PERFORMANCE AUDIT

Oklahoma Department of Veterans Affairs

July 1, 2011 to June 30, 2012

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

Audit Report of the Department of Veterans Affairs

For the Period July 1, 2011 through June 30, 2012

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Oklahoma State Auditor & Inspector

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April 17, 2013

TO GOVERNOR MARY FALLIN:

The Oklahoma Department of Veterans Affairs (ODVA) exists to serve one of the most revered populations within our state: our honored veterans of military service. This state agency performs a wide variety of services for Oklahoma veterans and their families, from assisting with filing benefit claims to providing residential care. The agency's sole mission is to provide *excellent* health services and long-term skilled care. It is apparent that a high quality of care is evident in selected aspects of ODVA's operations, but many ODVA practices fall short of the standard of quality that its constituents deserve and to which they are entitled.

Questionable ODVA practices, such as inconsistent training, pervasive substandard wages, and some administrators' disregard for staff input, have contributed to a problematic work environment where human resources are not properly allocated or valued. Furthermore, the veteran centers' decentralized structure, originally designed to promote accountability, causes inconsistent policy implementation and insufficient independence in performance of internal investigations involving alleged misconduct. These issues could be either effectively managed or altogether avoided with appropriate oversight by ODVA's governing board, the War Veterans Commission (the Commission), but commissioners neither appear fully aware of their own governance responsibilities nor conscious of their own deficiencies.

Excellence in service delivery should permeate every aspect of ODVA operations, from Commission governance to the daily care afforded by the nursing staff. Veterans who live at the centers call these facilities *home* and trust the staff to aptly manage many aspects of their lives. However, despite the fact that these residents have all served our country during times of war, not every center guarantees resident veterans some of the most basic provisions, such as a clean set of sheets on the weekend or an appropriate response to a complaint of alleged abuse. These deficiencies in essential services hardly seem a suitable way to repay those who have sacrificed to protect the rest of us and will likely spend the remainder of their lives in such conditions.

Though a number of programs may have been ineffectively governed, the current Commission appears to have taken some action toward the betterment of our veterans. Such initiatives include the recent appointment of a full-time deputy director to oversee daily operations. However, there remain abundant opportunities to further advance and maintain consistent high quality service delivery for current and future veteran residents.

Our audit provides several recommendations detailing how the Commission may overcome its challenges and institute incentives that promote operational consistency and accountability, yet these merely represent a "starting point" for ODVA. A unique opportunity exists to positively alter the agency's culture to one of active participation and thoughtful discussion, rather than of apathy and disengagement. A cultural shift will better position the Commission and the agency to successfully achieve its mission of providing *excellent* health services to our veterans now and for many years to come.

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

TABLE OF CONTENTS

Commissioners i

Introduction and Background 1

Methodology 2

Objective I: Management and Organizational Structure 4

Governance 4

Divisional Structure and Centralization 14

Human Resources Practices 28

Objective II: Management of Veterans Center Funds 38

Prospective Areas for Further Study 44

Appendix A: Additional Methodology 46

Appendix B: Executive Director Operating Policy #3 49

Appendix C: ODVA Deputy Director Job Description 50

Appendix D: ODVA Standard Operating Procedure #1046 52

War Veterans Commission

2011-2012

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Harlan "Jay" Bjorgo ..... Member

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Dennis W. Parrott ..... Member

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2012-2013

Richard Putnam ..... Chairperson

Jerry Riley ..... Vice-Chairperson

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John Wes Benge ..... Member

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Introduction and Agency Background

Pursuant to the request of the Governor and in accordance with 74 O.S. § 213.2.B, we conducted a performance audit of the Oklahoma Department of Veterans Affairs (ODVA) for the period July 1, 2011 through June 30, 2012.

The mission of ODVA is "to ensure all Oklahoma veterans and their families receive all benefits to which they may be entitled and to provide excellent health services and long-term skilled care in a residential environment to all qualified veterans residing in the state."

ODVA provides benefits, services, and care to 350,000 veterans living in Oklahoma through claims and benefits assistance and residential care. Approximately 1,420 veterans reside in its seven long-term care centers located in Norman, Clinton, Ardmore, Sulphur, Claremore, Talihina, and Lawton.[1] Residents must meet certain medical eligibility requirements, but the pool of eligible applicants is already great enough that some centers have up to 288 applicants on a waiting list for admission. This figure continues to rise as the number of potential applicants grows. Residents rely significantly on the centers to manage many aspects of their lives, from medical needs to financial affairs, from the time they enter the center through the end of their lives.

The War Veterans Commission (the Commission) is the controlling board of ODVA. It is composed of nine members appointed by the Governor and confirmed by the Senate, from a list of names submitted by the American Legion (4 members), Veterans of Foreign Wars (3 members), Disabled American Veterans (2 members). The Commission is responsible for carrying out the laws passed by the Oklahoma Legislature. It administers the veterans program in Oklahoma through a director appointed by and responsible to the Commission.

Those charged with governance and lead management of ODVA have changed between the period audited and the release of this report. In July 2012, the governor appointed eight new commissioners, while one prior commissioner continued to serve. In November 2012, the previous executive director retired, and a new director has now been appointed.

[1] ODVA 2014-2018 Strategic Plan, figures unaudited.

The agency has three major programs:

- **Nursing Care** operates the seven residential care facilities. This program represents the bulk of the agency's activities and expenditures.
- **Veterans Claims and Benefits Administration** assists veterans and their dependents with claims before the U.S. Department of Veterans Affairs (USDVA). This division also assists veterans, widows, parents, or any persons who receive benefit payments in completing necessary eligibility forms. There are four claims offices throughout the state.
- **Central Administration** is the departmental headquarters in Oklahoma City, and includes the executive director, deputy director, program administrators, human resources, and accounting.

ODVA also provides administrative support to the State Accrediting Agency, which is the approval authority in Oklahoma for programs of education and training under the G.I. Bill. It is a federally funded program with its own board, director, and staff, and is not considered a division of ODVA.

While this report addresses many shortcomings and recommendations for improvement at ODVA, we did note during our visits and procedures at the veterans centers that in general, staff members appear to care greatly for the residents they assist, and residents seem content.

This report is a public document pursuant to the Oklahoma Open Records Act (51 O.S. § 24.A.1 et seq.), and shall be open to any person for inspection and copying.

Methodology

Considering the size of the agency and the broad scope of the Governor's request, we conducted a preliminary risk assessment on the three major programs. Nursing Care was identified as the highest risk program based upon its rate of expenditures and number of employees, the critical services it provides to a large, human population, its dispersed locations and potential lack of central office oversight, recent legislative concerns, and past audit results.

We further analyzed the risk present at each of the seven veterans centers and determined that due to their size, level of expenditures, staff turnover rate, USDVA inspection and peer review results, and other known

factors, our procedures would focus primarily on the Ardmore, Claremore, and Norman Veterans Centers. However, we did visit all seven centers while obtaining our understanding of the agency and the Nursing program.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusion based on our audit objective.

Sample methodologies can vary and are selected based on the audit objective and whether the total population of data was available. Random sampling is the preferred method; however, we may also use haphazard sampling (a methodology that produces a representative selection for non-statistical sampling), or judgmental selection when data limitation prevents the use of the other two methods. We selected our samples in such a way that whenever possible, the samples are representative of the populations and provide sufficient evidential matter. We identified specific attributes for testing each of the samples. When appropriate, we projected our results to that population.

See additional information about our methodology, including planning and sample selection, in Appendix A.

OBJECTIVE I	Determine whether the management and organizational structure of the Oklahoma Department of Veterans Affairs (ODVA) is effective in ensuring health care and long-term skilled care in the residential environment is provided in accordance with ODVA's mission.

Conclusion

Per its mission statement, ODVA purports to provide "excellent health services and long-term skilled care." The agency relies on the center administrators to operate the veterans centers, but lacks integrated supervision and oversight necessary to ensure the centers have positive working environments and sufficient resources to provide that excellent quality care to the residents. This places the veterans center residents' well-being at risk.

During our procedures we identified three main areas of operations in need of improvement: ODVA's governance, divisional structure, and human resources practices. Not all aspects of these areas require attention, but some changes might represent opportunities for ODVA to improve its service delivery and ultimately benefit the veterans it serves.

GOVERNANCE

Observations

As with most state agencies, ultimate governing authority at ODVA rests with its governing board, the Commission. The Commission is charged with overseeing ODVA operations, administering veterans programs through an appointed director, and carrying out federal and state laws pertaining to the agency. Assessing management effectiveness therefore begins with the Commission.

Commission Size and Composition

Governance guidelines do not provide recommendations on a board's exact size, but they do recommend that a board should be composed of enough members to have a diversity of perspective, knowledge and skills so that the governing body can understand and evaluate issues and

options before it.[2] Members should have motivations, values, experience, and skills to help the organization.[3]

Nine members compose the Commission, with appointments made by the Governor with the consent of the Senate from a list of names submitted by Oklahoma's three largest service organizations.[4] The vast majority of veterans, who are not members of these organizations, cannot serve on the Commission. [5]

The vast majority of Oklahoma's veterans are ineligible to serve on the Commission.

The primary condition to serve on the Commission is that of veteran status. A comparison of four states similar to Oklahoma revealed that only two of the four had qualification requirements, other than veteran status, to serve on the state's governing board.[6] For instance, California requires one member to reside at a veterans facility, and another member to have education or experience in health care administration.

