetings are now held in Oklahoma City, and visits by commissioners are reportedly rare. This cut in communication has been a somewhat shocking change for center staff, who are concerned that the Commission may not be aware of the extent of issues at the centers, from construction projects to difficulties with central office management.

In addition to seeing the Commission cut off from the workings of the agency, various administrators and center staff reported feeling purposefully cut off from each other and discouraged from pooling information, comparing procedures, or making visits between centers. This appears to be an effort to effectively turn each veterans center into a silo, receiving one-way communication from the central office. This silo effect impedes the flow of quality information between levels and units of the organization, hindering the agency from meetings its objectives and, as evident in our discussions throughout this report, damaging employee morale, increasing risk, and impacting the quality of resident care.

One survey respondent succinctly summarized what has occurred in other areas of the agency: "Quickly after General Deering took the reins, this Agency eliminated the regular meetings and feedback from clinical staff in the State Veterans Homes (particularly Medical Directors, Directors of Nursing, Lab Directors, & Pharmacy)." As another employee pointed out, feedback is necessary for continuous improvement, and the feedback loop within the agency has been cut.

The responses to our employee survey included some interesting discussions of the silo effect, alleging that management prefers hiring young staff with no state experience who might be more easily manipulated and kept in the dark, and that knowledgeable staff was let go. They also mentioned that past administrations were more teamwork oriented. Clearly ODVA employees are keenly aware of this communication breakdown and conscious of its effects.

Some employees are also concerned that the centers are not treated equally, some receiving harsher treatment, stricter rule enforcement, or worse cuts to staff or budgets. The most extreme example of this appears to be the treatment of the Talihina center, but general inequity in the treatment of the other six centers, their administrators, and their staffs were often mentioned as well.

Internal communications have continued to deteriorate over recent months. As we began our procedures, administrators were concerned not only that they had been cut off from commission meetings but that the audit period agency director visited their administrator meetings only briefly to "cheerlead," and not to offer any real information or listen to their ideas and concerns. Most recently, we discovered that the central office has cancelled and postponed administrator meetings. The center administrators recently requested to hold a meeting and presented a list of topics they wanted to discuss; central management addressed the topics with short responses and set a meeting for several months in the future. Commission meetings have also decreased in frequency and are now held at the central office, whereas previously they were held at centers statewide.

While several administrators we met with expressed that they attempt to present information from the central office in a positive light and keep up morale, our survey responses made it clear that staff is aware of central management's attitude even when they do not experience it directly. Staff reported that their administrators were being threatened and retaliated against, even "bullied," by central management.

A variety of other concerns related to communication were brought to our attention through our surveys and interviews. For example, the agency's channel for reporting improprieties or grievances funnels directly to executive management, not a neutral party, so staff does not feel comfortable using it. According to one survey comment, the then-deputy director stated in a meeting in 2015 that he would 'try to be less caustic' when speaking. The survey respondent felt the caustic language had continued and that the clinical compliance director speaks in the same manner. These leaders reportedly speak in an unprofessional tone and scold employees in front of third parties and other staff.

Of 209 survey respondents with an opinion, 53% disagree to some extent with the statement, "Management effectively communicates its decisions to all employees." Communication from the central office is generally conducted by phone or email, and is often inconsistent and unclear. According to center staff, top management rarely visit centers, and the visits they do make are perceived as being only when something is wrong or for disciplinary purposes. Multiple administrators noted instances when the deputy director or director of clinical compliance showed up unannounced, especially after a disagreement; visited a center when the administrator was out on approved leave; or bypassed administrators and went directly to speak to their staffs.

Again of 209 survey respondents with an opinion, 52% disagree to some extent with the statement, "An atmosphere of mutual trust and open communication has been established within the organization," and 51%

disagree with the statement, "The interaction between management and our organization enables us to perform our jobs effectively."

The agency has also suffered challenges in project implementation due at least in part to a lack of planning and communication. An overnight change from established, customized nursing policies to agency-wide standardized policies, without input from center administration or nursing leadership, caused much confusion and concern, and occurred without time to review the policies or train staff. This is discussed further on page 51.

The agency's implementation of PointClickCare software[4] in the centers caused concerns about what staff perceived as arbitrary deadlines, central office threats of disciplinary action if training was not timely, general limitations in the new program, and determining what information was transitioning to this software versus still housed in other programs. Most recently, we received several comments regarding pharmacy software that had been purchased by the agency and whether or not it may be compatible with PointClickCare or be usable by the agency. The variety of details and estimated costs (generally over $2 million) we were given by staff for this implementation reflect the lack of communication about the project within the agency. We also learned that central management had terminated their connection with a long-time OMES employee, who was well versed in the agency's systems, after a disagreement regarding compatibility. Central office has now assigned the continued PointClickCare implementation to a recent central office hire whose background has been questioned by many employees (see further discussion of LPN on page 22).

It is possible that, due to the atmosphere of fear and intimidation present throughout the agency, management is not even aware of the extent of concerns and difficulties being experienced at the centers, due to their staff's reluctance to raise a question or bring up a problem. We reviewed an email chain begun by the deputy director in June 2017 as we were initially interviewing center administrators and staff, and a legislative interim study with some similar topics was occurring. In the initial email, the deputy director asked administrators a slew of questions that make it clear he is aware of issues of concern to the centers, some legislators, and other vocal critics of the agency:

[4] PointClickCare is care management software popular in the long-term care and nursing home industry. Its modules range from medical and patient records to financial recordkeeping, and its implementation at ODVA is discussed further beginning on page 57.

Team,

Please see the attached interim study that appears to be driven by the same individual(s) that issued the last complaint to another legislator.

I need to know how many of you have done the following and please reply to the entire group so that we have clarity on the issues.

Have any of you eliminated crash carts or locked up EKG machines??

Who has provider housing that exceeds the comparable rate in the community??

Have any of you been directed to discriminate on your admissions due to the resident's disability percentage??

Have any of your recent resignations voiced the raise in meal costs to be a reason for their leaving your center??

Do any of believe that you would be able to recruit a new Physician from Med School to begin their career in geriatric care??

Do any of you believe our rate of pay for PCAs is not competitive with the private sector??

If any of your answers are yes please give me dates, numbers and reasoning for your opinion or reason for doing so.

In a later response to this email, the deputy director informed one administrator that, "FYI, no one answered any question below in the affirmative." However, many of these issues were brought up as concerns during our interviews and employee surveys. It is concerning not only that agency management does not already know the answers to some of these significant questions, but that the deputy director claimed no one had answered "yes" to any of them, suggesting that either he or the administrators were not being truthful.

More recently, we were provided with a copy of an email sent to administrators and other staff by the now-director that included the following language[5]:

> **Sent: Thursday, March 29, 2018 3:45 PM**
> **Subject: Incentive pay/Retirement**
>
> **Team,**
>
> **I expect the audit to come out soon, possibly tomorrow and if I'm not fired due to findings of mismanagement, toxic environment, improper purchases or whatever other allegations I have heard of in the rumor mill we will be moving forward with the incentive/excellence pay after the dust settles from those allegations. We have been working on average numbers and achievable goals for certain metrics and patient care events.**

[5] As we received a photograph of the email on a computer screen, it has been retyped here for legibility.

Again, it is clear that central leadership is aware of the control environment issues affecting the agency. The inclusion of a promise of incentive pay if the director remains employed, and despite repeated claims of budget difficulties, is also of interest.

Some respondents offered the perspective that management is making helpful changes and the rest of the agency is resisting change. Most who conceded that some of the changes being made might be worthwhile still argued that the way the changes were implemented caused unwarranted stress and confusion. One central office employee who remarked positively on their experience at the central office offered that "if the director had gone to each of the facilities to give a speech regarding his mission and goals . . . hearing it directly from the horse's mouth would have prevented a communication breakdown."

This breakdown appears to have played a particularly crucial role in aggravating employee and public concerns regarding the Talihina center. While events specific to Talihina are discussed in their own section of this report, it must be noted here that many of the staff's concerns and theories related to the closure of the center's special needs unit and legislative efforts to relocate the center clearly derive from a lack of viable information. The lack of clarity in management's statements as to *why* they wanted to close the special needs unit, or decertify its beds, or relocate the center altogether – from mold problems, to staffing issues, to declining demand from potential residents – is often interpreted as management not having a clear motivation or having an ulterior motive for these changes. It's likely that to some degree this is in fact due to management lacking the ability or willingness to clearly communicate its plans and reasoning to staff and the public. This type of transparency is expected of ODVA as a state agency, and its absence obviously causes suspicion, which is then compounded by the air of fear and intimidation present at the agency.

Other Control Environment Concerns

Additional issues related to the overall agency environment at ODVA came to our attention during our work and as a result of our employee surveys. Overall, this degraded control environment increases the risk of misappropriations, errors, and declining quality of care for the veterans the agency is designed to serve.

Snap Decisions

Staff at all levels relayed concerns and examples of central office management attempting to operate on generalizations, assumptions, and numbers, without acknowledging the complexities and human factors

truly involved at the veterans centers. Management has even reportedly told administrators directly to focus on the numbers, not the people.

Many staff interviewed and surveyed noted that management does not take advantage of the expertise available from their center administrators, medical staff, and other experienced employees. They also stressed that management is known for making immediate decisions without time for research and analysis, often leading to their directives later being reversed. Examples included the following issues, also discussed elsewhere in this report:

- Replacement of nursing policies agency-wide with no warning or training, leaving centers with unfamiliar policies that didn't even apply in some cases
- Removal of EKG machine access at the centers
- Center business managers being terminated or moved before policies and procedures were updated and new responsibilities were made clear

In another example, the clinical compliance director reportedly indicated routine physician orders would no longer be permitted in the centers, and then, a few days later, asked administrators to send lists of their routine orders to the central office so management could decide which orders would be followed. Medical staff was concerned not only about the inconvenience and impact to care, but that the clinical compliance director was not in a position to override physicians' orders or clinical judgment.

One survey respondent described the phenomenon as follows: "They abolish jobs without even seeing what these jobs do for the facilities. Then these job functions are given to other staff that do not have the knowledge or time to adequately do them. They send out emails with changes that are not based on current policies or rules or regulations. They may send another one a few days later, changing it again. They have the departments in total chaos by their emails."

Consolidations

During our audit procedures, central management initiated a consolidation of business office staff at the centers, including terminating via a Reduction in Force (RIF), the business managers at five centers, and absorbing the other two business managers (from Ardmore and Norman) into central office finance staff. Some of these business managers and other staff contacted us with concerns about the way they were informed of the consolidation, the terms of their departures, potential noncompliance with state merit rules, as well as the demoralizing lack of a "thank you" or "goodbye" after years and even decades of service.

Center administrators must now rely on central office personnel who are new to their positions and in some cases unknown to the administrators, to conduct the financial activities and control the budgets of their centers. Center staff have relayed that it now takes weeks to make a purchase, instructions for the remaining financial duties at the center are unclear or non-existent, there are no clear provisions for emergency purchases, the accounting technicians remaining at the centers are overwhelmed, and back-ups for these positions may not be available.

GAO standards for internal controls state that management should establish an organizational structure designed to achieve the entity's objectives. This entails assigning responsibility and delegating authority to key roles throughout the entity. By withdrawing more and more control to the central office, executive management is doing the opposite, thereby decreasing the presence of expertise at the centers and further hindering agency-wide communication, as there are fewer individuals entrusted with authority and information at each location.

Another troubling aspect of this removal of financial oversight from the centers is that it removes control from the administrators, not only hindering their ability to efficiently and effectively run each center, but potentially threatening their long-term care licenses. The Administrator Code of Ethics outlined in the Oklahoma State Board of Examiners for Long Term Care Administrators (OSBELTCA) administrative code (490:10-13-1) includes the following expectations and admonishments:

- Individuals shall strive, in all matters relating to their professional functions, to maintain a professional posture that places paramount the interests of the facility and its residents.
- The Health Care Administrators shall not: Defend, support, or ignore unethical conduct perpetrated by colleagues, peers, or students.
- Administrators have a fiduciary duty to the facility.

Further, 490:10-13-2 outlines that: "It is the responsibility of the long-term care administrator, as the managing officer of the facility to plan, organize, direct, and control the day-to-day functions of a facility and to maintain the facility's compliance with applicable laws, rules, and regulations. The administrator shall be vested with adequate authority to comply with the laws, rules, and regulations relating to the management of the facility."

It is clear from these guidelines that the administrator is expected to be in effective financial and operational control of his or her facility. As the administrator's control diminishes, and their fear of termination or central office retribution rises as has been described by all levels of center staff, their ability to stand up to unethical directives or activities impacting their facilities and residents surely diminishes as well. Without

licensed and capable administrators to run its centers, ODVA could not legally serve its many resident veterans.

As discussed earlier, the removal of center business managers also negatively impacted our ability to gather detailed, reliable, independent financial information from the centers. Agency employees also expressed numerous concerns about this consolidation in our surveys, including

- The centralization of purchasing food and medical supplies, which has led to delays in ordering and receiving these essential products
- Bills not being paid on time since the consolidation occurred
- The loss of institutional knowledge and expertise at the centers regarding policies, rules, and regulations related to purchasing and financial activities
- The breakdown of key financial internal controls previously in place at the centers
- Administrators losing their ability to control their spending and budgets and to expediently meet the needs of the facility
- Feeling like the central office had "pulled the rug out from under" center staff and failed to communicate about terminations and process changes
- Negatively impacting processes underway at the centers such as debt collection
- Potentially unqualified individuals being left in charge of the center business offices
- The feeling that no cost savings actually resulted from this and other terminations, while the quality of life of residents and remaining staff have suffered

We received a specific report of an accounting technician in the business office of the Norman center who had previously misappropriated funds at that center, allegedly from the veterans' trust fund, had repaid the money, and is still employed there – now without business manager oversight. Additional records, including related legal records, will be provided to the Attorney General's office for follow-up on this matter.

One employee commented that central office had stated its centralization of the business offices was based on a recommendation by the auditor's office, which they "know is a lie." We were made aware several times during our procedures that personnel actions and process changes were being explained by central management as "auditor recommendations." We contacted the agency to let them know these changes were not recommended in any past report, and clarified the only consolidation-related report contents we had provided in the past, including specific support of decentralized maintenance. We noted in this correspondence that we did not endorse the ongoing changes and found it unusual for

such sweeping changes to take place during an investigation or audit. Their reply to us deflected that statement and the changes continued.

Survey responses included concerns about the recent Fire & Safety and Maintenance department consolidations at centers as well. This change resulted in pay cuts to Fire & Safety supervisors, no security presence during the day shift, which is now covered by a Maintenance employee, and a newly combined staff whose members may be unqualified to perform the duties of either department. Employees expressed concerns that such a change indicates resident and staff safety are not a priority for central management. Changes such as this have broader implications as well: the effectiveness of center emergency plans may be decreased as trained staff is no longer available during the same hours, and job classifications may be inaccurate as employees are performing duties from various departments.

The Government Accountability Office report *Streamlining Government: Questions to Consider When Evaluating Proposals to Consolidate Physical Infrastructure and Management Functions* (GAO 12-542) contains some helpful best practices regarding consolidations:

- The key to any consolidation initiative is the identification of and agreement on specific goals, with the goals being evaluated against a realistic expectation of how they can be achieved.
- The initiative needs to be based on clearly presented business-case or cost-benefit analysis and grounded in accurate, reliable data.
- As stakeholders often view consolidation as working against their own interests, it is critical that agencies identify who the relevant stakeholders are and develop a two-way communication strategy that both addresses their concerns and conveys the rationale for and overarching benefits associated with the consolidation.
- Agencies should have an implementation plan for the consolidation that includes active, engaged leadership of executives at the highest possible levels; a dedicated implementation team that can be held accountable for change; and a strategy for capturing best practices, measuring progress toward the established goals of the consolidation, retaining key talent, and assessing and mitigating risk.

In summary, employee buy-in, clear support data, two-way communication, and a strong implementation strategy are essential for a successful consolidation. It is clear from our interviews and survey responses that employee buy-in and two-way communication were not present in ODVA's consolidations discussed above. Any planning or strategizing that may have taken place prior to these changes appear to have been inadequate and obscure.

While the GAO's report focuses on consolidations, these general implementation steps could be very effective in the case of some other

changes underway at the agency, such as outsourcing services. Regarding the agency's recent move to outsource laboratory services, a study including factors such as cost effectiveness is still underway, although the outsourcing is already implemented. Survey comments and interviews suggested the agency is likely to outsource physical therapy, x-rays, or maintenance services next; following project implementation best practices in such a situation could help central management to ensure these moves are financially and operationally sound and to gain employee buy-in through communication.

Management has often presented its reasoning for changes such as outsourcing services and eliminating or consolidating staff positions – both to the public and to internal staff – as the need to conserve funds due to cuts in state appropriations. As reflected in our discussions of budget and revenues later in this report, the agency does not in fact appear to have experienced significant budget problems. While state appropriations have declined at ODVA as they have statewide, the agency's overall revenues in fact increased during the audit period.

In its response to a legislative inquiry in April 2017, ODVA explained its temporary removal of EKG capabilities from the centers as a regulatory and liability issue. They then shifted gears to claim the agency was seeking efficiencies due to budget cuts: "Should ODVA's budget be restored with the $10 million that it has lost in the last seven years it could easily restore all the services that were once present, hire additional doctors, operate 24-hour lab services and many other luxuries that are currently not feasible." Management's ongoing moves to outsource services and centralize financial control do not appear easily reversible in the case of a financial upswing at the state level, nor do its actual revenue trends appear to justify these "efficiency" measures. Management's activity during and since the audit period gives no indication that they intend to add "other luxuries" at the centers. Employees are aware of this contradiction, and this perceived false excuse for internal changes has impacted staff morale, eroded trust in central management, and may damage the agency's public reputation.

Favoritism, Bias, and Other Issues with Central Office Staff

It should be emphasized again that tone at the top and throughout the agency is fundamental to an effectively functioning internal control system. Without strong ethical leadership, awareness of risk can be diminished, responses to risk may be inappropriate, control activities may be ill-defined or not followed, information and communication may falter, and feedback from monitoring activities may not be heard or acted upon. Therefore, tone can be either a driver or a barrier to internal control, influencing the control consciousness of all employees. GAO

standards also emphasize that "management should demonstrate a commitment to recruit, develop, and retain competent individuals."

Even as this report was being written, we were receiving calls and other forms of communications from various parties concerned about management's actions and their impact on the veterans and staff. Despite the proliferation of comments and concerns we have received, we continue to hear that there are others who are still afraid to share their experiences and worries with us. As described earlier, staff is fearful of management retribution. They also alleged in survey comments that within the central office, inner circle members receive preferential treatment and may lack the necessary qualifications to run the agency and oversee veterans centers.

We received multiple reports of incentives, such as training opportunities, being preferentially offered to some individuals and not to others in the same position. Similarly, we were made aware of instances where rules were circumvented in favor of certain employees. The overlooked parties alleged that it was "all about who you know." It is the perception of some current staff that only male veterans (primarily having served in the National Guard) are being promoted, treated appropriately, or in line to be administrators of centers. Others alleged favoritism for specific friends of management. For example, one individual was terminated by a center, then immediately given a job at the central office, and is now the deputy director of a different center. One survey respondent pointed out that this favoritism is discouraging for newer employees seeking long-term employment with the agency. There is also a widespread understanding that new hires at the central office are generally former National Guard, and have no experience in long term care or health care.

Numerous staff expressed concerns that center funds are being redirected to the central office, causing a cut to the level of veteran care in order to increase the staff size and comfort of the central office. Many center staff reported central office employees getting large raises, special treatment, and excessive travel opportunities, while long-time employees are demoted or terminated to make room for central management's "cronies." While we did not complete detailed staffing analysis procedures, for reasons discussed on page one, we did note that a total of 46 pay raises were granted to staff designated as central office in statewide accounting system HR records, between July 1, 2014 and mid-May 2018. Of those raises, 22 were $5,000 or greater per year, and 10 were $10,000 or greater per year. In addition, over half of those raises occurred in fiscal year 2018.[6] This is accounted for to some degree by central office

[6] For reference, the central office currently employs approximately 34 individuals, not including IT staff, as of June 2018. It should also be noted that some individuals who received raises while working as central office employees may have been subsequently transferred to other departments or terminated.

expansion and centralization of certain functions, but also explains why the volume of raises has piqued employee interest.

It is integral to note that while some of these allegations could be an issue of perception, the effect of that perception on morale and the overall control environment at the agency is very real.

The majority of comments regarding central office centered around the actions and attitudes of the audit period deputy director (who became ODVA's director February 1, 2018) and the clinical compliance director. In addition to the issues discussed throughout this report, staff commented that

- The deputy director screams and yells when angry, and both individuals dictate orders, threaten staff, curse, and speak unprofessionally in front of staff and third parties.
- The deputy director has poor knowledge of federal regulations, and the clinical compliance director focuses on private care regulations when federal rules are more applicable.
- Both individuals encourage staff not to circumvent the chain of command and call them directly.
- They display a vengeful, "gotcha" attitude.
- They have an agenda to close the Talihina Veterans Center and other centers.
- They and other central management ignore the employees and the resident veterans. Several individuals commented that central management, including the audit period director, refused to eat with the veterans at the centers, for reasons ranging from not liking the food to not wanting to eat with enlisted men.
- "The two people making all the decisions in this agency have never worked a day in a State Veterans Home."
- If you challenge them, you will be fired.

We encountered a number of additional concerns specific to the clinical compliance director throughout our procedures:

- Administrators were not told she would be overseeing them until she showed up unannounced to give them performance evaluations. On a separate occasion, she handed evaluations out publicly at an administrators' meeting.
- Many rumors are circulating in the agency that she was terminated from past long-term care and health care positions, which impacts the staff's respect for her.
- Her instructions and new policies are presented in an inconsistent, incomplete, or informal manner. Center personnel reported that she has granted them informal permission to deviate from particular instructions or policies, but always verbally, and sometimes with warnings such as, "we never had this conversation." This includes allowing deviations from the

standardized menu (substituting items), and allowing lab techs to read EKG results.

In 2017 ODVA hired an LPN to serve as a central office programs administrator position working with the clinical compliance director. This new hire had recently been arrested for attempting to obtain a controlled substance using a forged prescription. Many survey respondents commented that this history would prevent him from being hired at a center by the agency's own policies, and requires him to have additional supervision. They suggested his employment by the very director responsible for compliance, as well as the fact that they believe he is paid more than an LPN working at a center, has outraged employees.

While the audit period director was not mentioned specifically in as many cases, some surveys and interviewees brought up concerns that his serving as director of the agency and Secretary of Veterans Affairs simultaneously seemed like a conflict of interests. We did not perform detailed procedures related to this concern, as the two positions were joined at the governor's request, but it does appear to remove one layer of independent oversight, and of potential influence on the tone at the top.

We were also made aware of concerns about the fact that after the appointment of the audit period director/secretary in February 2015, the following month the agency hired the former secretary of veterans affairs as "administrative assistant to the director." She was paid $100,000 per year until her retirement in February 2017, and employees reported rarely seeing her at work.

Commission

As discussed earlier, GAO standards emphasize the key role the governing board, in this case the Commission, plays in the agency's overall environment and tone at the top. It is also essential that the Commission gather appropriate information to properly maintain oversight of the agency and deal with any issues that may arise:

> The oversight body should receive quality information that flows up the reporting lines from management and personnel. Information relating to internal control communicated to the oversight body should include significant matters about adherence to, changes in, or issues arising from the internal control system. This upward communication is necessary for the effective oversight of internal control.
>
> Personnel should use separate reporting lines to go around upward reporting lines when these lines are compromised.

As discussed in our communication section, ODVA staff generally reported not having access to or contact with the Commission, which

would clearly hinder the flow of information to the commissioners whether through normal reporting channels or through separate lines. It would also be difficult for a commission that is removed from the agency to set an appropriate ethical tone for its employees; indeed, it appears a questionable tone is being set in the Commission's effective absence.

Our prior performance audit report[7] recommended the Commission expand its financial oversight, approve agency SOPs, and enhance its monitoring activities. Prior to our current audit period, additional finance-related committees had been created and various financial and general performance reports were being provided to the Commission. We reviewed the meeting minutes available on the ODVA website, which covered calendar year 2017, and noted that general reports were still being provided during this audit period and info presented by the CFO during meetings. Meeting packets and agendas from February and May 2018 made available online include a variety of top-level financial and statistical reports as well as detailed information about pending legislation and capital projects.

72 O.S. § 63.3 states that it is the power and duty of the Commission to appoint the director of the Department of Veterans Affairs and provide for the employment of all such other personnel as may be necessary to carry out the provisions of that title, and any other duties prescribed by law. The salary and tenure of the Director of the Department are determined by the Commission. Our prior report also recommended the Commission adopt a formal policy and consistent process for evaluation of the executive director. In their response, the agency stated: "The Commission will standardize and formalize the evaluation process to insure a proper annual evaluation of the executive director is conducted. It should be noted that the executive director is under evaluation at all times by the Commission, and is not limited to an annual evaluation." If the Commission indeed takes this level of responsibility for the director's performance, it is accountable for the environment currently being created by the director and his staff.

[7] Oklahoma Department of Veterans Affairs performance audit, for the period of July 1, 2011 through June 30, 2012, available online at *https://www.sai.ok.gov/Search%20Reports/database/ODVAWebFinal.pdf.*

LEVEL OF CARE

Disfunction in the ODVA control environment is clearly damaging staff morale, and that employee experience is no doubt intertwined with the morale of veterans center residents and the quality of care they receive. It stands to reason that the agency must provide an effective work environment for veterans center staff in order for that staff to provide adequate care to the veterans. Many survey comments related concerns that ODVA management is not concerned with the wellbeing of staff or residents, and while many staff members fear for their jobs, as one survey respondent put it, "Veterans are also extremely scared that they will lose their home."

In developing our objectives for this investigation, we were asked to determine whether ODVA is actively decreasing the level of care provided to residents of its veterans centers. Our employee surveys and interviews echoed this question with frequent statements of worry that the level of care provided to veterans is declining.

The consensus appears to be that the major advantages of an Oklahoma state veterans center over a typical long-term care facility have always been the on-site medical care, the pharmacy and laboratory services, and the adequate number of caring staff. One survey respondent described the "old" ODVA centers as follows: "The resources the ODVA Centers had at one time was amazing. Lab, XRAY, Medical Providers in house 5 days a week (and more often), on call 24/7, Pharmacy . . . all in house. A patient on sick call would be seen by a provider that day. Their medication could be available to them in minutes if needed. Hospital visits could be avoided because almost anything a hospital could do was available in the Center. We had an amazing working relationship with our counterparts in the Federal VA and they provided medications to the Center at Fed VA contract pricing. Waste was minimal."

Many changes have occurred at the centers in the past several years that impact the care provided to resident veterans. Some of these are discussed to an extent in other areas of this report.

- **Laboratory Services:** Most laboratory services have been contracted to an outside firm; see further discussion beginning on page 63. Center personnel indicated that now that in-house lab services are limited, veterans are sent out to the hospital more frequently, although providers feel they could give quicker medical attention with in-house testing, especially for infectious diseases. The agency's laboratory and radiology programs administrator further indicated that "after outsourcing, lab testing results are not available for 24 to 36 hours. On weekends results can take up to 4 days. Critical lab results are called to the on call

medical provider 10 to 24 hours after the specimen is obtained. The inability to provide lab results in the facility can result in the veteran being sent to the local ER for evaluation and treatment. Veterans that are less than 70% service connected[8] receive bills for all ER and ambulance services that are not covered by insurance or Medicare." The agency's contract with DLO, the firm to which lab services are now outsourced, outlines that DLO may bill the residents' insurance or the residents/their families for services not covered by ODVA or the United States Department of Veterans Affairs (USDVA). Several interviewees expressed concerns that a veteran's inability to pay newly enforced fees may result in them opting out of needed testing.