Orientation and Training

Board training protocol suggests numerous benefits of proper board member orientation and training. According to one source, board members should be carefully selected, oriented, and trained. Members should receive orientation and ongoing training to keep them focused and informed.[7] Another source suggests that ongoing training also serves the purpose of keeping board members current with information on changes in governance practices and in the regulatory environment.[8] Educating new and existing board members can also contribute to the board's strategic focus.[9]

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[2] Lakey, B.M. (September 2010). *Board Fundamentals: Understanding Roles in Nonprofit Governance, Second Edition.* Washington, DC: BoardSource, http://www.cisnet.net/CIS/files/ccLibraryFiles/Filename/000000004257/Board%20Fundamentals.pdf.

[3] BoardSource. *The Nonprofit Board Answer Book: A Practical Guide for Board Members and Chief Executives*, 2nd Edition. Jossey-Bass, 2007.

[4] Additional membership provisions can be found in 72 O.S. § 63.2.

[5] According to a representative from the Disabled Veterans, Oklahoma has approximately 387,000 veterans; Disabled Veterans has 19,784 members (5.1% of the total), Veterans of Foreign Wars has approximately 15,300 members (4%), and the American Legion has 21,000 members (5.4%). These figures were not verified by SAI.

[6] Oklahoma was compared to four states with similar numbers of veterans' residential facilities: California, Florida, Missouri, and Texas.

[7] BoardSource, *Nonprofit Board Answer Book*.

[8] U.S. Government Accountability Office, *Legal Services Corporation: Governance and Accountability Practices Need to be Modernized and Strengthened,* August 2007, http://www.gao.gov/assets/270/265463.pdf.

[9] U.S. Government Accountability Office, *Washington Metro Could Benefit from Clarified Board Roles and Responsibilities, Improved Strategic Planning*, June 2011, http://www.gao.gov/products/GAO-11-660.

Former and current Commission members mentioned receiving an orientation manual consisting mostly of information about the ODVA. Current members also recalled meeting with the executive director and legal counsel to discuss their responsibilities as Commission members and rules that apply to all state boards and commissions, such as the Open Meetings Act. One member noted feeling as though the information covered prohibited activities, as opposed to approved activities. Overall, members did not note significant guidance regarding their oversight responsibilities.

Commissioners do not appear to receive training outside of the orientation process. Though commissioners have indicated that they are all actively engaged in fulfilling the board's purpose, ongoing training might further benefit members by keeping them apprised of issues that pertain to the Commission and to veterans in general. Commissioners might also benefit from periodic reeducation on oversight duties.

Delineated Governance Responsibilities and Delegation

Governance guidelines dictate the need for delineated responsibilities both amongst board members and between the board and staff. Within the board itself, creating committees to divide board work will enable more in-depth attention to specific governing issues, thereby enhancing expertise,[10] without occupying the time of the entire board. Board and staff responsibilities should also be clearly defined to enable the board to provide oversight and governance, while staff provides day-to-day management.[11]

Former commissioners (those serving prior to July 2012) indicated they had only one committee: the Executive Committee, comprised of the Commission chairman, vice chairman, and secretary. The current Commission has not formally created any additional committees either, but has created several subject areas of focus for members, given their personal or professional backgrounds. These functional areas include facilities, medical, finance, and others, on which members may provide input or advice. It is unknown whether these groups will formally report or provide recommendations to the Commission due to their recent development.

[10] Corporation for National and Community Service. *Best Practices of Highly Effective Nonprofit Boards*, http://www.nationalserviceresources.org/best-practices-boards.
[11] BoardSource, *Nonprofit Board Answer Book*.

With regard to delegating responsibilities, commissioners appear to understand their role as an oversight board which delegates authority to the executive director to manage day-to-day operations. However, some commissioners seem unsure of the extent of their own authority over ODVA policies and procedures. Some members felt it was the Commission's responsibility to annually review and approve agency-wide Standard Operating Procedures (SOPs), while others adopted a more passive approach, either indicating that responsibility fell to the centers' administrators or noting the sufficiency of the peer review process in ensuring policies were enforced and current. SOPs and peer reviews are further discussed in the following section.

Oversight

One of the more critical functions of the board is that of oversight. This governance function is necessary to ensure duties delegated to staff are carried out to the board's wishes, the organization is succeeding in its mission, and resources are used wisely. The Center for Nonprofit Success offers the following four components of oversight:

1. Financial Oversight
2. Risk Management
3. Program Monitoring and Evaluation
4. Evaluation of the Chief Executive[12]

Details on each of these components and how they apply to ODVA are as follows:

1. **Financial Oversight –** includes monitoring the organization's budget, long-range financial trends, implementing and following financial management policies, and reviewing an annual audit, to ensure the organization's financial well-being.

   The Commission has delegated financial responsibilities to the executive director and limited their financial oversight to approving agency budgets and emergency purchases, reviewing travel reports, and reviewing expenditure reports. The Commission does not appear to receive or review detailed information regarding the financial status of individual veterans centers.

[12] Center for Nonprofit Success, as referenced by the National Association of Veterans' Research and Education Foundations, *Overview of Corporate Governance,* http://navref.org/bestpractices/pdf/Heyman_Overview_of_Corporate_Governance.pdf.

2. **Risk Management –** includes establishing policies that guard against the loss of financial, human, and reputational resources to safeguard the organization.

   In order to comply with applicable state and federal laws, ODVA maintains three sets of policies:

   1) Oklahoma Administrative Codes, which include rules and executive orders that apply to the agency;
   2) Standard Operating Procedures (SOPs), which establish broad procedures all centers must follow; and
   3) Center policies and procedures, which provide detailed guidance to staff on operating in accordance with the SOPs.

   Commissioners only approve the agency's Administrative Code, and have delegated creation of the SOPs to the executive director. Center administrators are responsible for establishing and maintaining their own written policies and procedures.

   While this method of policy implementation allows for the seven centers to cater policies to their own facilities, it also allows for the possibility that seven different policies address the same SOP, which could create inconsistencies in operations.

3. **Program Monitoring and Evaluation –** includes overseeing all operations by monitoring and evaluating staff implementation plans to ensure the organization's programs are achieving the mission.

   The Commission has a number of tools at its disposal to monitor agency and center operations, including agency financial reports, monthly reports on the centers, annual peer reviews, and annual inspections performed by the United States Department of Veterans Affairs (USDVA). Not all of these tools, however, are being utilized for monitoring and evaluation purposes.

   Center reports typically contain a summary of resident status (deaths, transfers, etc.), personnel statistics (number of new hires, number of vacancies, full time employees), resident activities, and letters of appreciation from residents' families. Though commissioners receive this information at each board meeting, they do not appear to use the report for monitoring purposes or to suggest improvements.

   Peer reviews are inspections conducted by a team of employees from the various centers in preparation for the annual USDVA inspection. Peer review results are not shared with the Commission until federal

inspection results are shared, which could occur up to three to four months after the peer review. All the Commission sees regarding peer review results is a letter indicating the facility passed the inspection, which they will then use to issue a license to the center to continue to operate.[13]

4. **Evaluation of the Chief Executive –** includes assessing the chief executive's performance, providing regular and revelant feedback on the executive's progress, and ensuring the executive is accountable to the board.

   Multiple sources recommend annual evaluations of the chief executive. The Executive Service Corps of Washington suggests that at least two board members should annually evaluate the executive on the basis of a performance agreement or board policies with measurable outcomes clearly established in advance of the evaluation period.[14] Evaluation of the executive serves three purposes:

   1. Clarify expectations between the board and the executive on roles, responsibilities, and job expectations.
   2. Provide insight into the board's perceptions of the executive's strengths, limitations, and overall performance.
   3. Foster growth and development of both the executive and the organization.[15]

   Governance resources also suggest creating an evaluation form with both quantifiable and open-ended questions.[16]

   Commissioners do not use uniform criteria in their assessment of the executive director.

   Alignment of expectations between the Commission and the executive will establish a foundation by which the executive and Commission can move forward with the organization's goals while mitigating the risks of misunderstanding. During interviews, current commissioners explained that it was the Commission's practice to evaluate the executive director in accordance with Executive Director Operating Policy #3. However, this policy is

[13] USDVA inspections and peer reviews are further discussed in the 'Divisional Structure and Centralization' section of this report.
[14] Executive Service Corps of Washington, *Best Practice Materials for Nonprofit Boards,* http://www.escwa.org/files/bbp.pdf.
[15] Center for Nonprofit Success, *Overview of Corporate Governance.*
[16] BoardSource, *Nonprofit Board Answer Book.*

vague and does not prescribe specific evaluation measures.[17] Each commissioner could therefore choose the factors on which to base the evaluation. Documentation of evaluations in August 2011 and April 2012 does not show any evaluation criteria -- only that the Commission found the executive director's performance to be "outstanding."

Recommendations

In an effort to improve ODVA's governance processes, we offer the following recommendations:

Recommendation #1: Modify Commission Membership

State statutes currently limit potential commissioners to the veteran population. Potential commissioners are further limited to the membership of three service organizations, which represent less than 15 percent of Oklahoma's veteran population of 387,000. [18] Given the constraints of the current appointment structure, the Commission should consider requesting amendatory language from the Legislature to modify its membership to more accurately and comprehensively represent the veteran population.

To enhance the skill sets of board members, the Commission should contemplate adding membership criteria, such as educational or professional qualifications candidates must possess. To expand the pool of candidates, potential commissioners could be chosen from outside of the three service organizations. This change could lead to a more highly qualified board able to provide greater insight into decision-making, which would ultimately positively impact the veterans they serve.

Recommendation #2: Implement Ongoing Training

Commissioners do not appear to receive any ongoing training or continuing education. Considering the Commission's involvement in complicated and highly regulated subjects, such as healthcare policy, government finance, and long-term care, additional training would improve ODVA's governance by keeping members more informed and engaged.