- **Diets:** As discussed on page 61, management has decreased the use of specialty diets at the centers, a move that aligns with trends in private long-term care but limits options for residents with certain medical conditions. They have also standardized menus across the seven centers, resulting in some complaints about the items offered and decreased choices.
- **EKG machines:** As discussed on page 62, EKG machine use was temporarily prohibited but is now allowed, officially for physician use only, at the centers.
- **Other outsourcing:** Many employees responding to our anonymous survey expressed concerns that physical therapy, x-ray, and pharmacy services will soon be outsourced. While this does not appear to have yet occurred, the belief has exacerbated fears about further declines in the level of care provided at the veterans centers.
- **Medical care:** During our visits to centers, we were informed that medical providers (including doctors, physician's assistants, and nurse practitioners) have been directed by management to not take sick calls; veterans are now directed to go to the nurse instead. Some staff suggested that doctors are there primarily to meet regulatory requirements and not to provide care.
- **Additional factors:** The level of care provided to veterans may be impacted in various ways by other issues discussed throughout this report: seeking Centers for Medicare and Medicaid Services (CMS) certification, with the attendant requirements; prolonging or cancelling capital projects such as the roof replacement in Lawton or the boiler replacement in Talihina; policy changes causing confusion, requiring review and training, and removing

[8] See discussion of service-connected compensation on page 53.

center-specific procedures; and of course the overall impact of poor employee morale.

During our interviews and procedures, various individuals related that central management rarely visits the centers, and when they do, they go directly to speak to an administrator or other individual, usually for disciplinary reasons, and do not walk the halls, speak to veterans, or greet staff. Several center employees shared anecdotes about central management refusing to eat with the veterans because they did not like the food served at the centers, or because they would not eat with lower ranking veterans. They also related that the Commissioners, who used to visit the centers both for commission meetings and voluntarily on other occasions, rarely visit now and have been effectively cut off from center management and staff. Communication is apparently severed to such an extent that some staff members worry whether the Commission has any idea of the true goings-on at the centers, and others blame the Commission – and even the governor – for problems at the agency.

In relating their concerns about the declining level of care, many survey respondents provided commentary along the following lines:

- Multiple comments opining that central office doesn't care about resident care, or that they don't understand the effect of their decisions on veteran care – and on veterans' families, and staff.
- Frequent comments that removal of in-house lab services keeps elderly residents from getting timely care they need.
- Related concerns that laboratory outsourcing is costing the residents money, and about how resident's finances will be impacted by Medicare and Medicaid revenues being sought.
- Statements that removing the business managers and to some extent shutting down the business offices has slowed down purchasing and receiving of supplies, which directly impacts the veterans.
- Comments that the veterans complain about the food. One respondent noted that the poor choices of food are inappropriate given the amount of money the agency receives for veterans' care, while another noted food was the only thing residents previously had control over and they're no longer happy with the menu.
- Concerns about other changes, such as removing phones from individual residents' rooms at a center, or having to fight for certain day trips.

In several cases, employees even expressed the perception that the number of resident deaths has increased due to level of care changes, as well as the removal of veterans after the closure of the special needs unit at Talihina. One respondent stated: "The number of deaths has increased substantially over recent months due to changes in how we are to treat residents, cuts to medical staff, and directives to medical staff regarding

how they can practice medicine. The transition to the new computer system has been over a year and is still not complete. This also has a significant impact on the ability to provide quality care to our residents." Multiple letters we received alleged that individual residents removed from the Talihina SNU may have passed away prematurely due to complications resulting from their removal from the center. No matter its level of certainty, this perception impacts morale.

Overall the survey respondents repeatedly worried that the centers are being turned into nursing homes. Respondents seemed particularly distressed because they truly care about, respect, and admire the resident veterans, and feel that central office does not share this care and respect, despite the military background of some central executives.

While the results of our discussions and procedures showed that the level of care provided within the centers does appear to be declining, we determined it was important to also ask whether this change ultimately contradicts any significant laws, regulations, or other guidelines that apply to the agency.

According to GAO standards, the oversight body and management reinforce the commitment to doing what is right, not just maintaining a minimum level of performance necessary to comply with applicable laws and regulations, so that these priorities are understood by all stakeholders, such as regulators, employees, and the public. The following is a survey response, echoing a sentiment expressed in multiple surveys: "The philosophy of this Agency has changed to 'meeting regulatory requirements.' That is far from the best we are capable of."

While current management is making changes to the historical level of in-house care provided at the centers, and this has caused internal concerns and brought forward some vocal critics among stakeholders outside the agency, the situation is complicated by the fact that the changes do not appear to violate any applicable laws or regulations. Veterans centers are licensed as long-term care facilities, and are therefore liable to the standards of such a facility, including Oklahoma State Department of Health regulations for nursing facilities and VA regulations. The care and services provided above that standard could be considered "extra," and while staff repeatedly expressed the feeling that the veterans deserved this excellent care as a result of their patriotic service, the requirements are more minimal.

We again noted that the centrally directed changes impacting residential care may be impacting authority of the center administrators. Under the terms of the Administrator Code of Ethics outlined in the OSBELTCA administrative code (490:10-13-1):

- Individuals shall hold paramount the welfare of persons for whom care is provided.

- Individuals shall strive, in all matters relating to their professional functions, to maintain a professional posture that places paramount the interests of the facility and its residents.
- Individuals shall honor their responsibilities to the public, their profession, and their relationships with colleagues and members of related professions.

Given our earlier discussions of the agency-wide environment and broken communications at ODVA, if an administrator believed a change such as outsourcing services negatively impacted residents' welfare or interests, or otherwise conflicted with their professional responsibilities, they would likely not be in a position to question or prevent the change. Administrators stripped of their authority and seeing the provisions of their own Code of Ethics ignored are in a precarious position: Should they leave a position – often a long-term career – caring for patients for whom they respect and feel a deep responsibility for, to protect their own licenses, integrity, and self-worth? It is our understanding, as a result of our discussions and surveys, that several administrators, as well as other personnel within the centers, feel that they are in this state of quandary, subject to management's instructions but questioning the impact on the veterans, center staff, and their own mental and professional wellbeing.

External laws and regulations are not the only principles guiding the agency. As discussed earlier, GAO standards state that the oversight body and management are to lead by an example that demonstrates the organization's values, philosophy, and operating style. One way management expresses its values and philosophy are within the agency's mission statement.

The mission of ODVA has changed over time, and as presented on the agency's website, is currently clear and succinct:

> Provide to Oklahoma Veterans and their families residing in the State of Oklahoma the highest quality services and care available anywhere in the Nation.

The agency's mission and vision are presented in greater detail[9]:

Mission: In partnership with the Secretary of Veterans Affairs, the Oklahoma Department of Veterans Affairs, state and local agencies, and Veterans Services Organizations, the state of Oklahoma will facilitate in providing to the Veterans residing in the state of Oklahoma the highest quality support and care available anywhere in the Nation.

Additional characteristics of ODVA style and services driven by the mission include:

- Each center's atmosphere is comfortable and relaxed

[9] Full text from ODVA website, "About ODVA" page, last accessed May 8, 2018.

- All employees are sensitive to residents and their families
- Employees communicate well and enjoy coming to work
- Employees' knowledge, skill and experience are recognized and leveraged
- Facilities are maintained in good repair
- Eligible veterans are assisted with claims
- Benefits include both VA and others

Vision: The state of Oklahoma is a state known for the best Veterans care and services in the nation, where Veterans are provided tools that are readily accessible, while facilitating their needs and requirements to continue a quality life among the community in exchange for their service to the nation, which has been paid in advance.

Explanation: It is the vision of the Oklahoma Department of Veterans Affairs that all programs administered by this agency to Oklahoma veterans will always be first in the nation in:

- Services
- Benefits
- Care
- Facilities
- Employees
- Relationships

An alternate vision is presented in a document provided to us by the central office:

> An agency known for providing model services and state of the art facilities which honors the extreme sacrifices and superb achievements of our veterans and their families.

We did not perform detailed procedures analyzing the agency's compliance with its own mission and vision. However, it seems clear that ODVA has farther to go to reach their vision. The issues already discussed in this report present a stark contrast to goals such as

- Providing the "highest quality support and care available anywhere in the Nation"
- Employees who communicate well and enjoy coming to work
- Employees' knowledge, skills, and experience being recognized and leveraged
- Providing "state of the art facilities" and being first in services, benefits, care, facilities, employees, and relationships

A letter from Governor Fallin in January 2015 asked the Oklahoma Veterans Commission to join her in a "new and expanded vision to serve all of Oklahoma's veterans and their families," asserting that as a state we

offer services to far too few veterans and must expand our reach. Management has shown clear intentions and movement toward expanding its services to veterans outside the seven residential centers. This is commendable, and no doubt necessary, as Oklahoma has a population of veterans outside the centers far larger than the population receiving long-term care from the agency. A high-level mission and planning document provided to us by the central office documented ODVA's progress and further plans in place to increase the agency's outreach to veterans in need of services other than residential care and claims and benefits assistance – including education, employment, and mental health aid. Central office efforts include increased social media presence and other visibility tactics, community and government partnerships, events, and legislative initiatives.

Employees believe the central office is defunding the veterans centers in order to support these other services. Whether or not this is the case, this situation highlights the breakdown in communication within the agency. Employees are left to wonder whether and how their leaders are choosing to serve the veterans, and they cannot assist in meeting the mission and vision of the agency without being educated about them. If management indeed believes it is necessary and appropriate to alter the level of agency involvement in residential care in order to adequately attend to the state's other veterans, transparency and communication with both internal staff and the public would be crucial to securing buy-in and support.

Several other factors remain unclear: Are the commission or the legislature aware of the decline in service level provided at the veterans centers? Is it their intention to decrease in-house services provided to veterans? Could the decrease in medical care provided at the centers, as survey respondents worried, affect the volume of federal reimbursements the centers are eligible to receive?

The agency's handing of the Talihina center also conflicts with its mission to provide the "highest quality" care. A detailed discussion of events at the Talihina center begins on page 32. While the agency has sought legislative authority to move the Talihina center to a different location, it has also reported that it will take at least five years to do so. Management's avoidance of maintenance responsibilities at the center in the recent past, and its consistently negative public statements about the center, do not place the administration there in a position to provide excellent care in the interim.

The following responses from our surveys illustrate two employees' feelings related to the ODVA mission:

- It seems our efforts are lost in the process of what's really important for our vets or maybe I don't understand the mission. Do we just provide healthcare, food, and shelter? Are families important and part of their health care plan? Do volunteers

matter? . . . Our vets know the difference between lip service and action and what we do is more than just another job.

- It sure doesn't look good when the resident's worry if they are going to have a place to live and people to take care of them in the right way when they gave their lives for this country.

As it stands, the veterans centers are by far the most visible and highest cost division of the agency, and are relatedly the focus of most of the concerns we were asked to address. The same mission and planning document we received that outlines the expansion in veterans services also details the agency's "values," which reflect those of the various military services: loyalty, duty, respect, honor, integrity, and selfless service, among other laudable characteristics. Unfortunately, the majority of ODVA's staff does not see these values reflected in management's tone or actions, and the fear and confusion they are experiencing is impacting their morale and the care they are providing.

TALIHINA VETERANS CENTER

In response to the volume of questions and concerns brought forward during this engagement specific to the Talihina Veterans Center, we have endeavored to present some information about occurrences in Talihina under the current administration. As our procedures and access to reliable documentation have been limited as discussed beginning on page one, we were unable to provide a lengthy and detailed timeline of events. However, some additional information on events at the Talihina center has been made available publicly by news publications.

Background and Events in Talihina

The Talihina Veterans Center was originally constructed as the Eastern Oklahoma Tuberculosis Sanatorium in 1921. In 1975, the Sanatorium was transferred to the control of the War Veterans Commission to provide nursing care to Oklahoma veterans. The center is located approximately two miles northwest of Talihina and is situated on 600 acres at the western edge of the mountainous Ouachita National Forest.

In recent years, the Talihina center has been the focal point of a battle between ODVA central management and the staff at the center, legislators, concerned citizens, and the City of Talihina. Various allegations and actions, which include the looming effects of the center potentially relocating, have caused many concerns among these parties. Concerns related to the center mentioned throughout our interviews, in surveys, and described in the media vary widely and include the age of the center, water quality concerns within the town of Talihina, questions about staffing levels related to the remote location of the center, the closing of the center's special needs unit (SNU), explained variously by central management as being due to mold, inadequate staffing, or low demand.

Several events have impacted the Talihina center in the past few years. After being asked to replace the HVAC system in the SNU, management had the unit tested and mold was detected, leading to complications in cleaning or replacing the duct system. This situation is discussed in further detail later in this section. Controversy surrounded the center in October 2016 and again in January 2017, as a result of resident deaths. Details regarding these unfortunate deaths have been made available in various publications, and the circumstances surrounding them were complex. They led to the resignations and terminations of various employees, including a physician's assistant and three nurses. They also led to a lengthy process through which central management eventually succeeded in having a nurse practitioner's license revoked.

These events were reported in the press and comingled with claims of other problems at the center by central management. These included low staffing and high turnover levels, a limited pool of qualified applicants in the rural Talihina area, and a comparably small wait list for the center when compared with other centers. Where these claims were made in the press, they did not appear to be accompanied by evidence.

In a December 2016 a local news station interviewed Senator Frank, who explained that he had listened to complaints from Claremore, Norman, and other facilities over the past five years, and he was part of the move to overhaul the administration of the state agency. He expressed the belief that relocating the Talihina facility to a more easily accessible area would be the best long-term solution for both recruiting and retaining qualified staff members in the future. The Senator was also quoted in the same article saying, "I know there are concerns about the economic impact it would have on the community, and those are serious concerns that we've got to take a look at, but my primary concern is to make sure we can provide the quality care that our veterans need."