[17] Executive Director Operating Policy #3 may be found in Appendix B.
[18] See Footnote 5.

Recommendation #3: Create More Committees to Address Specific Issues

The former Commission formed only one committee, the Executive Committee, comprised of the Commission chairman, vice-chairman, and secretary. The current Commission has made some effort to improve this process by assigning a subject area for each member to oversee. We recommend formalizing these groups into committees to empower the existing commissioners in making recommendations to the full board and to similarly benefit future commissioners.

Recommendation #4: Improve Financial Oversight

To ensure the long-term financial viability of an organization, the governing authority must provide adequate financial oversight by closely monitoring a budget and anticipating how changes will affect its constituents. Considering the degree to which veterans rely on the services provided by ODVA, and the fact that the Commission represents the veteran population, this function is an essential component of the Commission's responsibilities and should not primarily be delegated to the executive director.

To improve financial oversight, we recommend the Commission or a designated committee not only review emergency purchases, but also those over a certain dollar threshold. Such a dollar threshold would be determined by the Commission. Requiring Commission approval for these purchases will provide direct guidance for existing and future commissioners.

We also recommend that the Commission request more detailed financial information related to the centers' budgets and expenditures. Doing so will better enable commissioners to identify financial trends common among centers and will facilitate discussions on other financial matters.

Recommendation #5: Approve Agency SOPs

It is imperative that the Commission perform all functions within its power to mitigate risks associated with the agency and those it serves. We therefore recommend that the Commission approve ODVA's SOPs to ensure they guard against financial, human, and reputational losses.

Recommendation #6: Enhance Program Monitoring and Evaluation

The Commission's current approach to receiving updates on the centers creates a missed opportunity to address problems residents might be having. However, the Commission has multiple ways in which it may improve its monitoring and evaluation functions. Firstly, commissioners should obtain copies of the completed peer review and inspection forms along with management's corrective action plans. Additionally, performance measures, such as average employee turnover rates, average restraint use, and infection rates, could be incorporated into center reports to enhance existing information, thus creating a more useful tool with which commissioners can monitor operations at the centers.

Recommendation #7: Adopt a Formal Policy for Evaluation of the Executive Director

Though the Commission annually evaluates the executive director, the evaluation process does not appear to follow standards for best practices. We recommend that the Commission standardize their evaluation process by having all commissioners use the same evaluation criteria and a common set of quantifiable and open-ended questions. The Commission should also formalize the process in board policy.

Views of Responsible Officials

Management concurred with six of our seven recommendations related to governance, and provided the following responses. Each response is numbered to correspond to the accompanying recommendation:

Response #1, Modify Commission Membership: The current War Veterans Commission meets criteria established in §72-63.2 of the Oklahoma State Statutes. These statutes require that the Commission be selected from a list of representatives from the American Legion, the Veterans of Foreign War and the Disabled American Veterans. The list of recommended representatives is then submitted to the Governor for appointment and subsequent confirmation by the Senate. Changes in the composition and qualifications of the Commission are currently being discussed.

Response #2, Implement Ongoing Training: Three Commission members recently participated in training conducted by the National

Association of State Veterans Homes Administrators and we anticipate this will be a routine event in the future. We recognize that ongoing training is an important component of professionalism and Commissioners discuss their duties regularly.

Response #3, Create More Committees to Address Specific Issues: The current War Veterans Commission has been functionally structured from which various committees can be appointed by the Commission Chair. Committees are currently appointed on an ad hoc basis; however, the Commission recognizes the need to permanently assign committees to the more significant functional areas. The War Veterans Commission will work toward the goal of identifying pertinent committees and formalizing this process.

Response #4, Improve Financial Oversight: The War Veterans Commission is routinely advised of significant emergency purchases; however, we will establish a minimum threshold and formalize this process. The War Veterans Commission currently requires detailed financial information related to centers' budgets and expenditures. This information is outlined in Monthly Financial Reports to the Commission; however, the Commission will work with ODVA management to determine if additional information should be provided. A Finance Committee will be established to improve the oversight.

Response #5, Approve Agency SOPs: Standard operating procedures (SOPs) are approved by the executive director before becoming final in accordance with the authority delegated to the executive director. SOPs outline ODVA's processes and procedures for day-to-day operation of the agency. The War Veterans Commission will continue to exercise oversight of all operations as outlined in the SOPs. Should a deficiency arise the Commission will address those concerns to the executive director.

Response #6, Enhance Program Monitoring and Evaluation: ODVA management will consult with Commission leadership to develop a program monitoring and evaluation report that makes full use of all the data available to the agency. Commissioners will be provided with all

evaluation reports and management's corrective action plans. A briefing will be prepared and delivered upon request. Management and the Commission will develop objective performance measures that accurately assess agency personnel trends and veterans center operations and outcomes. Members of the Commission have been geographically assigned to monitor various aspects of each veterans center. These Commission members will also attend and monitor the veterans center peer reviews.

Response #7, Adopt a Formal Policy for Evaluation of the Executive Director: 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.

DIVISIONAL STRUCTURE AND CENTRALIZATION

Observations

One difficulty ODVA has faced in fulfilling its mission is developing a highly effective agency structure with an appropriate balance of centralization and delegation.

In a successful organization, management is responsible for establishing and maintaining an effective internal control structure that provides reasonable assurance the agency operates effectively and efficiently. The foundation of an effective control structure is a positive and supportive attitude toward internal control and responsive management. The working environment can be strongly affected by management's display of integrity and ethical values, commitment to competency, its organizational structure, and the manner in which the agency delegates authority and responsibility.[19]

An organization should be structured so that clear areas of authority and responsibility and appropriate lines of reporting are established.[20] ODVA's nursing program uses a divisional or decentralized structure in which each of the seven veterans centers functions as its own division within ODVA. Each center controls its own internal components,

[19] Government Accountability Office, *Standards for Internal Control in the Federal Government,* GAO/AIMB-00-21.3.1 (Washington, D.C.: November 1999)
[20] Ibid.

including human resources, training, nursing, administrative, housekeeping, and maintenance departments. Each department head reports to the center administrator. The administrator then reports to the ODVA executive director, who reports to the Commission.

The former executive director indicated that the centers were structured as separate divisions because each administrator is a licensed long-term care administrator and must be held separately accountable for center performance under that license. This arrangement has created an environment where the administrator has a significant amount of responsibility and authority for how his or her center operates and, as discussed earlier, the governing Commission provides limited oversight.

Centralizing Key Functions

Decentralizing certain tasks, such as maintenance, housekeeping, and human resources, appears logical, as those functions are generally isolated within a center, are likely individualized to meet the center's needs, and require minimal oversight on a regular basis. However, several responsibilities currently delegated to the individual administrators or their respective staffs may be more effective for ODVA if they were centralized.

Development of Policies and Procedures

Each of the seven veterans centers is responsible for creating a separate set of policies and procedures outlining steps for compliance with ODVA's SOP as well as state and federal regulations. Although each center must have some autonomy in how it functions, this practice increases the risk of inconsistent care among the centers, and creates inefficiencies in policy implementation and monitoring. Each center has to review and update its policies and procedures any time there is a change in SOP or regulations, resulting in duplications of effort.

For example, policies related to restraints at some centers vary in the period of time allowed for a nurse to notify the medical provider of emergency restraint use, the length of re-evaluation periods for restraint orders, and the use of chemical restraints. We are not aware of any factors which would call for variance among such policies, and the topic seems significant enough in the subject of patient rights to merit Commission and central management input.

We also noted that agency SOP #713, "Patient Abuse/Neglect," requires each center to develop policies and procedures designed to prevent abuse, neglect, or exploitation, to protect victims of alleged abuse, and to ensure the prompt reporting and investigation of all reported instances. These policies are to be based upon federal, state, and agency laws, rules, regulations, and guidelines. According to our analysis, each of the centers' policies and procedures on this topic contain generally the same information, with small variations in format and wording. It appears inefficient and potentially confusing for users of the policies to have an agency-wide SOP and center policies covering the same information.

Investigations

Each center is responsible for performing internal investigations when allegations of abuse, neglect, or exploitation are made. Tips leading to investigations are gathered from staff, residents, family members, or via the agency's hotline number. Investigations are generally conducted first by an internal three-person team at the center where the reported event took place. These investigations are begun and teams are formed at the discretion of the administrator or administrative programs officer. For central hotline calls, the executive director reviews the information submitted and decides whether an investigation will take place and what staff will participate. The safety programs administrator may also conduct an extended investigation at the request of the executive director, especially if the event being investigated is serious in nature (such as criminal). The safety programs administrator works from the central office and has a background in investigations.

Internal investigation teams lack independence and proper training.

The center administrator is responsible for reporting any incidents to the central office and to the Oklahoma Department of Human Services (DHS)[21], and the safety programs administrator also reports relevant events to DHS, local police, the district attorney, and other entities as appropriate. Investigations related to employees must also be reported to the Oklahoma State Department of Health's (OSDH) Nurse Aide Registry or applicable licensing agency (such as the Board of Nursing)[22].

The fact that internal teams of employees are conducting investigations leads to several concerns. First, internal employees may not be

[21] Reporting to DHS is required by 43A O.S. § 10-104.
[22] Reporting to OSDH Nurse Aide Registry or applicable licensing agency is required by SOP #713.

independent. Not only are the investigators likely to know the individuals being investigated, but the administrator, who sometimes participates as a team member and receives the investigation results before they are reported to the central office and outside entities, may be in a position to have the report results changed (for instance, changing a "substantiated" report to "unsubstantiated").