Senator Simpson authored SB 544 during the 2017 Legislative session, to relocate the Talihina veterans center. The bill read in part:

> The Oklahoma Department of Veterans Affairs is authorized and directed to relocate the Oklahoma Veterans Center at Talihina, Oklahoma, to a new location eligible for approval or recognition by the United States Department of Veterans Affairs as a State Veterans' Home.
>
> The Oklahoma Department of Veterans Affairs is further authorized and directed to proceed with the development of a new facility to assume the operations of the Oklahoma Veterans Center presently located in Talihina, Oklahoma, subject only to such geographical constraints as may be imposed by the United States Department of Veterans Affairs.

The bill failed to pass in the Appropriations and Budget Health Subcommittee. During this same time period, a group of individuals met with the Attorney General's office regarding concerns related to the ODVA. Many of those concerns were directly related to the potential relocation of the Talihina center and views of the current administration.

In March of 2017, the Talihina administrator received an email from the ODVA deputy director instructing her to inform the families of residents residing in the SNU that due to the need for repairs and lack of staff, they would need to find an alternate location to receive care. The deputy director also stated that his intent was not to lose the beds but to remediate the rooms that have mold or preferably locate to a new facility.

The following is the entire body of the email, dated March 28, 2017, with the header removed[10]:

> **We can no longer operate under the scrutiny you are receiving. You are being treated as a focus facility by the Health Department. Therefore, please Inform the Muskogee VAMC you will no longer be admitting elopement risks or dementia with behaviors due to the inability to meet the special needs of these types of residents. Your staffing has reached critical levels and your change to 12 hour shifts not only hurts morale but lessens your ability to hire anyone for your vacancies. Furthermore notify the residents and families in the SNU that due to the lack of staff and the need for repairs to the SNU that they will need to a find an alternate location as soon as possible. If they do not find an alternate location by June 1st we will begin the process of transferring those residents to other state homes. It is not my intent to lose these beds but rather remediate the rooms to eliminate the mold or preferably relocate to new facility rather than spending 8 million on the remediation and the 200K on the wander management system. Please inform the health department surveyors of this decision as soon as possible. If you have any questions please do not hesitate to contact me.**

Following the receipt of the above email, the administrator wrote a letter to the Federal Veterans Affairs Medical Center dated March 28, 2017, informing them of the planned closure of 48 beds in the SNU.

> The Oklahoma Veterans Center, Talihina Division will be closing the 48 bed Special Needs Unit effective June 1, 2017 for necessary remodeling. Effective immediately the Oklahoma Veterans Center, Talihina Division will no longer be able to accept Veterans with dementia who are an elopement risk or exhibit aggressive behaviors or have the potential to do so.
>
> The families of current Veterans of the Special Needs Unit will be notified of this closing in order to allow time for placement at other facilities. The staff of the Talihina Veterans Center will be available to assist in this process.
>
> The Oklahoma Department of Veterans Affairs has given careful consideration to this decision and regretfully makes this notification. We have the honor of caring for America's heroes and our focus will remain on providing the best care for the Veterans.

The administrator then called a meeting with the department heads notifying them of the instructions she had received from the deputy director to close the SNU by June 1, 2017. She also stated that no employees would lose their job and that they would assist the families of the SNU residents in finding an alternate facility for them to live. The administrator also stated in the meeting that it was the intent of the director to reopen the unit once construction is complete.

She further explained that the reasons given for closing the unit were the HVAC system and lack of staffing.

After the closure of the SNU, and continued loss of employees, and the loss of residents in October of 2016 and January of 2017, the Federal VA Medical Center informed the administrator that until the issues could be addressed, a 90 day hold was being placed on all referrals. The following

[10] Correspondence has been limited to the body of each document, with significant parties and dates noted in the report text, both to save space and to eliminate the inclusion of any unnecessary identifying information.

is the body of the April 14, 2017 email from the assistant chief of social works service at the Muskogee USDVA office:

> **Due to issues of concern regarding staffing, ongoing decrease in beds levels, and recent patient incidents, it has been determined by Social Work Service, in consultation with EOVAHCS Administration, that a 90 day hold be placed on referrals. It is our sincere hope, that within this time frame, the above issues will be addressed in a manner that will regain our confidence in referring our Veteran Patients to your facility.**

This email was subsequently released to the press, which prompted complaints from the USDVA assistant chief who had written it. The deputy director replied to that individual as follows on April 17:

> **My sincerest apologies for using the VA hospital as a proxy to show that we are indeed involved in a staff shortage. It was absolutely necessary as we are rehiring the same folks in that area just to make staffing numbers. Ms. Williams had told me that you were upset with your email being released to the Oklahoman but I am doing all I can to convince our legislators that a problem does exist. It is imperative that we know about these admission holds and somehow convince the legislators to permit a relocation. I'm having a difficult time keeping everybody happy but please know I released your email for the right reason, to ensure quality care for veterans.**

On June 9, 2017, the deputy director sent the following to the Talihina administrator:

> The lack of staffing for nurses in Talihina and the need to rehire personnel that were previously fired leaves us at a crossroads. I do not believe it to be fiscally responsible to put individual rooms with separate air controls back in the SNU if we can't staff it with staff the genuinely want to work. I would like to decertify the rooms in the SNU, remediate the mold and look at turning that area into an activities area. It will increase your per diem and I think you will be able to hire quality people regardless of whether the center stays in Talihina or moves to another location. Take the weekend to think about it and let me know your thoughts on Monday.

The administrator responded with the following on June 12:

> I understand your concern but I will have to respectfully disagree. This Special Needs Unit is important to the state of Oklahoma. If you review the November and December 2016 numbers the facility did not have staffing issues, RN vacancies 2.5 and LPN vacancies 6.5, but after the barrage of negative media the staffing was effected. We do have quality people caring for America's heroes at this facility and if any staff member was terminated for abuse/neglect they are not eligible for re-hire.
>
> I do believe decertifying the beds with the coming construction is the appropriate decision but re-certifying these beds will return revenues as previously projected.
>
> Although I disagree, I will support the decision made in this matter by you and Director Deering.

It has been represented by management at certain times that low staffing levels at the Talihina center were one of the main reasons for closing the SNU and for relocating the center. In their December 2017 response to allegations, management indicated that the Talihina turnover rate for certified nursing assistants (CNA) was 100 percent. They went on to claim that turnover is approximately 50 percent at all of the other centers, even in metro areas where more competition exists.

We summarized the hires and terminations at the agency by location for fiscal years 2015, 2016, and 2017. While the terminations were significant at the Talihina center, they did not appear to differ greatly from or exceed the other centers when accounting for their size and terminations likely related to the SNU closure. (Veteran counts by center are included in the table on page 53.)

Terminations	Claremore	Ardmore	Clinton	Norman	Sulphur	Talihina	Lawton	Central Office	Others	Total
FY 15	225	83	91	304	99	153	196	5	7	1163
FY 16	322	97	97	271	102	161	199	2	13	1264
FY 17	248	84	101	284	70	190	168	6	13	1164

Source: Statewide accounting system HR records

In reviewing the hires for the same time period, it appears all seven centers trended toward hiring fewer individuals than were terminated, and this was the case for all centers in FY 2017, and for Talihina in each fiscal year.

Hires	Claremore	Ardmore	Clinton	Norman	Sulphur	Talihina	Lawton	Central Office	Others	Total
FY 15	261	104	116	306	96	133	193	3	8	1220
FY 16	326	98	103	268	85	154	203	7	16	1260
FY 17	188	69	72	275	42	120	120	3	21	910

Source: Statewide accounting system HR records

Throughout our interviews, administrators and staff at every facility noted that turnover in the Patient Care Assistant (PCA; this is another name for the CNA position mentioned earlier) position is a huge concern. It is also significant that the agency now hires PCA/CNA employees with assistance from the Galt Foundation who, in exchange for an administrative fee, recruits staff and arranges interviews. It appears employees were not regularly hired through Galt until FY17, although they were used for temporary services, such as moving and assembling furniture, during FY15 and FY16. According to statewide accounting system records, ODVA paid over $2 million to Galt in FY 2017. The marked drop in hires in FY 17, coupled with the situation discussed on page 9 in which Galt employees have lost their previously promised opportunity to become state employees after one year, suggests they are not included in the statewide accounting system and therefore not represented here. This presents a complicating factor in interpreting turnover figures, including those presented publicly by management.

Many legislators continue to be at odds over relocating the Talihina center, but during the 2018 Legislative session, HB 3042 passed, creating the Oklahoma Veterans Facility Investment Act of 2018. The bill reads in part:

A. The Oklahoma Department of Veterans Affairs is authorized to plan, develop and construct a long-term care facility for the purpose of assuming the operations of the Oklahoma Veterans Center established in Talihina pursuant to Section 229 of Title 72 of the Oklahoma Statutes. The Department may construct new facilities or refurbish any existing facilities on property currently owned by the State of Oklahoma or on property purchased or donated from other sources, including but not limited to private owners or other governmental or municipal entities.
B. The location of the facilities shall be subject only to such geographical constraints as are imposed by the United States Department of Veterans Affairs to preserve and continue recognition and certification of the facility as a State Veterans Home.
C. The location and site of the facility shall be determined by the Oklahoma Veterans Commission. The Oklahoma Veterans Commission may consider any and all criteria which, in its sole discretion, further the interests of Oklahoma veterans.
D. Operations of the Oklahoma Veterans Center established in Talihina pursuant to Section 229 of Title 72 of the Oklahoma Statutes shall continue until such time as its operations are transferred to the location identified pursuant to the authority.

As one of the authors of the relocation bill, Representative Chris Kannady, R-Oklahoma City stated in the Tulsa World, "The way we improve it is to move it. If it remains the same, that facility will close. Whatever (the new facility) is in five years, it will be significantly better than (Talihina) is now."

The move of the center was bitterly opposed by Rep. Brian Renegar, D-McAlester, in whose district the center is located, but was backed by several veterans in the House who say the aging Talihina center is not viable in the long term. It is unclear whether the legislators performed independent research to support this stance or based their opinions on statements from ODVA management. It should also be noted that this bill gives the authority to determine the location and site of the new facility to the Commission, which, as discussed on pages 22 and 23, may not be fully in touch with operations at the center level.

Following a 2017 interim study regarding the center that he spearheaded, Representative Renegar released a statement that included the following refutations of some of management's concerns:

> An ODVA spokesman told a Fort Smith, Ark., television station in February that maintenance of the 100-year-old Talihina center is expensive. He also said it's difficult to recruit doctors to the facility. The town has had some issues with its water system, as well, the ODVA contends.

> "We have spent approximately $5 million to upgrade our water facility in Talihina," said Mayor Don Faulkner, who attended Renegar's interim legislative study last month.
>
> He also said the Talihina center is constantly being renovated and has been up-to-date since 2004. "Talihina is actually one of the better centers and the facility with the lowest turnover rate in nurses and employees," he told KFSM-TV.
>
> Roy Griffith, who was the administrator of the Talihina Veterans Center for 25 years, said it's a great place to live and work. He, too, disagreed with the ODVA's findings. "I just don't know where this is coming from," said Griffith, who also attended Renegar's study.

The press release also noted that no one from ODVA attended the interim study, and only four of the nine members of the House Committee on Veterans and Military Affairs were in attendance.

Additional Information Related to Capital Project Cancellations

HVAC Replacement and Mold Issue

According to Talihina Center staff, in March 2015, the Talihina administrator informed central management that the SNU needed a new HVAC system, and budgeted the project for fiscal year 2016. Documentation provided to the ODVA construction programs administrator in early April 2016 suggests a professional engineer had developed a proposal for HVAC system replacement at the center, and outlines a detailed plan designed to minimize disruption within the SNU and to maximize efficiency, with considerations tailored to residents' needs based on the engineer's experience with a previous duct replacement project at the Sulphur center. This plan included replacing air handling units, fan coils and attached heating and chilled water piping serving them (all of which the engineer states need to be removed from service), and the duct system, which the engineer states is only sized to handle the outside air portion of the system, about 20% of the total volume of circulated air. The following is an excerpt from the letter outlining the plan, dated April 6, 2016:

The only ductwork serving the residential and support areas is sheet metal with insulation liner (internal insulation). As we have previously indicated, the use of internal duct lining in a healthcare setting is considered a health risk and cannot be cleaned. The mold found on the duct liner at the Sulphur project required the ductwork be totally removed, since the liner could not be

cleaned. Nor can the liner be economically stripped from the ductwork so that new "wrap" insulation could be installed (that is more expensive than removing and replacing the duct with new).

The main issue about re-using the ductwork serving the residential areas is that the duct is very small compared to the size required for an all-air system to deliver air to each room. The existing installation primarily uses ductwork to bring outside air to each room, with one VAV box serving up to 6 rooms (i.e. no individual control). The rest of the load is served by ceiling mounted fan-coil units that circulate the room air, heating and cooling as dictated by the season. The fan-coils are served by the existing chilled water and heating water piping. All of the fan-coil units need to be retired.

The existing ductwork described above is not large enough to handle the HVAC load of the areas served, since it was only sized for the outside air portion of the system (about 20% or less of the total volume of circulated air that is required to properly handle the load).

In addition, the heating and chilled water piping serving these fan-coil units is deteriorated and needs to be removed from service. The piping runs above the corridor ceilings and branches off into each room. Adaptive re-use of this piping is not possible (to serve replacement fan-coil units, as an example).

Management chose to have the building tested for mold, and Terracon Consultants, Inc. conducted. The scope of the project included collecting surface samples within the air duct system of the building and collecting air samples for culturable and non-culturable mold spores from within the site building. The inspection results, conclusions, and recommendation are as follows:

5.0 RESULTS

The laboratory analytical results for the surface mold sampling conducted at the on-site facility are attached in Appendix A. The total results are summarized below:

1. Mold was present from the mechanical room AHV#2 access point;
2. Mold was present from the mechanical room AHV#1 access point;
3. Mold was present from the north basement SNU return access point;

4. Mold was present from the diversional activities hallway return;
5. Mold was present from the diversional activities hallway air supply;
6. Mold was present from the doctor's office hallway west hall coil duct;
7. Mold was present from the SNU–W–200 coil duct;
8. Mold was present from the SNU-E-172 coil duct;
9. Mold was present from the SNU central hallway duct trunk; and,
10. Mold was present from the SNU-N-153 coil duct.