Administrators may also opt to override recommendations from outside parties. For example, the 2011 USDVA inspection report for the Ardmore Veterans Center indicates an investigation conducted by both the center and DHS substantiated a case of abuse by a certified nurse aide (CNA) and recommended termination for the event. The administrator did not terminate the employee, and that CNA was later charged with rape by instrumentation. A subsequent internal investigation revealed that three additional residents had been assaulted by the same CNA.

Additionally, most internal employees have not received training in investigative techniques, and may have other responsibilities at the center, leaving little time to conduct a complete and thorough investigation.

While performing our procedures related to investigations, we noted two areas of concern regarding reporting hotlines and reporting incidents to outside entities.

According to our discussions, it is ODVA's practice to post contact information for the center's ombudsman[23], the DHS statewide abuse hotline, and ODVA's internal central office hotline. During our visits we noted that all seven centers consistently posted the ODVA internal hotline and the ombudsman information. However, we only saw the DHS hotline posted at the Ardmore center. In addition, four centers had posted separate *center* hotlines, which connect directly to the centers' administrators, and the postings were generally visually dominant over the other hotlines. Because the information is not reported outside the

[23] The Ombudsman Program housed at the Oklahoma Department of Human Services serves residents in long-term care facilities, including nursing homes, and includes ombudsman supervisors and volunteers at each ODVA veterans' center. Ombudsmen are independent advocates for the residents; they receive complaints and attempt to resolve those complaints within the center. They have the authority to investigate and recommend corrective action.

center, these internal hotlines may not be independent and consequently may not lead to effective consideration and potential investigation of the problems reported.

The agency's policies for self-reporting incidents do not appear to be effective. As discussed earlier, center personnel are required to report incidents about which they receive complaints to the central office, DHS, and applicable registry or licensing agencies. We performed detailed procedures related to the consistency of reporting by the veterans centers to the central office and required outside entities, and our testwork indicated the centers did not consistently report incidents. Of the 48 investigations we reviewed that were required to be reported, five were not reported to the central office, five were not reported to DHS, and eight were not reported to the Board of Nursing or the OSDH Nurse Aide Registry.

ODVA methods for self-reporting incidents appear ineffective.

Hiring and Background checks

Due to the large number of staff at each center, having separate human resource departments appears to be a reasonable way to operate. Human resources directors at the centers conduct state background checks and verify licensing and certification prior to hiring new employees. An applicant with a violation listed in 63 O.S. § 1-1950.1[24] is not permitted to be hired by ODVA. This procedure allows center management to judge whether certain offenses excluded from the statute, such as bounced checks, DUIs, and dismissed charges, disqualify an applicant. This flexibility increases the risk that administrators may overlook potential risks related to an applicant because the center is understaffed.

Training

Training material and testing requirements are not standardized between centers, despite common occupational and resident needs. Training concerns are discussed in further detail in the Human Resources section of this report.

[24] This portion of the Nursing Home Care Act requires criminal history background checks for nurse aides, and prohibits the hiring of individuals who have been convicted of, pled guilty or no contest to, or received a deferred sentence for a variety of serious crimes, including abuse, neglect, or financial exploitation; rape, incest or sodomy; child abuse; murder or attempted murder; manslaughter; kidnapping; assault and battery; and first degree arson. Other crimes committed in the past seven years (such as burglary or larceny) can also prohibit hiring.

Tools for Managing the Current Decentralized Structure

If ODVA is unable to reach an optimal level of efficiency and effectiveness in meeting its stated mission using a more centralized approach, improvements must be made to the monitoring and strategic management of its current decentralized structure. Best practices show that organizations can achieve success using a decentralized structure, and that such a structure beneficially increases the accountability of each division's management. [25] However, it stands to reason that in order to hold each administrator accountable for the performance of his or her center, those charged with governance must closely monitor center performance by developing clear standards and setting measurable goals. The tools used by executive management and the Commission in the past to monitor the performance of individual centers are simply not adequate. Whether or not the agency chooses to centralize key functions, these tools must be improved or replaced in order to optimize monitoring of center operations.

Management and the Commission lack adequate monitoring tools to ensure effective center performance.

USDVA inspections

The USDVA conducts an annual inspection of each facility recognized as a "State home," as required by federal regulations. As a result of this inspection, the director of the VA medical center of jurisdiction certifies whether the facility and facility management meet, provisionally meet, or do not meet applicable standards. A provisional certification is issued if the facility or management does not meet one or more standards, the deficiencies do not jeopardize the health or safety of the residents, and the facility management and the director have agreed to a plan of correction to remedy the deficiencies in a reasonable amount of time. The inspection is conducted during the same month each year (as specified in federal regulations), so center management knows the general time frame in which they will be inspected by the USDVA.

The former Commission received the overall results of the USDVA inspections, but did not review the detailed results or corrective action plans.[26] This high-level review of "pass/fail" information could not have

[25] Stephen Bragg, CPA, *Divisional Organizational Structure.* http://www.accountingtools.com/divisional-structure.
[26] The Commission did receive detailed results for the USDVA inspection of the Claremore Veterans Center for the audit period year, but did not receive detailed results for any other centers.

sufficiently informed the Commission of potential risks or key strengths and weaknesses at the centers. Because it is possible for a center to pass an inspection but not meet federal standards, the Commission may have voted to license centers with serious deficiencies.

We also noted that the USDVA inspection currently represents the only active oversight over ODVA's nursing home operations provided by an independent, outside entity. While the USDVA team inspects the centers and requires a corrective action plan for any problems found, the Commission is still ultimately responsible for licensure of each center.

In the past, ODVA was subject to the Oklahoma Nursing Home Care Act, under which inspections were performed by the Oklahoma State Department of Health, but OSDH was not afforded the enforcement capabilities necessary to ensure its approved corrective actions were completed. Veterans centers also received accreditation from the Joint Commission on Accreditation of Healthcare Organizations prior to 2000, but discontinued the practice.

If the Commission does not take responsibility for detailed review of inspection results and enforcement of corrective action plans, it must enable another independent reviewing body such as OSDH with enforcement power, to ensure the problems found during inspections are actually corrected.

We discussed the USDVA inspections with the center administrators, and several of them commented that the inspection is focused on nursing and patient care, and does not necessarily look at all areas of the facility's operations. This suggests the USDVA inspection results must be used in concert with other tools to effectively monitor center performance.

Peer review

Sufficient enforcement does not exist to ensure corrective actions take place as a result of inspections and peer reviews.

As mentioned earlier, an annual internal peer review is also conducted at each center. The peer review team includes a variety of administrative, medical, and other staff from centers other than the one being reviewed, and the team leader is appointed by the executive director. The review consists of two days of procedures followed by an exit conference, and a formal report is issued within ten days, after which the administrator has an additional ten days to create a plan of correction. If

the plan is acceptable, the team leader recommends continued licensure to the executive director.

Conducting a peer review using ODVA staff presents a significant risk of reviewer bias. For instance, reviewers may have former dealings with the personnel being reviewed, or may evaluate procedures using their own centers as the standard against which to judge. Again, the former Commission reviewed only the overall results of the peer review, and did not review or follow up on detailed results or corrective action plans. This greatly limits the validity of the peer review as a monitoring tool for center performance, as significant issues could exist at a center despite it "passing" peer review.

According to our discussion with the peer review team leader, centers would ideally correct any deficiencies noted during the review before the USDVA inspection is conducted. However, this is not always possible, due to problems with staffing levels and turnover as discussed later in this report. It is also possible that without proper attention from those charged with governance to the problems found, and without enforcement of the corrective action plans as discussed in the previous section, center administrators may choose not to correct issues or may not have the support and resources needed to correct them.

Patient satisfaction surveys

Each center conducts an annual patient satisfaction survey. The surveys are distributed by social services personnel to the residents or, if the residents are incapable of filling out the survey, to their family members. The surveys include questions about areas such as facility, recreation, social services, food services, administrative staff, physicians, and nursing services. Procedures for tallying the results vary by center, but generally admissions or other administrative personnel log the responses and generate a report, which is reviewed by the administrator. The results are then provided to the executive director.

While resident surveys may be a helpful tool for center personnel to gather feedback from residents and their families, they are not necessarily an appropriate tool for center performance monitoring by top management or the Commission. The administrator (or the staff member logging the results) has the opportunity to alter results to make them appear more favorable by removing surveys or manipulating percentages on the survey summary reports.

Even if the Board were able to collect this survey information more independently (such as through the center ombudsman), it is important that they develop written expectations of survey results, which are not currently in place. These expectations could include goals such as the rate of satisfaction expected in each key survey topic area. It is also important that survey results be reported in a consistent manner for each center, so the information is comparable. This is not currently occurring. For instance, we reviewed survey summary reports for all seven facilities for 2012, and while five of the facilities presented satisfaction percentages by department and overall, two did not, and these rates did not appear to be easily determined from the information provided.

In addition to those tools discussed here, it is imperative that management focus on maintaining excellent communication between the central office and the centers, and amongst the centers, to ensure top performance from the full agency. We noted during our visits to the veterans centers that some centers were experiencing problems to which other centers had found a solution. For example, one center had trouble maintaining a large enough stock of clean linens to last staff through the weekend, while other centers had maintenance staff load extra linen carts during the week to solve this problem. Proper communication channels should allow center management or personnel to share solutions to common problems such as this, so that all centers benefit from one another's ingenuity and hard work.