The laboratory analytical results for the airborne mold sampling conducted at the on-site facility are attached in Appendix A. The total results are summarized below:

1. The total airborne non-culturable mold spore concentration in the conference room was 147 counts per cubic meter of air (counts/m^3). The total airborne culturable mold spore concentration in the conference room was 127 colony-forming units per cubic meter of air (CFU/m^3).
2. The total airborne concentrations in the physical therapy room were 507 counts/m^3 and 163 CFU/m^3.
3. The total airborne concentrations in the sitting area were 853 counts/m^3 and 35 CFU/m^3.
4. The total airborne concentrations in room 192 were 1,133 counts/m^3 and 197 CFU/m^3.
5. The total airborne concentrations in room 150 were 52 counts/m^3 and 63 CFU/m^3.
6. The total airborne concentrations outside of the site building were 1,773 counts/m^3 and 155 CFU/m^3.

6.0 CONCLUSIONS

The results of the swab sampling indicate the presence of mold within the areas of the HVAC system that were tested.

The results of the air sampling indicate that the types of the culturable and non-culturable mold spores identified in indoor air in the conference room, physical therapy, and room 150 were generally similar to those found in outside air and mold spore concentrations indoors were less than those found outside; consequently, the primary source of the indoor airborne mold spores in these rooms is likely to be outdoor air rather than spores released from indoor mold growth.

The results also indicate that concentrations of *Aspergillus/Penicillium* Group spores in the sitting area and *Aspergillus/Penicillium* Group and *Stachybotrys* spores in room 192 were greater than found in the outside air; consequently, the primary source for these spores is likely indoor mold growth. This is supported by the identification of culturable *Penicillium* in these rooms but not in the outside air. The highest concentration of culturable *Penicillium* was found in room 192 (155 CFU/m^3).

7.0 RECOMMENDATIONS

Terracon recommends the following:

- Clean the duct system. Cleaning should be done by a professional certified by the National Air Duct Cleaners Association (NADCA).
- Additional investigation to identify the source(s) of mold growth and reason(s) for excess moisture.
- Thorough inspection of the spaces to determine if water-damaged materials and/or mold growth are hidden by walls, ceilings, furnishings, and equipment.
- Small areas of mold growth can be removed using detergent and water.
- Suspect ACMs that will be disturbed if remediation is required should be sampled prior to disturbance by a licensed asbestos inspector and analyzed by an accredited laboratory. If the materials involved in the remediation contain asbestos, they must be removed prior to any disturbance that could create an airborne asbestos hazard for workers or building occupants.
- Once the source of excess moisture is identified and repaired, if extensive mold growth is present, remediation by an experienced mold abatement company should be conducted in affected areas.
- Environmental testing should be performed following the remediation to ensure the effectiveness of post-remediation air and surface cleaning.

Source: Terracon Consultants, Inc. Report on project No. 04167092

After the mold was identified, the administrator indicated that an estimate of $50,000 was received from Office of Management Enterprise Services (OMES) to clean the ventilation system. However, central management elected to close the SNU. In December 2017, management explained that the Terracon mold report failed to mention that the duct has an internal liner for which cleaning is costlier than replacing (and, per the previous engineer's letter, potentially a health hazard). Management also indicated that OMES concurred in the ODVA's assessment that cleaning of the duct was not a feasible option, although we were not provided evidence of this.

Interestingly, none of these mold discussions appear to address the aspects of the initial HVAC replacement plan that call for new air handling units and the retirement of fan-coils and related heating and chilled water piping. Mold abatement and duct replacement would not address the need for HVAC improvements to the equipment handling the other 80% of airflow.

Eventually the SNU was closed and patients were removed from that affected area. However, according to staff members at the Talihina center, the same ventilation system feeds into various other sections of the building that are still being used today. These areas still in use by both staff and veterans include the physical therapy room, exam rooms, and stock rooms.

Nurse Call System

We received documentation of a purchase request for an upgrade to the Nurse Call Responder 4 project at the Talihina Veterans Center that was approved by the CFO and director on June 12, 2017. The center administrator had been informed by the distributors that this nurse call system had reached its "end of life" and that replacement parts and repairs were no longer available.

On July 31, 2017, Governor Mary Fallin gave the ODVA director the directive that "no funds be expended on the infected wing of the Talihina Veteran Center until we thoughtfully and thoroughly consider the best options for moving forward and providing the level of care that our veterans deserve." See the full letter:

Mary Fallin
Governor

July 31, 2017

Myles L. Deering, MG (USA Retired)
Secretary of Veterans Affairs
Oklahoma Department of Veterans Affairs
2311 N. Central
Oklahoma City, OK 73105

Dear Secretary Deering:

I write with concern regarding the persisting mold issue at the Talihina Veterans Center. I support your decision to shut down the entire wing of the facility that is affected in order to protect residents and staff from exposure. Providing quality care and a safe home environment for the men and women who served our country remains a top priority to me, as I know it does to you too.

I also know that there are no easy solutions to this issue; each option comes with its set of drawbacks and financial quandaries. For this reason, as Governor of the state of Oklahoma, I request that, life-critical situations excepted, no funds be expended on the infected wing of the Talihina Veterans Center until we can thoughtfully and thoroughly consider the best options for moving forward and providing the level of care that our veterans deserve.

Sincerely,

Mary Fallin

Mary Fallin
Governor

On August 1, 2017, the deputy director emailed a copy of this letter to the Talihina administrator with the message, "Please see the attached decision by the Governor concerning future capital improvement at Talihina." When the center's administrator argued that not updating the call system was a life safety concern as there were remaining veterans residing at the center that were not in the infected area, the matter was forwarded to the central office clinical compliance nurse, who asked the administrator essentially to prove that not updating the Nurse Call System was a life safety concern. The administrator provided detailed

information from discussions with the system manufacturer and distributor and related documentation, including the approved purchase request (which lists the reason for replacement as "old system no longer able to be repaired") and a letter from manufacturer Rauland-Borg Corporation stating, "In order to ensure the continuity of your life safety nurse call system, please contact your local Systems Integrator to create a strategic plan to upgrade to Responder 5." It also states that they will honor the Responder IV's warranty as long as they can continue to procure required components, suggesting that this may become difficult.

The deputy director and clinical compliance nurse responded with further questions about parts availability, then asked the central office construction programs administrator to verify the information provided. Her response was as follows[11]:

"I've known that the Responder IV system is nearing functional obsolescence meaning Rauland is no longer manufacturing parts for that version of the system. I have a call in to my contact but from what I understand parts can be shipped to them for repair but at some point in the future they cease to provide that type of support. I don't know when that will be (could be 6 mos., 1 yr., or 2-3 yrs.). So yes the system can be repaired for right now."

Based on this opinion, the clinical compliance nurse informed the Talihina administrator that "Based on the information provided by [the construction programs administrator] we will not be replacing the system at this time. That isn't to say we won't in the near future but it doesn't seem to be as big of an emergency as reported earlier." Although the construction programs administrator's email clearly stated that she had "a call in" to her contact, and had therefore not actually yet verified the Talihina administrator's statements, these instructions that "we will not be replacing the system at this time" were emailed only six minutes later.

Once again, the administrator reinforced not updating the Nurse Call Responder system was a life safety concern and should not be dismissed, the administrator also provided the contact information for the representative for Rauland Borg and stated the representative would be willing to speak with anyone about the matter. The clinical compliance nurse then sent the construction programs administrator instructions that "should the system go down they would be replacing quickly and to put together a POC should we be required to repair in an emergency situation."

The decision to avoid preventive maintenance of the nurse call system could easily be interpreted by the average citizen as management not prioritizing the veterans' wellbeing. The Governor did give the directive to not expend funds on the infected wing, due to the reported mold

[11] Minor typographical errors have been fixed for ease of reading.

issues; however, there was no such language that would have given central office permission to not update crucial lifesaving medical equipment; her letter specifically says "life-critical situations excepted." The Nurse Call System plays an integral role in basic veteran care, allowing the veteran to push a button and notify medical staff of a possible medical emergency. In the instance a veteran is bed ridden or there is a medical reason that prevents a veteran from verbally being able to ask for help, the Nurse Call System provides an immediate notification to medical staff. Medical staff cannot properly and efficiently do their jobs without having reliable medical equipment.

Management's dismissal of an administrator's concern that there is a risk that could adversely affect a veteran in their care is illustrative of the tone at the top of ODVA's administration discussion earlier in this report. Additionally, reluctance to update lifesaving equipment until it has failed does not appear to support the ODVA mission to "provide to Oklahoma Veterans and their families residing in the State of Oklahoma the highest quality services and care available anywhere in the Nation."

According to the central office, the centers in Norman, Clinton, Claremore, and Lawton use Responder 5. The Sulphur center has Responder IV on Units 1,2,3,6 & 7, while units 4 & 5 have Responder V system. Clinton has the Rauland Responder IV/4000 Nurse Call System. It appears the agency has seen fit to outfit some centers with the more recent version of the Responder nurse call system. The other centers or units are potentially at the same risk for failure without possible replacement or repair as is the Talihina center.

Boiler System

The records of audit period ODVA Projects we reviewed also included a steam boiler replacement project in the amount of $310,498.81 that had been cancelled at the Talihina Veterans Center. During our interviews we had been told that a steam boiler project at the center was approved and subsequently canceled, which led to the center incurring a multitude of emergency repair costs. We obtained a copy of a purchase order for this steam boiler replacement signed by the CFO and director in June 2016, but did not encounter documentation as to why it was later canceled. According to center management, many boiler system repair costs have been incurred since that time.

Employee Perspective

Staff are clearly uncertain of the direction management has chosen for the Talihina center, and particularly the motivation or reasoning for that direction. There are no clear lines of communication about the future or how and when the changes will occur. The comments gathered through our employee surveys are a true reflection of how individuals feel and

what they believe the situation to be, and often frankly express the conviction that central office is sabotaging the Talihina Center in order to close it by firing employees, removing medical equipment, closing the SNU for unclear reasons, not allowing input from veterans, and allowing holds to be put on admissions. The following is a sample of comments received, in the survey respondents' own words:

- Central Office is leading the charge to have our facility relocated, at any cost. Our SNU has been closed and I have heard 3 different excuses for this closure: 1. mold in the air system which staff and residents are still being submitted to each day as it supplies air to other areas of our building, 2. Staffing – our direct care staffing numbers do not indicate staffing is an issue, 3. Admissions – the most recent excuse that our director stated during the hearing for the Nurse Practitioner. I'm not sure Central Office know why they directed the SNU to be closed.
- In normal circumstances a new building for veterans is a good thing, but it's my understanding that the new building model would not meet the needs of a large majority of our current resident population, leaving families with the burden of taking care of our veterans.
- The center at Talihina has been portrayed in a terrible light in the media and rather than fix things wrong in the building central office personnel are seeking to abandon it and move it to another town so it will be a "feather in their cap". I have been told that the mold in the Alzheimer's unit is very fixable and the whole building does not need to come down.
- Central office has refused to fix life safety issues at Talihina while fixing them at the other centers. One is the nurse call system which is in the infirmary part of the facility. Without it we would have to close rooms and not admit residents. This system is needed to install another type of wander management system for dementia residents. Without it we cannot keep residents that show dementia signs. They have to be discharged or not admitted at all at Talihina.
- [The audit period deputy director] loves to send E-mails with a double meaning. He said his main agenda is to close Talihina. Now how stressful would you say that would be for someone with kids . . . . And there are very little to no jobs in our area. Please help these state employees.
- I would like to know why they have chosen to attack Talihina in the papers? If Central Office wanted to close the Talihina center – why did they choose to lie, tell ½ truths + slander one of their own centers? Why not just close it?
- It appears Central Office is trying to divide the staff at Talihina – encouraging an atmosphere of distrust – manipulating the administrative + upper level nursing till you can't trust anymore.

Two survey comments addressed fears of additional centers being closed, alleging that the deputy director

- "has said in a public meeting he was going to bulldoze Ardmore, Sulphur, Clinton, and Talihina centers because they were not good enough for America's heroes. Sulphur has had renovations and new buildings over the past several years."
- "told administration at the Sulphur center that he plans to shut down 5 of the 7 state veterans centers. This is a direct contradiction to what he has been telling legislators and news media about closing only the Talihina center. Another lie."

Once again, we must note that no matter the level of veracity of employees' beliefs, central management does not appear to be doing anything to refute them, and those beliefs damage morale and increase risk.

Whether or not a different facility eventually replaces the Talihina center, one key fact is clear: there are residents living in that center today, and employees working there, and by all appearances that will continue to be the case until a new facility can be made ready. Estimates for that time period have typically been in the range of five years. Providing care for these residents in the interim necessitates that the agency maintains the center at an acceptable level, staffs the facility adequately, and supports that staff in providing care and operating the center.

Management's negative statements about the Talihina center in the press might give the impression that they are not responsible for the condition of the center, even as they centralize various functions, removing facets of the center's autonomy one by one. Based upon our surveys and interviews, Talihina center staff is clearly convinced that central management has a vendetta against the center, and fears for their jobs and residents' wellbeing. As previously discussed throughout this report, the toxic environment at the agency and breakdown in communication that are impacting all veterans centers have no doubt exacerbated the situation, and must be rectified if the center is to regain the internal support needed to care for its residents today, no matter where they may be relocated in the future.

RESULTS OF PROCEDURES AND EMPLOYEE SURVEYS

As discussed beginning on page one, after feeling that our access to reliable, independent information related to center operations had been compromised, we ceased detailed procedures and moved forward to report on the current environment at ODVA. The following information comprises the results of our procedures as they then stood, as well as related information from our survey of ODVA employees. These topics may also be discussed in terms of the agency environment and level of care in previous report sections.

Sources of Revenue

The agency's main sources of revenue are federal funding, state appropriations, and institutional care charges.