Deputy Director Position

The Commission relies on the executive director to manage many ODVA functions, including day-to-day agency activities, communication with center administrators, and SOP implementation. Though the current structure was designed to foster accountability at the individual veterans centers, this has left the executive director with a significant amount of responsibility. Many state agencies also employ a deputy director to share some of these responsibilities and to shoulder many of their own. ODVA's deputy director job description contains a lengthy list of such functions. [27]

Despite the apparent importance of the deputy director position, ODVA operated for many years without one. Only in 2009 did the executive director request one center's administrator to fill this position as a part-

[27] See ODVA deputy director job description in Appendix C.

time acting deputy director. This administrator not only acts as the deputy director, but continues to serve as the center administrator in Talihina.

Given the demands of the center administrators, the effectiveness of this arrangement seems questionable.

Recommendations

It is up to those charged with governance to determine whether a more centralized structure would be the most effective way for ODVA to provide "excellent health services and long-term skilled care" to Oklahoma's veterans. Even with increased centralization, the Commission and top management must improve the tools used to monitor and direct center activity. This includes ensuring the independence of key information, analyzing the details of vital documents such as USDVA inspection reports, and enforcing necessary changes at each center. At most state agencies, the failure to implement recommended actions from an audit or inspection might result in control breakdowns or financial losses, but at ODVA it could result in a lowered quality of resident care and even loss of life.

Failure to implement appropriate corrective actions could result in lower quality care for residents, and even loss of life.

It is also imperative that the quality of governance be improved overall, as discussed in the Governance section of this report, to ensure individuals with the proper experience, tone, and employee trust are providing this oversight.

Considering the overall needs of the Commission and the centers, we offer the following recommendations:

Recommendation #8: Centralize Appropriate Functions within ODVA

We recommend the agency centralize functions which could more effectively be performed by a central unit, not separately at each of the seven veterans centers. As discussed in the text of the report, this includes centralizing the development of policies and procedures, reporting of certain events to outside entities, and development of training and testing materials for medical personnel. It would also improve the independence and reliability of incident reporting if center hotlines were discontinued

and the only ODVA internal reporting hotline were managed by the central office.

Recommendation #9: Restructure and Improve the Investigation Process

There are multiple ways in which ODVA may improve its investigations processes, including replacing the internal center investigations with a central investigative unit, and requiring decisions about whether cases warrant investigation to be made by someone in addition to the center administrators or executive director. The investigative unit could also receive central office hotline calls as mentioned in the previous recommendation.

Creating a central investigative unit headed by the safety programs administrator could greatly improve the independence and effectiveness of investigations by ensuring they are conducted by trained staff, with sufficient resources, who do not report to center management and are not as likely to be on familiar terms with the personnel being investigated. An independent investigatory department or committee could also provide feedback on corrective action and potential policy and procedural changes resulting from the investigation, and follow up to ensure the appropriate action is taken. This would help mitigate the risk that center management, such as the administrator or director of nursing, may override recommendations made by outside parties.

The agency could also enhance its investigation decision-making process. The safety programs administrator, an experienced investigator, could share responsibility for deciding when an investigation is needed and its scope, or a committee of Commission members with relevant knowledge and experience could participate in the decision.

Recommendation #10: Improve Hiring Processes

It appears the hiring process could be improved by seeking the input of the safety programs administrator or another party knowledgeable in legal and personnel issues and independent of center operations. As the safety programs administrator now conducts national background checks but is not responsible for making hiring decisions, his aid in interpreting background check data may also enhance the hiring process.

The agency could also further develop its internal "do not rehire" list, which currently only includes center employees terminated for positive drug tests, to include employees terminated for reasons such as abuse and neglect. This would help prevent the inappropriate rehiring of a terminated employee at another center.

Recommendation #11: Appoint Full-Time Deputy Director

In order to assist the executive director with day-to-day agency management, and to properly fulfill the wide array of duties assigned to the position, management should appoint a full-time deputy director. This could include seeking the advice of the Commission when selecting an appropriate applicant. It is important that the person appointed to this position be able to devote his or her full attention to the position, and be reasonably independent from center personnel, whom the deputy director will be responsible for managing.

Recommendation #12: Improve the Quality and Independence of Monitoring Tools

Executive management should examine the resources and information it has available to monitor performance at individual centers, and the Commission should examine the tools it uses to monitor the agency overall. They should ensure the information used is reliable, timely, and independent (not susceptible to alteration or omission). They should also ensure the agency has clear rules and standards in place across all centers, and that measurable goals have been defined in order to effectively track performance.

These improvements could include the following:

- Review USDVA inspections in detail to gain an understanding of the true issues at each center, not merely their "pass or fail" status. Limit acceptance of provisional certifications, and evaluate whether violations were repeated from the previous year's inspection.
- Research the possibility of using independent personnel to conduct peer reviews. Review detailed peer review results in a timely manner, and compare peer review results to USDVA inspection results after identifying how many repeat violations will be considered permissible.

- Develop a method for following up on and enforcing corrective action plans created to address inspection results (for both USDVA inspections and peer reviews). Enforcement efforts could include linking these results to an evaluation of the administrator's job performance. If the Commission is unable to perform these tasks, the responsibility for evaluating and licensing centers should be transferred to an outside entity.
  For example, the veterans centers were previously subject to the Oklahoma Nursing Home Care Act. If OSDH were to resume responsibility for inspections, it would be imperative that they also have enforcement abilities, including the right to determine whether the centers maintain their licenses.
- Ensure presentation of resident survey results is consistent between centers and set expectations for those results, such as a certain percentage of satisfaction that all departments should meet. In cases where the goals are not met, evaluate the potential cause to determine whether the failure was due to poor performance or other issues, such as the lack of sufficient resources. Work with management to develop and follow up on a plan for improvement.
- Consider gathering information from the veterans center ombudsmen, who could be an excellent independent resource. Ombudsmen visit the centers regularly and are familiar with both residents and staff. They could also be involved in center inspections, as they attend Oklahoma State Department of Health nursing home inspections as "citizen observers." Ombudsmen perform their own inspections and could provide the results directly to those charged with governance, rather than to center personnel.
- Ensure the Commission is able to gather information about center performance on more than an annual basis, as many of the tools discussed here are performed once per year. This could include more detailed presentations from center management at board meetings, electronic reporting, and occasional visits to the centers.

If OSDH resumes responsibility for performing center inspections, it is imperative that OSDH also has enforcement capability.

Views of Responsible Officials

Management concurred with all of our recommendations related to structure and centralization, and provided the following responses:

Response #8, Centralize Appropriate Functions within ODVA: ODVA SOPs are the policy for the agency and are compliant with state and federal laws and regulations. The procedure manuals maintained by each of the veterans centers are the documented process for implementing and ensuring compliance with SOPs. Opportunities exist for the standardization of documented business processes across the veterans centers. We will begin the process of standardizing documented business processes.

ODVA management will revise policies and develop internal controls to help ensure that reporting of events to outside entities is completed in accordance with state and federal requirements.

ODVA management is evaluating our current training and testing materials and will implement an updated program based on our findings.

Response #9, Restructure and Improve the Investigation Process: Currently we are developing and implementing an Investigation unit within the Safety and Security Department at Central Office. This office will be available to conduct investigations as directed. ODVA is in the process of hiring another full time investigator and developing policies and procedures for this unit.

Response #10, Improve Hiring Processes: The newly developed Investigation unit will conduct all federal criminal background checks on all potential new hires. In addition, we will maintain a spreadsheet that shows the results of those checks. We are developing policies and procedures for the centers to provide information to the Investigation unit on all employees that are discharged. The Investigation unit will maintain a record of all ineligible personnel and inform the centers of their findings.

Response #11, Appoint Full-Time Deputy Director: Deputy Director was appointed as of March 18, 2013.

Response #12, Improve the Quality and Independence of Monitoring Tools: The development of a formalized program monitoring and evaluation reporting system will provide management and Commissioners with a better understanding of how the organization is performing. Agency performance measures will be objective, quantifiable, and will be benchmarked against established industry standards.

ODVA management recognizes that internal evaluation (peer review) has its own strengths and weaknesses. We believe that a rigorous internal evaluation program complements external evaluation and enhances the overall quality of our services. We expect the emphasis of the peer review process will shift from licensure recommendation to increased quality of care. Management will work to improve the reporting and follow-up procedures of our peer review process.

ODVA management is researching options to have resident and family satisfaction surveys conducted by an independent third party. We believe this could result in greater participation and more objective results. Management will establish satisfaction goals and courses of action to follow if goals are not met.

A formalized program monitoring and evaluation reporting system will provide management and Commissioners with timely information regarding the current status of the agency as well as trend analysis of past and projected performance.

HUMAN RESOURCE PRACTICES

Observations

As discussed throughout the Senate Task Force hearings[28] and discussions with center administrators, one of those most significant challenges all seven ODVA centers face is that of high staffing turnover. Primarily, turnover results in difficulty in maintaining staffing levels as required by federal law.[29] Without the necessary staff to perform any number of duties, the centers find it extremely challenging to care for their residents. Ultimately, however, centers' residents feel the greatest impact of insufficient staffing as every aspect of their lives, from medical care to food service, depends on the actions of the staff.

[28] SAI viewed meetings that took place during 2012 in which the Oklahoma State Senate conducted an interim study of multiple aspects of ODVA operations.
[29] 38 CFR 51.130(d) and 38 CFR 51.210(g)(1)

We isolated a number of areas with the greatest human resources impact, including staff training, wages and benefits, and the centers' philosophies regarding staff appreciation, and assessed each of those areas to determine whether improvements could reduce staff turnover.

Staffing turnover represents a challenge at all of the veterans centers.

Training

Certain levels of training are required under state and federal law for nursing and personal care staff.[30] Neither state nor federal entities require specific training programs to be used, and ODVA SOPs only specify a number of training hours required for certain procedures. As a result, centers do not uniformly follow the same training and testing protocol.

Discussions with staff and training coordinators revealed opposing viewpoints regarding the quality and extent of training provided. Staff generally felt satisfied with their training, but training coordinators felt somewhat unsatisfied. These viewpoints appear to indicate the training process has inconsistencies, inefficiencies, and inadequacies.

Training at three centers visited[31] consists of the following:

- A mentor program for new hires,
- An orientation program for new hires,
- In-service training for new hires and established staff, and
- Nursing skills assessments for existing staff

Inconsistencies can be found in most training practices. For instance, the practice of mentoring new hires varies from center to center, with some employees reportedly receiving mentoring for a week or more, and yet others not receiving any mentoring. Some employees are mentored on their assigned unit, and others are mentored on a separate unit that may function differently from the employee's assigned unit. This likely results from the fact that, although mentoring occurs to some degree at all the centers, neither SOPs nor centers' policies related to the program appear to exist. Furthermore, mentors do not appear to receive formal training on how to properly train new staff, despite the availability of such training.

[30] Training requirements are issued by the USDVA, the State of Oklahoma, the Oklahoma State Department of Health (specifically for CMA and CNA positions), and the Oklahoma Nursing Board (for RNs and LPNs).
[31] Though all centers were visited during our procedures, only the three highest risk centers were assessed with regard to training: Ardmore, Claremore, and Norman. See Introduction for more information on risk determination.

ODVA SOP #1046 provides for a $1,000 bonus to be paid to certified nurse aides who complete the LEAP (Learn-Empower-Achieve-Produce) mentorship program, but one training supervisor interviewed was unaware of why the program was not being utilized.[32] Moreover, administrators appear to assign mentors based on staff availability, rather than qualifications or abilities.

Topics covered in the orientation program and in-service training are generally the same, but some centers cover in-service topics as needed.

Nursing skills assessments also exhibit some inconsistencies. These assessments typically consist of three areas: competency tests, skills tests, and medication tests. Competency and medication tests are usually multiple-choice, whereas the skills tests provide more hands-on assessment of nursing skills, with functions such as bathing, taking vital signs, etc. Some facilities only administer competency and skills tests to nursing aides; others administer these to all nursing staff. Some facilities use the same tests from year to year, while others create a new test every year or rotate between three. Similarly, medication tests are not even administered at some facilities, whereas at others, the same test is given to licensed staff every year.

In addition to inconsistent training practices, inefficiencies appear to exist as well. Training coordinators are responsible for creating their own tests, rather than being able to access a test bank. Nursing skills do not change from center to center, therefore a number of basic tests could be accessible to all training coordinators. The coordinators could then have the ability to customize those tests to fit the needs of their facility.

ODVA has attempted to provide a degree of centralized training through the HealthCare Academy, an online training program for the long-term care industry. Staff enjoys the flexibility of the online forum, but training coordinators have concerns about the program's content, citing an insufficient level of detail to comply with ODVA SOPs and center policies.

One concern brought to our attention was that staff received test answers during training exercises to expedite the training process. None of the staff interviewed acknowledged this occurrence, but one of the training coordinators said it had been brought to her attention after it had occurred.

[32] For more information on ODVA SOP #1046, please see Appendix D.

Competitive Wages and Benefits

> *ODVA nursing salaries fall up to 41% below the market average.*

A 2011 Annual Compensation Report compiled by the Office of Personnel Management indicates that salaries for multiple nursing services positions fall up to 41 percent below the market average.[33] Additionally, positions in the classified category have not received a legislated salary increase in seven years.[34] Discussions with staff further illuminated this issue, with multiple staff members indicating a pay increase would positively impact the work environment and encourage employees to remain at the agency.

According to ODVA staff, ODVA has adopted the following three-phase hiring process:

- Phase 1: Temporary status for six months with no benefits, and the employee can be terminated for any reason;
- Phase 2: Probationary status for twelve months, the employee receives benefits and can be terminated for any reason; CNAs, specifically, receive a $1 per hour reduction in wages now that benefits are provided; and
- Phase 3: Employee achieves classified status, receives benefits, and is subject to progressive disciplinary actions prior to termination.

The practice of hiring employees without immediate benefits could hinder ODVA's ability to hire qualified, experienced staff.

Recognition and Respect of Staff Contribution

A number of practices occur between staff and administrators that appear to contribute to a poor work environment, including shift changes, scheduling conflicts, a lack of communication with administrators, and a lack of sufficient equipment and supplies. We explored each of these areas through extensive discussions with administrators and staff at the centers.

[33] Nursing services positions and corresponding market comparison include Patient Care Assistants (0.82% to 1.18% below the market average), Licensed Practical Nurses (12.7% to 13.82% below), and Registered Nurses (30.98% to 41.14% below).
[34] ODVA personnel records show nursing positions fall into both classified and unclassified categories. Classified employees' salaries are restricted to certain pay bands and are subject to the Merit System of personnel administration; unclassified employees' salaries are determined by the employing agency and are generally considered at-will. For more information, see the Oklahoma Personnel Act at 74 O.S. § 840.

During the audit period, all centers conducted an employee survey to determine staff interest in working a 12-hour shift, resulting in the decision to transition to such a schedule beginning in October 2012. Transition implementation varied among centers, with some changing to 12-hour shifts by unit and depending on volunteers to staff the shifts, and one center effecting an immediate change for all units but one. Management felt that a 12-hour shift would alleviate some of the staffing shortages and improve the continuity of care, but did not anticipate some of the problems it would cause the employees.

Despite the goal of improving continuity of care, some staff actually felt that the 12-hour shift was simply too long given the level of care employees are expected to provide to residents. Others commented on how the schedule change led to accrual of compensatory time without the ability to redeem those hours. Another problem it caused for employees was that a standard work week totals 40 hours, leaving three days of 12-hours shifts and one day with a 4-hour shift. Each center has a different approach to the remaining four hours, with some allowing employees to choose when to work a separate 4-hour shift, and other centers allowing employees to extend one work day to 14 or even 16 hours. Some might question the quality of care provided by an employee who had been laboring in excess of 12 hours in a single day, let alone 14 or 16.

Scheduling represents another challenge for staff. Schedules for the coming month are typically posted approximately one week in advance. Administrators have to adjust the schedule as needed based on those who call in sick or shortages for other reasons, resulting in employees being asked to work on different shifts at the last minute or being called in to work on their days off. Shift supervisors will, at times, relocate employees to understaffed units due to shortages. These practices could negatively impact the quality of care residents receive because if employees work in an assigned unit for extended periods, they become more familiar with the residents and vice versa, enhancing continuity and quality of care.

Some employees expressed concerns regarding a lack of administrative presence on the floor. At one center, some nurses indicated they never see the administrator, and at another, employees reported the director of nursing (DoN) and assistant DoN never make rounds and generally act unapproachable by remaining in their offices with their doors closed and were unavailable by phone. Administrators reported either making rounds themselves or asking their administrative assistants to make rounds. Generally, staff felt as though administrators needed to make a

greater effort to communicate with them, considering their direct involvement with the residents.

Employees also noted a lack of equipment and supplies at their facilities. At one location, staff reported medical equipment was out of date and weekend staff would often run out of pillowcases and other linens. Inadequately supplied centers would likely cause difficulties for staff and, in turn, the residents who rely on those services.

Studies in the nursing home industry have shown that when positive human resource practices are implemented, residential facilities experience a reduction in staffing turnover and increase in employee satisfaction.[35] An increase in employee satisfaction would likely lead to improved quality of care and life for centers' residents.

Recommendations

In an effort to improve these processes, we offer the following recommendations:

Recommendation #13: Modify Mentor Program

An employee's primary learning experience at a center will take place under a mentor. It is therefore necessary to properly educate mentors in how to train new employees to ensure only proper practices are applied when caring for residents.

The length of the mentor period appears to be informal and the unit assignment for the mentoring inconsistent. Further, employees appear unaware of available financial incentives and available mentor training opportunities. We therefore recommend that ODVA utilize the LEAP program, or explore other mentor training options to ensure mentors have the necessary skills to provide adequate training.

The importance of the mentoring phase may also warrant the implementation of a formal, written policy by the Commission, providing for sources of mentor training, length of the mentoring period, and qualifications mentors must meet.

[35] Dellefield, M.E. (2008). Best Practices in Nursing Homes: Clinical Supervision, Management, and Human Resource Practices. *Research in Gerontological Nursing, 1*,197-207.

Recommendation #14: Implement Healthcare-Specific Supervisor Training

Supervisors do receive some training per statutory and ODVA requirements. Though the standardized training offered by the Office of Management Enterprise Services is necessary to a supervisor's general job functions, it does not satisfy the need for supervisor training specifically in the healthcare industry. We recommend ODVA contemplate the possibility of implementing such a training program.

Recommendation #15: Enrich Compensation through Legislation

To ensure wages and benefits are competitive, management and the Legislature should consider a variety of statutory options to enhance employee compensation and optimize employee classification status. As classified employees, staff is subject to legislatively mandated pay bands and would therefore require legislation to increase salaries. Transitioning certain positions to unclassified status might enable ODVA to offer a compensation package that more closely aligned with the market, depending on the agency's budget, and would also enable ODVA to base pay on job performance rather than pay band.