Federal reimbursements include

- Per diem payments from the USDVA based on the veteran's eligibility, calculated based on the daily rate and the number of days that a Veteran has been a resident. (Over 95% of federal reimbursements are per diem payments.)
- Funding for ODVA construction projects that have been placed on the federally approved construction priority list; the USDVA pays 65% of the cost of construction while ODVA pays a 35% match. (Just under 4% of federal reimbursements)
- Funding for approving veterans for on-the-job training and apprenticeship programs, managed by the State Accrediting Agency. (Less than 1% of federal reimbursements)

State dollars are appropriated by the Oklahoma legislature. During our interviews and review of press articles, we noted that management often references this decrease when discussing the need for changes within the agency and cost-cutting measures. While ODVA's state appropriations decreased by nearly 13% during the audit period, this resulted in their overall revenues decreasing less than 3%, and it appears federal revenues increased nearly 9%. See table below for details. Overall, the agency's revenues fluctuated but did not actually decrease between FY 2015 and FY 2017.

Institutional care comprises care and maintenance charges collected from the residents who are not eligible for federal per diem reimbursements (i.e. not 70% or greater service-connected disability). These charges amount to 85% of the resident's income, or 50% for residents contributing to the support of legal dependents, with a current cap of $3,925/month (with additional specifications outlined in 72 O.S. § 63.5). The agency noted that this funding is used for the general operations, state match for construction projects and financial assistance.

Revenue sources bringing in less than $150,000 over the three fiscal years (and totaling less than a tenth of a percent of the agency's income altogether) are grouped as "Other Revenues" in the table. These minor revenue streams are derived from various sources and include sales and auctions of assets, court awarded judgments, other sales and services, and commissary and concession income.

	FY 2015	FY 2016	FY 2017	TOTAL	% of total
Federal Reimbursements	88,285,119	96,643,990	96,159,462	281,088,571	60.96%
Net appropriations	34,396,712	31,005,211	30,011,916	95,413,838	20.69%
Institutional Care	28,889,625	26,520,378	26,592,967	82,002,970	17.78%
Other Grants, Refunds, & Reimbursements	858,995	51,151	-	910,146	0.20%
Food & Beverage Sales	256,510	260,834	237,777	755,122	0.16%
Refunded Money Prev. Disb - Gds & Svc	342,896	109,232	157,055	609,183	0.13%
Other Revenues	89,893	156,035	94,756	340,684	0.07%
	$ 153,119,750	$ 154,746,831	$ 153,253,933	$ 461,120,514	

Source: Combining Trial Balance reports from Statewide Accounting System

Budgeting of Carryover Funds

Carryover budgeting is handled by central office accounting staff as part of the overall budgeting process, which is overseen by the Office of Management and Enterprise Services (OMES). According to the CFO, the centers' three funding sources are handled as follows:

- The general appropriations budget is typically fully expended on payroll and operations, or any carryover is re-budgeted in the next fiscal year for the same purposes.
- Revolving funds are budgeted for center operations and capital projects, and carryover is pooled for budget preparation and split between operating and capital budgets as needed.
- Federal funds are budgeted for operations and capital projects, and carryover is used to offset reductions to appropriations, for major maintenance and repairs, and for grant projects.

Our initial interviews suggested center administrators and business managers submit annual budget drafts to management and otherwise have little control over how funds are transferred between locations. Staff at some centers suggested the budget is volatile, with regular changes made by central office without explanation. However, they generally believed their budgets were adequate and in fact expressed that they did not understand some "cost-saving" measures effected by the central office when there were funds remaining in their budgets. See discussions regarding MDS coordinators, general staffing concerns, and other potentially cost-cutting measures throughout this report section.

Annual Budgets by Location

Using data from the statewide accounting system and approved budget reports, including revisions, provided by the Office of Management and Enterprise Services (OMES), we compiled the annual budgets for fiscal years 2015 through 2017. The table below provides the centers' annual budgets in terms of average number of veteran residents. Also presented are annual budgets for Central Office and "Other," which consists of Information Technology, Claims and Benefits, Capital Lease, Veterans Services, and Financial Aid.

Budget Comparison Analysis

Fiscal Year	2015			2016			2017		
Center	Annual Budget	Avg. Number of Veterans	Budget Breakdown Per Veteran	Annual Budget	Avg. Number of Veterans	Budget Breakdown Per Veteran	Annual Budget	Avg. Number of Veterans	Budget Breakdown Per Veteran
Claremore	$26,318,037.00	289	$ 91,065.87	$26,640,537.00	287	$ 92,824.17	$26,706,385.00	284	$ 94,036.57
Ardmore	17,924,277.00	168	106,692.13	18,470,594.00	169	109,293.46	18,107,273.00	167	108,426.78
Clinton	16,091,071.00	145	110,972.90	16,829,101.00	143	117,686.02	16,009,570.00	145	110,410.83
Norman	26,419,023.00	297	88,952.94	27,038,930.00	299	90,431.20	26,766,461.00	296	90,427.23
Sulphur	14,239,098.00	109	130,633.93	14,635,214.00	115	127,262.73	13,953,467.00	117	119,260.40
Talihina	18,202,224.00	175	104,012.71	18,165,181.00	174	104,397.59	18,141,131.00	153	118,569.48
Lawton	20,395,099.00	195	104,590.25	21,043,435.00	196	107,364.46	20,475,943.00	196	104,469.10
Central Office	3,636,408.00	-	-	4,333,467.00	-	-	3,537,016.00	-	-
Other	6,582,332.00	-	-	6,662,491.00	-	-	7,439,025.00	-	-

The noticeable drop in Talihina's average resident count in FY 17 is due to the closure of the center's Special Needs Unit; see further discussion beginning on page 32. Note that central office figures in this table do not include central IT costs (included in Other).

FY 2018 Budget

When compared with the data in the previous section, the agency's budget for FY 2018 presented higher expenditures for most locations, with a significant drop in Talihina and smaller drop at the Lawton center.

Budget Comparison Analysis

Fiscal Year	2015	2016	2017	2018 as of February 2018
Center/ Location	Annual Budget	Annual Budget	Annual Budget	Annual Budget
Claremore	$ 26,318,037	$ 26,640,537	$ 26,706,385	$ 27,182,189
Ardmore	17,924,277	18,470,594	18,107,273	18,532,912
Clinton	16,091,071	16,829,101	16,009,570	16,034,039
Norman	26,419,023	27,038,930	26,766,461	26,914,257
Sulphur	14,239,098	14,635,214	13,953,467	14,048,223
Talihina	18,202,224	18,165,181	18,141,131	14,967,984
Lawton	20,395,099	21,043,435	20,475,943	19,958,912
Central Office	3,636,408	4,333,467	3,537,016	4,254,910
Other	6,582,332	6,662,491	7,439,025	8,836,963

A comparison of the budget reports for fiscal years 2017 and 2018 also showed the following increases in central budgets, all of which are included in the "Other" category above and are therefore separate from the general increase in Central Office budget illustrated in the table:

- Central Administration IT (dept 8807011) increased 18%, from $2,378,787 to $2,815,672
- Veterans Services (dept 2000002) increased 38%, from $498,363 to $688,228
- Central Office IT (dept 8807001) increased 39%, from $38,800 to $54,000
- ODVA Commission (dept 1100002) increased 100%, from $5,500 to $11,000

Policies and Procedures

Over the past several years, central management has worked to centralize the agency's policies. Centers are permitted to develop procedures unique to themselves as long as they do not contradict or interfere with centrally approved policies. This is reportedly to ensure regulatory compliance and standardization prior to implementing policies, and center-unique procedures are required to be approved by the central office. However, some administrators expressed that they had center-specific procedures that had not been submitted to the central office for review. It stands to reason that, because each center is unique, individual procedures could be justified at the separate centers. Management may need to better communicate or enforce the requirement for central review of such procedures after discussion with the administrators.

ODVA policies are generally updated on a schedule, for regulatory and internal process changes and to ensure consistency, though not necessarily due to specific events. In the past, updates were distributed to the centers by the central office, but the agency now has an electronic system in place for handling policies and requiring staff acknowledgement of changes.

According to several interviewees and records obtained from the agency, in late 2016, all centers' nursing policies and procedures were removed from the agency intranet and replaced with one standard template set of policies. Reportedly, these policies were not provided to center administrators or medical staff for review prior to implementation, and initially lacked an index. This sudden change in policies and procedures created concerns within the centers that the removal of specific guidance previously put in place in response to inspections and peer reviews would leave them open to poor inspection results in the future. Center management also noted that without adequate time to review and provide training on over 1,000 pages of new policies, it is difficult to conform to, or to hold employees accountable to, those policies.

We received further concerned comments regarding the changing of policies and procedures (particularly these nursing policies) during our electronic surveys. These comments stressed that the centers' individualized, functioning policies were removed without warning and replaced with a set of unfamiliar, standardized policies, some of which did not apply to their operations. This left supervisors without time to review the policies or provide relevant training, and unable to enforce the policies with staff. Several survey respondents and staff members interviewed also brought up the implementation of reportedly unlicensed policies and subsequent legal threats from the company who owned them and payment to that company, claiming it was an embarrassment, an unwarranted expense when budget cuts were so frequently discussed, and an example of the level of ethics and competency at the central office.

It was also brought to our attention by several individuals that the standardized nursing policies may have been unlicensed, resulting in legal threats from the owner of those policies and subsequent payment to that owner. Our procedures led us to limited evidence of what central finance staff reported was a payment for such licensing; however, the size and timing of that payment did not line up with the allegations, and detailed documentation was not provided. We will recommend potential follow-up under Further Procedures at the end of this report.

Of 138 survey respondents with an opinion, 43.5% noted that they believe central office management "Seldom" or "Never" strives to comply with laws, rules, or regulations affecting the organization. Multiple comments referred to policy changes directed by central management occurring "on a whim," sometimes being quickly retracted, and creating chaos and confusion.

Cost per Bed

We were asked to provide the cost per bed at ODVA facilities. This was determined by verifying ODVA data on the applicable direct and indirect costs incurred, then recalculating the cost per bed using quarterly costs divided by quarterly patient days. The table below summarizes each center's average number of veterans per year and the corresponding cost per bed for state fiscal years 2015 through 2017 (July 1, 2014 through June 30, 2017). Also presented are total average veterans across the agency each year and the agency-wide average cost per bed, weighted by number of veterans at each center. Note that the significant drop in number of veterans at the Talihina center in 2017 is due to the closure of its special needs unit.

Fiscal Year	2015		2016		2017	
Center	Avg. Number of Veterans	Cost Per Bed	Avg. Number of Veterans	Cost Per Bed	Avg. Number of Veterans	Cost Per Bed
Ardmore	168	$288.28	169	$310.57	167	$289.98
Claremore	289	$246.63	287	$264.62	284	$256.27
Clinton	145	$306.89	143	$330.42	145	$302.80
Lawton	195	$295.02	196	$304.16	196	$275.95
Norman	297	$255.47	299	$258.92	296	$250.61
Sulphur	109	$354.09	115	350.19	117	$316.40
Talihina	175	$277.44	174	$292.60	153	$303.99
	Total Avg. Veterans	Weighted Avg. Cost per Bed	Total Avg. Veterans	Weighted Avg. Cost per Bed	Total Avg. Veterans	Weighted Avg. Cost per Bed
	1,378	$279.21	1,383	$292.05	1,358	$277.55

Service-Connected Compensation

We were initially asked to investigate the impact to the agency of the change in USDVA compensation for wartime veterans. However, this change took place well before the beginning of our audit period and before audit period management was in place. While eligibility and priority for admission to Oklahoma veterans homes are outlined in statute and in ODVA's administrative code, USDVA regulations (38 CFR 51.41) outline service connected compensation rules as follows:

Service Connected Compensation is payment for a disability that started or was aggravated while the veteran was on active duty. The amount payable depends on the degree of disability and the number of dependents. The veteran's income and assets have no effect on the amount of compensation.

Non-Service Connected Compensation is a non-service connected pension payable to any veteran who is permanently and totally disabled and who meets certain income and asset limits set by congress. The veteran must have served a minimum of 90 days active duty of which at least one day is during a wartime period. Income, unreimbursed medical expenses, and the number of dependents could affect eligibility and the amount of the pension.

The USDVA regulations state that the USDVA and State homes may enter into both contracts and provider agreements, through which the USDVA pays for each eligible veteran's care. Eligible veterans are those who

(1) Are in need of nursing home care for a USDVA adjudicated service-connected disability, or
(2) Have a singular or combined rating of 70 percent or more based on one or more service-connected disabilities or a rating of total disability based on individual unemployability and are in need of nursing home care.

In general, ODVA bears a much higher financial burden for non-service connected veterans housed at the centers. Changes described in other parts of this report, such as outsourcing of laboratory services and seeking to accept Medicare/Medicaid funding, may impact the costs to both the agency and veterans.

Central Office Travel Expenditures

In response to concerns about central management travel expenditures, we reviewed travel reimbursements to central office staff and commissioners, as well as direct payments and purchase card payments coded as travel in the statewide accounting system. Overall, the agency appears to have shifted from a high level of travel by commissioners in FY 15 to more agency employee travel activity and less commissioner activity in FY 16 and 17. Certain staff and commissioners attend one to two conferences per year; while these conferences involve out of state travel and airfare, they are hosted by national organizations and offer relevant training opportunities, and in our experience, this volume of travel is not unusual for an agency this size. Overall travel cost fell markedly during the audit period.

FY 2015	FY 2016	FY 2017
$ 71,402	$ 39,447	$ 31,185

Total expenditures in departments 1100001 and 1100002 (Central Office and Commission), account codes beginning with 521 and 522 (travel)

Source: Statewide Accounting System expenditure records

It should be noted that ODVA does have vehicles, and agency vehicle use would not be reflected in the above figures. They are also based on department and account code classifications assigned by central finance staff; controls over the accuracy of these classifications were not examined as part of our procedures. Training costs are included in account codes beginning with 522 and often incorporated with travel claims.

Statutory Exemption Allows ODVA to Hire Attorney

We received questions as to whether the agency had AG permission or an exemption from statutory requirements in order to hire its own attorneys. 74 O.S. § 18c exempts ODVA from the statutory prohibition against agencies hiring or appointing attorneys. This exemption became effective April 11, 2016 and is currently in place through January 1, 2022. ODVA hired an attorney on May 16, 2016, as permitted by this statute.