ODVA should also consider discontinuing the six-month temporary status so that staff could receive benefits immediately upon hire. Such a change might facilitate the hiring of more qualified, experienced staff, as studies suggest benefits play an increasingly important role in employee satisfaction.[36]

Recommendation #16: Analyze Scheduling Process for Staff Impact

Staffing schedules ought to be clear, well-organized, and posted well in advance of the work week, allowing employees to see efforts made to fill vacant shifts and prevent understaffing. Understaffing information, such as the number of shifts currently understaffed, should be provided to the staff in an effort to collaborate on scheduling needs. Additionally, administration and supervisors should minimize transferring employees between units at the beginning of a shift to improve continuity.

[36] Study of Employee Benefits Trends: Findings from the national survey of employers and employees, MetLife, http://whymetlife.com/trends/downloads/MetLife_EBTS09.pdf.

Management should also attempt to quantify the impact of the shift change regarding issues such as quality of medical care provided or staff's ability to accrue and use compensatory time.

Recommendation #17: Engage More with Staff

All administrators and DoNs should adopt open door policies to facilitate communication and foster positive relationships with staff. However, recognizing some employees might hesitate to approach the administrator or DoN, these positions need to allocate some time each day to walk amongst the staff and listen to any feedback they may have. This effort will assure staff their opinions are heeded and valued.

Recommendation #18: Fully Equip and Supply Facilities

Administrators should ensure staff has sufficient equipment and supplies to perform their job duties. Providing staff with adequate supplies enables employees to perform their duties and minimize time away from residents. In cases where equipment is outdated, management should keep staff apprised of efforts to update equipment in order to satisfy expectations.

Views of Responsible Officials

Management concurred with all of our recommendations related to human resources and provided the following responses:

Response #13, Modify Mentor Program: ODVA management is evaluating our current mentoring program and will implement an updated program based on our findings. We believe our new nurse supervisory structure as well as innovative training programs will provide new employees with an environment that will fully develop them as caregivers.

Response #14, Implement Healthcare-Specific Supervisor Training: ODVA management is continuing to develop a more aggressive professional development program for our supervisors. We intend to offer more high-quality training opportunities for our supervisors by partnering with external organizations such as the Alzheimer's Association and the Oklahoma State Department of Health. Management

will also encourage supervisors to attend professional events such as the Oklahoma Department of Human Services Annual Conference on Aging. Participation in these events will help our supervisors develop professional networks and resources. ODVA will continue to utilize the leadership module of the Healthcare Academy online training program for our supervisors.

Response #15, Enrich Compensation through Legislation: As current legislation allows for nurses to be in the unclassified service, all vacant licensed nursing positions are being reallocated to unclassified positions (LPNs, RNs, and other positions that require such licensure).

Additionally, we have approval from the Oklahoma Compensation and Unclassified Positions Review Board to add Certified Nurse Aide, Certified Medication Aide, Veterans Services Officer, and Investigator to the ODVA's authorized unclassified job table. We have also met with legislative leaders to assist the agency and sponsor legislation. The intent is that any new incumbents in the aforementioned positions will be hired as unclassified employees.

The initial hiring of temporary staff was an effort to utilize agency funds to aggressively hire staff. High turnover resulted in many employees leaving before benefits were started. The agency's current focus is to recruit full-time regular employees (with benefits) to get the best qualified staff and the benefit package as part of the value of the job. Temporary staff will continue to be utilized to fill in for full-time staff during absences.

Response #16, Analyze Scheduling Process for Staff Impact: ODVA management has been continuously evaluating our staff scheduling process. Our goal is to meet or exceed all state and federal staffing requirements while providing flexibility and options for our employees.

Response #17, Engage More with Staff: ODVA management supports an open door policy to encourage open communication, feedback, and discussion about any matter of importance to an employee. Routine administrative issues should be handled within the existing chain of command but employees have the ability to interact with management as they deem necessary. ODVA management encourages all administrators

and directors of nursing to walk throughout the center each day to be visible and approachable to the staff and residents.

Response #18, Fully Equip and Supply Facilities: ODVA management will inventory and evaluate their equipment and supply needs. Managers will analyze durable medical equipment life-cycles and establish equipment replacement schedules based on their analysis. This appears to be an isolated case.

OBJECTIVE II	Determine whether the veterans centers' administrators are managing funds appropriately.

As discussed earlier in this report, each of the seven veterans centers operates fairly autonomously. Each center is responsible for the majority of its own payments, including general or "miscellaneous" expenditures, purchase card expenditures, and payments related to resident trust accounts.

Each center is assigned a separate "agency special account" to maintain funds in resident trust accounts, as well as funds donated to the center on behalf of its residents (referred to as the Benefit Fund). Residents receive monthly statements detailing transactions that have occurred in their trust accounts.

We obtained an understanding of the expenditure controls in place over miscellaneous and purchase card expenditures, and over special accounts, at the Ardmore, Claremore, and Norman centers. This was accomplished through discussion with personnel, observation, and review of documentation. We then performed testwork as appropriate to ensure those controls were operating effectively.[37]

Conclusion

Veterans center administrators appear to be managing funds appropriately in some instances, while a number of processes warrant improvement.

Controls over *miscellaneous expenditures and purchase cards* at the Ardmore and Claremore centers appear to provide reasonable assurance that expenditures were accurately reported in the accounting records, while those in place at the Norman center do not. Controls over *agency special accounts* at the Ardmore and Norman centers appear to provide reasonable assurance that expenditures from those accounts were accurately reported in the accounting records, while those in place at the Claremore center do not.

The following observations provide details on areas of potential improvement.

[37] For more details regarding our methodology, please see Appendix A.

Observations

Management of Resident Trust Accounts and Benefit Funds

We also encountered two issues related to the centers' handling of resident trust accounts and Benefit Funds.

The funds in each center's agency special account earn interest, which accrues monthly.[38] ODVA SOP #322, "Patient Accounts," requires that interest earned on trust accounts belonging to deceased or discharged residents be allocated as follows:

- If the interest earned totals less than $5 and a) the account has been released, the interest accrues to the Benefit Fund; or b) the account has not been released, the interest accrues to the resident.
- If the interest totals $5 or more it is posted to the closed account and disbursed to the resident, next of kin, or Unclaimed Properties at the State Treasurer's Office.

According to the SOP, the remaining interest not allocated to deceased or discharged residents should then be allocated to the active resident accounts and Benefit Fund as appropriate.

Prior to May 2012, interest was allocated only to residents with active trust accounts, and not to the accounts of any deceased or discharged residents or to the Benefit Fund. Beginning in May 2012, the interest allocation was improved to allocate interest earned to all resident accounts (including those of deceased or discharged residents that were still active) and the Benefit Fund.

The centers' automated interest allocation process also resulted in calculation errors, potentially causing inaccurate interest payments to residents or to the Benefit Fund. Our discussions with business office staff indicate that they continue to encounter calculation errors in the allocation process. This could result in the same issue: residents or the Benefit Fund may receive too much in interest accrual, or conversely, too little.

When a center resident passes away, his or her remaining trust account balance and possessions must be distributed to the appropriate family member or other designee. ODVA SOP #600, "Disbursement of Deceased Residents Assets," requires that when a resident expires and leaves personal property or funds deposited at a facility, the center must contact the individuals listed on the resident's Designation of Property form, attempting to contact the designated individual multiple times within 90

[38] The average interest earned by agency special accounts across all centers during the audit period was $1,688 per month.

days. The policy further states that if the facility has not received a response 90 days after the initial notification, the property should be reported to the Unclaimed Property division of the State Treasurer's Office on form OST 497-UP-2.

Unclaimed funds in deceased residents' accounts are not being reported to OST after 90 days as required. Personnel at each center attempt to notify the resident's designee for a 90-day period, but only report the unclaimed funds on an annual (or longer) basis. As a result, the agency continues to earn interest on the deceased resident's funds, and that interest is either allocated to the other residents' accounts and the internal Benefit Fund (prior to May 2012) or retained in the resident's account (after May 2012). This deferred reporting also delays Unclaimed Property's ability to publicize the unclaimed funds, which may decrease the probability of the appropriate party discovering and claiming the funds.

It appears in both of these cases, center personnel were not following the established SOP, whether because they were not aware of the requirements contained therein or because management did not enforce them.

Veterans Center Internal Controls

During the scope of our procedures, we encountered internal control weaknesses at two of the centers. At the Norman Veterans Center, the accountant responsible for posting approved invoices to the state's accounting system (PeopleSoft) also initials the resulting claim voucher jackets with no independent review of the information she has posted. This arrangement of duties could allow the accountant to make an unauthorized payment without detection.

As stated in the US Government Accountability Office's *Standards for Internal Control in the Federal Government,*[39] "Key duties and responsibilities need to be . . . segregated among different people to reduce the risk of error or fraud. . . . No one individual should control all key aspects of a transaction."Management appeared unaware of the risk created by this arrangement of duties without additional review of expenditures posted.

[39] Although this publication addresses controls in the federal government, this criterion can be treated as best practices. The theory of controls applies uniformly to federal or state government.

At the Claremore Veterans Center, claims from residents' trust accounts were not properly approved by management and residents. We reviewed a randomly selected sample of 25 such claims from this center and noted the following:

- Two voucher authorizations for resident cash withdrawals were not signed by the administrator.
- A voucher to release trust account funds to a resident bore no signature. Management stated that this was due to the release being requested via telephone and that because the resident had no other payee for his benefits, no signature was required.

An effective internal control system provides for adequate management review of expenditure records. In addition, ODVA SOP #322, "Patient Accounts," requires that the center retain an audit copy of each voucher issued, to which the original approved voucher authorization and original invoice approved by the patient shall be attached.