Contracts with Arts Council and Related Issues

We were made aware of concerns related to contracts between the agency and the Oklahoma Arts Council for an art education pilot project, as well as the motivation behind these contracts and the methods of payment used. ODVA has signed two contracts for services from the Arts Council in recent years: one at the Norman Center in 2015 for $9,400, and one at the Lawton center in 2017 for $10,000. The Norman payment was made from the Veterans' Benefit Fund, a portion of resident trust funds and donations designated for expenditures that benefit the residents, as justified by the art classes provided under the contract being for the residents. The Lawton center, however, made arguments against this funding source and payment was made using appropriated dollars from their operating budget, as directed by the central office.

While we had heard allegations that a member of the Arts Council was somehow connected to a member of ODVA management at the time of these agreements, the director of the Arts Council stated that she personally contacted ODVA of her own volition and presented the pilot project. Both the Lawton and Norman Arts Council agreements were signed by the ODVA director. The center administrators reportedly had no prior knowledge or input into the agreements, and did not necessarily approve of the projects.

We noted some irregularities with the Lawton payment: the contract was signed and the original invoice received before any authorizing paperwork (such as the Departmental Purchase Request required in advance for all purchases by ODVA SOP 330.2) was prepared. The business manager had concerns with this timeline as well as other aspects of the project; these concerns were provided to us in memo form and documented in emails to the central office and administrator at the time of the payment. However, in the business manager's understanding she was instructed by central office personnel to pay the invoice in spite of her concerns about noncompliance with purchasing rules. These emails also documented concerns by the administrator that the Arts Council's services could be provided by volunteers and that she was unsure what the center was paying for. We reviewed documentation showing that the original invoice was dated April 28, 2017, a requisition signed by the administrator on May 17, 2017, and the same invoice then revised with a date of May 18, 2017.

Both contracts also included a requirement that full payment be received within 30 days of the agreement being signed. The Norman Agreement was signed on December 29, 2015, and payment was made on March 1, 2016. The Lawton Agreement was signed March 24, 2017, and was paid May 18, 2017. Both payments exceeded the 30-day deadline.

We considered whether these contracts were reasonable given the agency's mission to provide "the Veterans residing in the state of Oklahoma the highest quality support and care available anywhere in the Nation." The written agreements do appear to outline services that could

be beneficial to the veterans in terms of learning and engagement opportunities in creative writing, visual arts, and music. Multiple staff members with firsthand knowledge of what services were provided to the veterans expressed the view that the cost was not reasonable and the services could have been provided by volunteers free of cost. In addition, the Lawton agreement included the results of a resident survey that had been conducted. We noted that veterans did not express a high level of interest in the Arts Council Program. There were 75 veterans that responded to the survey and 46 of those expressed an interest in arts instruction. With an average of 196 residents at the center in 2017, this is less than a quarter of residents. Even fewer expressed interest in the classes that were eventually offered. No similar survey data was included in the Norman contract.

We reviewed ODVA expenditures in the state-wide accounting system for payments or transfers to other state agencies and did not note anything of concern. However, records of payments from the veterans' trust funds and benefit funds often do not record the specific vendor or payment recipient, instead listing general vendor names "Oklahoma Department of Veterans of Affairs" or "Refund Vendor," making analysis of such records extremely difficult. The risk related to these funds is compounded by the fact that the centers write their own vouchers and make cash disbursements from the funds, and by the recent removal of business managers from the veterans' centers, resulting in reduced accounting staff size, and likely impacts of such a change on the segregation of financial duties in these locations. We have therefore included a recommendation at the end of this report that further examination of these funds occur in the future.

ODVA Employee Bonus Programs

We were asked to research employee bonus programs in place at ODVA. Several bonus programs have been in place at ODVA over varying timelines:

- Prior to the audit period, the agency began the Peer Review Performance Recognition Program, which paid $500 annually to primary peer review team members and $250 annually to secondary members. Peer reviews are no longer performed and according to management, this program ended in January 2015.
- Under a pay for performance program corresponding with state merit rules (Merit Rule 530:10-7-27) and approved by OMES Human Capital Management, ODVA paid bonuses through a Pay for Performance Program in May 2013 and April 2014. The plan was to provide a performance-based adjustment not to exceed 5% for "Meets Standards" and not to exceed 10% for "Exceeds Standards" performance. Per central office staff, funding was available for this program as the result of a payroll lapse in the

benefits budget, attributable to high volume turnover and the related replacement of some staff with temporary employees.

- In February 2017, in accordance with state merit rule 260:25-7-24, *Skill-based pay adjustments*, ODVA developed a Registered Nurse Clinical/Leadership skill-based pay incentive program. According to central office personnel, this is a 30.5 hour continuing education program offered through the agency's educational department and Healthcare Academy, focusing on teamwork, communication, leadership, and geriatric clinical skills. Each year the units change and the lump sum payment can progress by $500 as the employee maintains certification and continues with the approved courses, with an accumulative maximum of $3,000 annually.
- In March 2017, ODVA developed a Certified Medication Aide skill-based pay incentive program, again in accordance with related merit rules and with 74 OS 840-2.17 governing raises. Per central office personnel, this program provides Certified Medication Aides (Patient Care Assistants III) with a differential above the employee's base pay of 3.5% for enrollment into the Advanced Certified Medication Aide (ACMA) certification program and a 6.5% increase upon completion of the ACMA program, full-time on medication cart, 5.5 hours in the Clinical/Leadership Program, and certification in CPR.

Medicare/ Medicaid Funding: Software and Other Issues

We were initially asked to consider the requirements and potential benefits or downsides of upgrading the ODVA receipting system to accept Medicaid and Medicare funds. ODVA is already in the process of implementing a new software system across the veterans centers, called PointClickCare. According to our interviews with staff with private industry experience, this is a common software option for long term care. Opinions of PointClickCare's functionality and ease of use were mixed among the staff we spoke with and there were concerns about its implementation and compatibility; see earlier discussion page 12.

ODVA does not currently have the authority to accept Medicaid or Medicare as revenue, but is seeking legislative authority to obtain dual Medicare and Medicaid certification. According to management, "Members of the Veterans and Military Affairs Committee have requested information and have been briefed regarding the additional resources and services that would be made available to the State Veterans Home (SVH) residents and the Veterans Centers operations through Medicare and Medicaid funded programs." Legislation granting this authority is actively being considered as of the writing of this report.

In general, accepting these funding sources would require the centers to provide an increased level of skilled nursing care, subject them to various rules and inspections in order to maintain certification with the Centers

for Medicare and Medicaid Services (CMS), increase their bureaucratic workload, and expose them to related fines.

A 2016 article from the State of Michigan[12] detailed the steps that state was taking in order to pursue federal CMS certification by FY 2018. Michigan's governor suggested the move was critical to the long-term financial stability of the state's veterans' homes and would align its quality of care with best practices in the veteran health care field. The article states that to those ends, the governor's 2017 budget included $8 million to fund the certification process, including a supplemental to the state's 2016 budget of $1.9 million, to create a Medicaid pilot program. The program included a Medicaid consultant to provide guidance to the homes on the certification process, and additional nursing staff to accommodate CMS specifications. The other $6.1 million was for construction and infrastructure improvements also mentioned as necessary for the goal of CMS certification at both centers in FY 2018. The state had also already made some improvements toward this end, including implementation of electronic medical records, construction of family rooms and living rooms for visitors at the centers, and surveillance and security improvements.

This information suggests that seeking CMS certification is likely a lengthy and expensive process. While Michigan has only two veterans' homes to bring into compliance with CMS requirements, Oklahoma has seven, several of which are in aged buildings that are, as suggested by other procedures in this audit and the agency's statements in the media, in need of varying degrees of maintenance and repair. It appears Michigan prepared and budgeted far in advance of its goal year for achieving certification. While ODVA is still in the process of seeking legislative authorization, it would benefit the agency to do as much financial analysis and advance preparation as possible now, to help accommodate this lengthy process. This analysis should include consideration of necessary infrastructure improvements as well as staffing – not only to meet care requirements, but administrative requirements. While ODVA recently decreased the salaries of MDS coordinators (see discussion on the next page) and reduced fire and safety staff across the centers, the volume and importance of each of their duties may now increase.

It should be noted that during our procedures, ODVA management issued a response to public allegations that included a discussion of Medicare/Medicaid funding. It shows their understanding of the complicated issues at play:

[12] Michigan Veterans Affairs Agency, "State veterans homes pursuing Medicare, Medicaid certification," February 10, 2016. *https://www.michiganveterans.com/a/State-veterans-homes-pursuing-Medicare-Medicaid-certification*

Acceptance of Medicare/Medicaid would be welcomed by ODVA, but be advised Medicaid comes with increased oversight and the possibility of monetary fines. Furthermore, there is state match or FMAP of 40 percent for all Medicaid dollars. We have assessed our funding streams and determined there would be an increase of $38 million to our centers under Medicaid alone but the reimbursement to the Health Care Authority would be approximately 20 million. Michigan recently made a special appropriation to convert to Medicare/Medicaid as their buildings were also aged and in need of replacement. Their task force quickly determined increased federal funding from Medicare/Medicaid was needed, and passed a state appropriation of roughly $1.1 Million per facility to update their State Veterans Homes facilities in order to meet facility standards for CMS certification. Medicare funding would allow the centers to enter into the skilled nursing environment which would increase funding for certain residents. ODVA will need legislative approval to seek CMS certification for either Medicare/Medicaid as our regulations do not authorize the centers to consider Medicare/Medicaid as a funding source. Be advised that should ODVA seek Medicaid funding for the centers, then qualifying Veterans would be faced with spending down assets and subject to a five year look back for eligibility for Medicaid funding and services.

MDS Coordinators

MDS[13] coordinators are responsible for continuously monitoring, evaluating, and managing care given to residents. The coordinators are responsible for assessing and evaluating the quality of emotional, mental, and physical care being given to long-term care residents and develop care plans with long-term and short-term goals for improvement. They coordinate with specialists, caretakers and families. As one center administrator put it, MDS coordinators "are an intricate piece of the puzzle when it comes to the veteran's plan of care and vitally important during an inspection process."

It appears the centers are able to meet their MDS requirements with the current staffing level, but this level is considered minimal by most center administrators. HR records from the statewide accounting system reflect that during the audit period, each center had one MDS coordinator employed, and Board of Nursing data available online confirms that each of these individuals is an actively licensed RN. However, some administrators noted that it would be acceptable to function with only LPNs as MDS staff, with an RN signing off on care plans and transmitting MDS batches to the USDVA as required by regulations. The Claremore center administrator reported functioning effectively in this manner.

Several administrators emphasized that MDS duties are vital to resident care and the nursing staff experiences frustration with the current staffing levels, for example when the only RN assigned to MDS duties is out on leave. Most MDS coordinators received a salary decrease of over $5,000

[13] Minimum Data Set (MDS) is a tool for assessing the residents' capabilities in certified nursing facilities. MDS coordinators, or nurse assessment coordinators, use these results in creating resident's individual care plans, and are responsible for transmitting MDS data. The federal regulations regarding resident assessment are set forth in 42 CFR 483.20.

annually in summer 2016. This resulted in some MDS coordinators quitting, or taking on additional duties in order to avoid the cut. This pay cut was directed by central office and resulted in this position now earning approximately $53,000 per year.

According to information regarding the MDS coordinator profession on PayScale.com, MDS coordinators earned $45,257 - $82,041 annually as of January 2016, with a median salary around $61,000. We found examples of MDS nurse job opportunities in Oklahoma showing salary estimates of $45,000 to $65,000 and $48,000 to $78,000. It appears ODVA is compensating its MDS coordinators at a below-average level nationally and statewide. However, they do not appear to be at the bottom of the pay range, and do receive a State of Oklahoma benefits package. Multiple administrators also expressed that this salary cut resulted in the loss of quality employees and they believe the salary should be increased again.

Our discussions with administrators with experience in private nursing homes where Medicare or Medicaid was accepted suggested that MDS coordinators' work would increase with the introduction of these revenue streams. This is supported by our research, which suggests that the additional requirements and inspections inherent in CMS certification would be accompanied by additional administrative responsibilities and that data collection and care planning would fall to MDS personnel.

As MDS staffing is already at a minimal level according to the administrators, staffing in this area will most likely need to be increased when additional Medicare/Medicaid requirements are introduced, and may need to be increased as the agency goes through the process of seeking CMS certification. This may require the agency to restore the MDS coordinators' salary level or face difficulties hiring and retaining qualified nurses to handle these responsibilities.

Administrative Overhead

We received inquiries about the level of administrative overhead spending at ODVA. To efficiently isolate central administrative costs for these procedures, we consulted budget reports from the statewide accounting system and included the following departments: Central administration; Central administration IT; Central office IT (added in fiscal year 2017); ODVA commission (added in fiscal year 2017). As a result, the data is totaled by budget year associated with the expenditures, which does not necessarily reflect actual spending within each fiscal year.

FY 2015	FY 2016	FY 2017
$ 5,816,508.30	*$ 6,141,548.88*	*$ 5,960,562.19*

Total central administrative expenditures by budget year, per statewide accounting records.

Headquarters Move and New Building Renovation

In late 2017, ODVA relocated its central headquarters from an aged building west of the capitol to a newly renovated building a few miles away, near the Military Department and several other state agencies. While it was reported in the press that the headquarters move and renovation costs exceeded $3 million, the approximate $3 million renovation cost in the news reports was the value of the project on the state's Capital Improvement Plan, and was paid by OMES, not by ODVA.

ODVA has paid for other costs associated with the move, such as rent, office furniture, moving fees, and supplemental construction costs. These have primarily been paid using state appropriations, although a portion of office furniture costs were paid from the ODVA revolving fund. Construction costs included supplemental needs for the facility, such as a flag pole and OMES IT services. According to ODVA, there was $700,000 budgeted for these purposes in FY17 and the majority of that has been rolled into FY18, as some expenditures related to the move, for which ODVA is responsible, are still being made.

The following table details actual ODVA expenditures for the central office move, through December 31, 2017. Management reported additional, pending construction expenses of $33,071 and audio-visual costs of $107,171. Monthly rent payments of $13,028 are ongoing.

Funding Source	Rent	OMES-Construction	Office Furniture	Moving and Storage	Commercial Movers	Total Expenditures
Appropriations	$47,510.18	$23,361.00	$249,244.35	$1,843.44	$326.00	$322,284.97
Revolving Fund	$0.00	$0.00	$95,167.04	$0.00	$0.00	$95,167.04
					Grand Total	**$417,452.01**

Specialty Diets and Menu Standardization

Specialty diets (diets that limit residents regarding ingredients, calories, solid food, or otherwise for medical reasons) have been limited at the veterans' centers. According to central management, this is to ensure regulatory compliance as well as resident satisfaction. Administrators did not report any health issues arising from the removal of specialty diets as of our discussions in August 2017. While various diets may be prescribed for veterans, they generally have access to alternative foods and have the right to eat what they desire. Several administrators mentioned, and our research supports, that it is the industry standard in long-term care to liberalize diets, easing restrictions and allowing residents more flexibility in choosing their foods. While our veterans centers are not typical long-term care facilities, standards supported by CMS show that liberalized diets can be beneficial in various realms of medical care because patients have access to familiar foods and can increase their intake as needed, thereby decreasing their risk of malnutrition, honoring their personal preferences and dietary needs, and potentially improving their overall quality of life.

Management has also standardized the center menu agency-wide, although they stated that this change was not related to the elimination of specialty diets. If the agency's focus in providing a more liberalized diet is on improving the quality of life and overall nutritional intake of residents, those factors should also be kept in mind in handling the standardized menu. We did receive reports of resident complaints about some of the items on the new menu, the decreased number of options, and the fact that regional preferences had been disregarded.

Accessibility of EKG Machines and Crash Carts in Centers

We were asked to investigate management having allegedly instructed that EKG machines[14] and crash carts be removed from the floor at the veterans' centers. During our discussions with center administrators, no one confirmed having been instructed to remove crash carts. According to central management, the only directive given was to remove all drugs from the cart that were not allowed in regulations, and the Talihina center, under a new medical director, was the only one to voluntarily remove the crash cart from the floor.

During our meetings with center staff, we were told that center administrators had been instructed to remove EKG machines at their respective centers. Center personnel reported that this was due to central management concerns related to liability and the medical qualifications of individuals using the EKG results. When contacted for clarification, central management stated that the EKGs required a server update and were potentially going to be outsourced. However, management claims the directive to lock up the EKGs was never given; "one administrator made a decision to lock up the EKG in Talihina while other administrators asked for clarification and were given authorization to continue EKGs for diagnostic purposes."

Central management stated that after consulting with the Board of Nursing, they concluded registered nurses are not trained to read EKG results, and the decision was made to have only medical providers perform the EKGs. According to center administrators, management revoked the instruction that EKGs would no longer be available without giving a formal reason or explanation of who would be allowed to read the EKG results going forward.

We were provided a copy of an email sent to administrators by the director of clinical compliance, and while it did not include a directive to "lock up" the EKG machines, its language could lead readers to conclude EKG machines would no longer be used:

> "EKG's will not be available as of March 1, 2017 due to being removed from server they will not be transmitted. If EKG is

[14] Electrocardiography machines, used to record the electrical activity of the heart, commonly used to record patterns in heart activity and detect cardiac problems.

required the resident probably needs to be in a different setting (acute)."

Further confusing matters, at least one center reported having been granted informal permission for lab techs to read the EKG results. These informal exceptions to written policies and requirements were reported in several areas during our procedures, as discussed on pages 21 and 51. In such an environment, it's possible that administrators were individually given varying instructions.

As of January 2018, EKG machines and crash carts are present at the centers. The agency recently stated the following: "ODVA will provide our physicians access to EKG equipment for the physician to personally conduct an EKG within his/her discretion but not as a criteria for admission."

Outsourcing of Laboratory Services

Since late fiscal year 2016, ODVA has discontinued on-call laboratory services and terminated all clinical laboratory scientists at the veterans centers. There are one to two laboratory technicians remaining at each center, available Monday through Friday. Lab techs draw blood and perform dipstick urinary analyses, rapid flu testing, and x-ray services. They are responsible for ordering and processing specimens to send to the reference lab, receiving and charting results, and are completing training to perform occult blood and gastroccult testing. One lab administrator, working from the Norman center, is now responsible for the labs at all centers, including traveling to the centers statewide regularly for administrative purposes, and is on call 24 hours a day.

The majority of laboratory services are now outsourced to Hospital and Health System Executive Diagnostic Laboratory of Oklahoma, L.L.C. (DLO). Throughout our procedures and as discussed earlier in our discussion of Level of Care, this decrease in on-site services has been repeatedly cited as a major concern by ODVA staff as well as outside parties. As stated by ODVA in their response to State representative Mike Ritze, "Veterans centers are not acute care facilities and the luxuries of a 24-hour lab service is no longer feasible due to budget cuts." However, the agency has not completed a cost analysis of this outsourcing decision.

While an analysis was reportedly underway throughout the duration of our audit procedures, it had not been completed as of March 2018. According to central office personnel, the analysis covers a variety of information, including data on residents' insurance status and review of test type and frequency across agency and by center, all of which seems like it would have been pertinent and necessary for analysis before choosing to outsource laboratory activity. When the analysis is complete, if it shows minimal or no cost savings, or increased burden to the residents, management will be in a complicated situation, having already

outsourced laboratory services without this data to inform its decision making. In addition, details of the planned analysis provided by central office make no mention of incorporating information from medical professionals at the centers regarding the qualitative effects of this outsourcing on medical care.

Per federal guidelines (38 CFR, Chapter 1, Part 51, Subpart D § 51.210), if the facility does not provide its own diagnostic services, it must have an agreement to obtain these services. The services must meet all applicable certification standards, statutes, and regulations. Radiologic and other diagnostic services must be available 24 hours a day, seven days a week. According to the ODVA Laboratory and Radiology Programs Administrator, when testing was available in the centers the medical staff had diagnostic test results, including notification of critical values, within two to four hours. After outsourcing lab testing to DLO, results are not available for 24 to 36 hours. On weekends results can take up to four days. Critical lab results are called to the on-call medical provider 10 to 24 hours after the specimen is obtained. The inability to provide lab results in the facility can result in the veteran being sent to the local ER for evaluation and treatment. In this case, the lab administrator stated that veterans who are less than 70% service connected receive bills for all ER and ambulance services that are not covered by insurance or Medicare. Central office personnel claimed this is not the case; however, their contract with DLO outlines provisions for billing veterans.

We obtained a copy of the agency's contract with DLO, effective for a one-year term beginning June 1, 2017, signed 05/22/17 by Director Myles Deering. In summary, it outlines that DLO will bill the resident for any services not covered by ODVA, USDVA, or insurance. Under the contract, it is ODVA's responsibility to provide adequate information to facilitate that billing.

3.2. DLO will bill and LTC Facility shall pay DLO for laboratory services provided to the following classes of residents of LTC Facility, at the rates set forth in the fee schedule attached hereto as Exhibit A, which fees may be adjusted by DLO upon thirty (30) days prior written notice:

a. Residents for whom LTC Facility receives reimbursement from any payer that includes the cost of laboratory services in such reimbursement (for example, payments from the Veterans Administration or certain managed care plans when LTC Facility receives an all-inclusive fee for care provided to such residents);

b. Residents for whom LTC Facility acts as financial guarantor or as custodian of the resident's funds;

c. Residents with no insurance coverage for laboratory services;

d. If LTC Facility is a Skilled Nursing Facility ("SNF") or has a distinct Part A SNF, residents with Medicare coverage for the period of time they are in a Part A stay at the SNF;

e. LTC Facility's patients who receive hospice services from LTC Facility for which LTC Facility is reimbursed by Medicare or other federally funded programs or payors.

3.3 LTC Facility agrees to pay DLO within forty-five (45) days of the date of each DLO invoice for laboratory services for which it is billed, after which unpaid invoice amounts shall be overdue. In the event that DLO sends the account for collection and/or initiates litigation in order to collect overdue amounts, LTC Facility shall be liable for all costs and expenses of such collection and/or litigation, including reasonable Attorney's fees, court costs and expenses. Interest on late payments shall be calculated in accordance with 62 O.S. § 34.72.

3.4 Subject to Section 3.1 above, DLO will bill and collect from an appropriate payer all charges for laboratory testing services provided to residents with insurance coverage that requires or permits billing to the insurance carrier (for example, Medicaid, Medicare, Tricare, private health insurance, long-term care insurance, etc.).

3.5 LTC Facility is not responsible for payment of charges when the payer source is the individual resident and the resident or the resident's agent fails to pay.

Details from ODVA-DLO contract effective June 1, 2017

The contract also states that it's the facility's responsibility to ensure all tests ordered, including standing orders, meet federal and state requirements, are medically necessary, and don't exceed frequency limitations.

Several other concerns related to laboratory outsourcing and related financial issues were brought to our attention:

- According to one administrator, since outsourcing laboratory services, medical providers have begun simply sending out veterans to the local hospital, with USDVA approval. They claimed that while ODVA is no longer bearing the burden of the lab cost, the federal VA is bearing that burden as centers must seek approval to send a veteran out for acute services.
- We received the related concern that veterans are being sent to the hospital for testing because sending urgent lab work directly to the hospital costs ODVA money.
- We received conflicting information as to whether and how DLO is billing veterans directly, but the DLO contract clearly provides for billing veterans.
- There are also concerns that while ODVA plans to cover the cost of lab work for veterans without Medicare coverage, those

veterans who have Medicare coverage for 80% of their costs are being left to cover the other 20% themselves.

Cancelled Capital Projects

We received concerns about ODVA capital projects that had been cancelled despite costs already invested. We were able to compile information related to the following projects:

Lawton Roofing Project

We determined through discussions with OMES staff and review of related contracts, correspondence, and other supporting documentation that this project involving replacement of the Lawton Veterans Center roof was originally handled via the OMES Roofing Program (RAMP). ODVA received a roof replacement proposal for a standing seam metal roof, under the heightened standards and guarantees inherent in this specific program. The proposal price was $3,229,369.50. After ODVA accepted the proposal and the contractor had begun work, ODVA leadership cancelled the project. An email from ODVA's construction programs administrator to OMES staff stated, "I was just directed to stop this project. Our Deputy Director wants to have the project publicly bid."

The project was now split into two pieces. One included the roof, with metal roof and shingle roof options, and the other included waterproofing the exterior walls, replacing doors and some windows, and making the site more conducive to moving rainwater away from the building. The winning bid was won by the original contractor, Clayco Industries.

The roof project bid totaled $2,354,918.00, and the second project bid totaled $1,345,000, plus OMES CAP fees on each project, for a total newly bid cost of $3,728,265.73.

Talihina HVAC, Boiler, and Nurse Call Systems

The cancellation of projects at the Talihina center are discussed previously in this report beginning on page 38.

RECOMMENDATIONS

The following recommendations stem from our discussions throughout this report:

1. The Commission should recognize the risks associated with a negative control environment and work towards evaluating and addressing the condition to ensure the mission of the agency is accomplished in the most efficient and positive manner possible. In addition, they should be cognizant of the risk associated with ineffective communication within the agency and work to eliminate any such barriers. The Commission should also recognize its authority and responsibility in appointing the director, as outlined in 72 O.S. § 63.3.
2. We further recommend that management establish a system of clear communication that relays information from the bottom of the organization to the top and vice versa. The tone at the top regarding internal controls will greatly impact the success of the agency's internal control framework.
3. The Commission should seek an independent evaluation of cost effectiveness and impacts to services prior to relocating any veterans center.
4. Management should ensure policies and procedures are standardized or customized to the extent that best ensures the agency meets its mission and complies with appropriate requirements. Relevant procedures should be developed and reviewed prior to making significant operational changes, and adequate time should be allowed for affected parties to reviewnew policies and procedures. Adequate training should be provided to ensure compliance with such policies and procedures.
5. Management should ensure appropriate cost-benefit analyses are performed prior to outsourcing key services or making other significant operational changes.
6. Management should pursue an independent examination of current financial controls and other significant operational areas, as outlined in the next section.

We also recommend further study of the following topics in the future:

- Thorough examination of expenditures from and controls related to Trust Funds. In light of the recordkeeping limitations in the resident trust funds, and in light of the agency's recent

dismantling of center business offices and move to consolidate financial controls in the central office, we believe a more in-depth examination of these 700 funds is warranted.
    - Relatedly, we received allegations that reconciliations were off on Norman trust funds and any reconciling items may be concealed as the center is transitioned from its Billing & Banking system to the financial module of PointClickCare.
- Reassessment of all significant financial internal controls, at centers and central office, given complete reorganization of financial staff and processes. Information that has come to light during our procedures in this engagement certainly indicates that controls relied upon during past audits are no longer in place.
- Review of medical staff to resident ratios. This was requested in the context of follow-up procedures but no such procedures were included in our past reports. Such an analysis may be informative but with staffing levels already cut, does not bear the time and effort involved at this point.
- Review of effectiveness of Galt in hiring medical staff for centers. This may include examination of the situation discussed on page 9 in which Galt employees were offered an option to convert to state employees after one year, which was subsequently revoked.

In addition, the Attorney General's Office may wish to follow up on these allegations that were repeatedly brought to our attention:

- The standardized nursing policies discussed beginning on page 51 may have been unlicensed, resulting in legal threats from the owner of those policies and subsequent payment to that owner. Our procedures led us to limited evidence of what central finance staff reported was a payment for such licensing; however, the size and timing of that payment did not line up with the allegations, and detailed documentation was not provided. One employee alleged the payment had been "covered up." Further follow-up could be performed.
- As discussed briefly on page 15, we heard many concerns about whether the reduction in force or other forms of terminations/buy-outs of center business managers were compliant with applicable laws and regulations. The survey responses also included general questions about the appropriateness of the agency's hiring and firing practices, especially failure to post available positions before they were filled.

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