Without proper management approval of cash withdrawals, inappropriate payments may be made and not detected by staff or residents in a timely manner. Without written approval to release account funds, it seems possible a fraudulent payee could request the release, and the agency would retain no documentation of the disbursal approval. Moreover, without proper approvals and complete documentation submitted to the Business Office, staff may fail to fulfill SOP #322.

It appears management was not aware of the risk created by a lack of timely review, or chose not to review all documentation as required.

Recommendations

In an effort to improve these controls and financial processes at the centers, we provide the following recommendations:

Recommendation #19: Independent Expenditure Review

A staff member independent of the expenditure posting process should review the approved invoices against the resulting claim voucher jackets to ensure the expenditures were posted accurately and appear reasonable. This reviewer should also obtain a PeopleSoft report of all vouchers generated in the time period being reviewed, to ensure all expenditures are included.

While this control deficiency was identified at the Norman center, use of a PeopleSoft report to ensure the voucher review is comprehensive could also improve the expenditure review process at all veterans centers.

Recommendation #20: Address Interest Allocation Errors

Management should work with their technical support provider to repair any interest allocation errors as quickly as possible. This should not only ensure that resident accounts and the Benefit Fund accrue interest appropriately, but should increase efficiency for center business personnel who must currently go through extra procedures to make sure interest is properly allocated.

Recommendation #21: Report Unclaimed Funds in a Timely Manner

Management should ensure that center business personnel report the contents of deceased residents' unclaimed accounts to OST on a timely basis. This may require clarification in the SOP language or additional training and monitoring of related center accounting activity.

Recommendation #22: Improve Trust Account Approvals at the Claremore Veterans Center

Management should ensure all cash withdrawals are signed by the required personnel in order to avoid inappropriate payments and to comply with ODVA SOP #322. Management should also ensure that signature approval is received for the release of trust accounts in order to verify the requestor is truly an authorized individual, and to maintain a record of the individual requesting and approving the release.

Views of Responsible Officials

Management concurred with three of our four recommendations related to funds management and partially concurred with the remaining recommendation. They also provided the following responses:

Response #19, Independent Expenditure Review: ODVA strongly believes that segregation of duties is a primary principle in any internal control plan in order to provide adequate checks and balances and that no one person should have excessive control over one or more critical processes. This recommendation however is primarily based on only two

of the seven centers and corrective actions have been implemented at the two centers as recommended.

Response #20, Address Interest Allocation Errors: ODVA believes in resolving problems that are identified in a reasonable time frame. We communicated with our technical support on a regular basis and it took a longer time to fix than anticipated. Corrective action is in place.

Response #21, Report Unclaimed Funds in a Timely Manner: SOP #600-Disbursement of Deceased Residents Assets was revised and updated effective January 2013. SOP provides specific guidance regarding reporting to OST to be compliant with ODVA Administrative Code 770:10-3-6 and 58 O.S. §§ 393 and 394. It should be noted that items that are not stored in a safe deposit box or other safekeeping repository are not accepted by OST per statute 60 O.S. § 657.3.

Response #22, Improve Trust Account Approvals at Claremore Center: This recommendation is based on one veterans center. A new administrator was hired on November 19, 2012 and with their hiring, a number of business practices have since been changed and revised. Quality Assurance will perform regularly scheduled reviews of patient trust fund accounts to ensure monies disbursed are in accordance with the provisions of SOP #322- Patient Accounts.

PROSPECTIVE AREAS FOR FURTHER STUDY

During the course of the engagement, the following issues came to our attention. While further procedures related to these issues were not performed, they merit future consideration:

- Consolidation of veterans centers
- Analysis of cost per resident
- Implementation of in-house training and certification program after staffing has been stabilized
- Centralization of procurement functions

APPENDICES

APPENDIX A

Audit Methodology

Additional Risk Assessment and Planning Procedures:

In order to gain an understanding of the agency, we performed the following:

- Interviewed ODVA past and present commissioners, management, and staff; relevant state legislators and cabinet members; and representatives of outside agencies as appropriate.
- Reviewed relevant federal and state statutes and regulations.
- Reviewed Oklahoma's Single Audit for fiscal years 2011 and 2010.
- Reviewed media coverage of events related to ODVA.
- Reviewed ODVA's board meeting minutes, fiscal year 2013 executive budget, policies and procedures, internal and external center evaluations, financial reports, and related documents and records.
- Viewed Senate Task Force hearings related to ODVA.

We performed additional interviews and procedures as necessary.

Our risk assessment of the three major program areas of the agency included an analysis of expenditures and full-time employees from each program, as follows (data obtained from the FY 13 Executive Budget, unaudited):

Expenditures:

	FY-2010 (Actual)	FY-2011 (Actual)	FY 2012 (Budgeted)
Nursing Services	$ 123,603,000	$ 113,546,000	$ 116,175,000
Claims & Benefits Administration	$ 1,876,000	$ 1,705,000	$ 2,243,000
Central Administration	$ 4,056,000	$ 4,104,000	$ 4,852,000

Full-Time-Equivalent Employees:

	FY-2010 (Actual)	FY-2011 (Actual)	FY 2012 (Budgeted)
Nursing Services	1884.6	1821.0	1824.8
Claims & Benefits Administration	24.3	25.6	31.8
Central Administration	24.1	26.3	33.9

Objective I Methodology:

To accomplish our objective, we performed the risk assessment and planning steps described on the previous page, and deepened our understanding of the relevant issues with the following procedures:

- Further review of relevant policies, procedures, statutes, and regulations;
- Further review of pertinent ODVA documentation and records, including peer review, inspection, and investigation results;
- Observation at all the veteran's centers and discussions with management, staff, and residents;
- Review of applicable best practices and comparison of those practices to ODVA's structure and procedures.

We performed further research, interviews, and procedures as needed.

Objective II Methodology:

To accomplish our objective, we performed the following:

- Obtained an understanding of internal controls related to the expenditure processes (including purchase card expenditures, miscellaneous expenditures, and agency special fund expenditures) at the Ardmore, Claremore, and Norman centers through discussion with personnel, observation, and review of documentation.

- Tested those controls using the following procedures:

    - Randomly selected 37 miscellaneous expenditure claims totaling $39,882.90 and 60 p-card expenditure claims totaling $26,617.39, chosen proportionately from each center based upon their rate of expenditures, and ensured they were properly approved by authorizing personnel independent of the expenditure initialization and posting processes. Note that miscellaneous expenditure claims were not tested for the Norman center because, as discussed in the report, they did not have adequate internal controls in place to rely upon for our testwork.

    - Determined warrants were received by personnel independent from the expenditure posting process.

    - Randomly selected 60 payments from residents' trust accounts totaling $26,760.21, divided proportionately between the three centers based upon their rate of expenditures (12 from Ardmore, 25 from Claremore, and 23 from Norman), and ensured they were properly approved by the residents and management.

- Determined resident trust account expenditures were approved by authorizing personnel independent of the expenditure posting process.
- Confirmed the centers provide a monthly trust account statement to each resident.
- Determined whether checks used to create payments from resident trust accounts and the Benefit Fund are pre-numbered and monitored for sequential use.
- Randomly selected three months (25% of the audit period) and reviewed the agency special account reconciliations for those months from each of the three high-risk centers, to ensure they were prepared and separately approved by personnel independent of the expenditure posting process.

APPENDIX B

Executive Director Operating Policy #3

The Commission will make an annual performance evaluation of the Executive Director on the anniversary of his employment. During this evaluation, the Director will review the performance of his management staff and Administrators with the Commission.

APPENDIX C

ODVA Deputy Director Job Description

DEFINITION:

Under administrative direction, plans, coordinates and directs various agency support programs and services; assists the agency director in planning and coordinating direct care programs, claims and benefits, and agency operations.

Position assigned responsibility for planning and directing agency programs as directed by agency director, which may include, but not limited to claims, human resources, finance, budget, and other support functions and the coordination of these programs with operational activities and requirements. Responsibility for continued agency operations is assigned in the absence of the Executive Director.

EXAMPLES OF WORK PERFORMED:

Directs, coordinates and plans major agency programs involving support of direct care operations and activities; advises Director on problems and issues of day-to-day operations; assists in interpreting laws and regulations concerning veterans' services and benefits and in developing policies and procedures to ensure compliance with state and federal requirements.

Reviews complaints and inquiries received by the Executive Director; conducts investigations and directs preparation of responses to complex or sensitive issues; recommends changes as needed to resolve complaints or potential problems; represents Director in meetings with individuals or groups as necessary.

Develops and implements agency procedures for compliance with the Administrative Procedures Act, Open Meeting Law and Open Records Act; advises agency Director, Division Administrators, Controlling Board and Supervisors on the statutory requirements of these laws; develops proposed rules and internal policy and procedures manual concerning various agency programs.

Serves as chairperson of agency Legislative Affairs Committee; identifies areas of concern for review and resolution; directs preparation of proposed laws, revisions or amendments; consults with legislative staff to coordinate drafting and introduction into the legislative process; responds to legislative inquiries as needed.

Directs Risk Management Program for the agency; reviews incident reports; recommends or implements solutions in problem areas; coordinates with safety committee to insure areas of risk are in compliance with laws related to safe working environments.

Coordinates purchasing and inventory activities for the central agency office; directs the preparation of property inventory records; ensures purchases are in compliance with the Central Purchasing Act.

Develops and directs the agency records disposition program; ensures records are maintained or destroyed in compliance with federal and state laws.

Performs related work as required and assigned.

KNOWLEDGE AND SKILLS:

Knowledge of federal and state laws and regulations concerning veterans benefits and services; of veteran services programs; of laws and regulations pertaining to administrative procedures, disposition of records and risk management; of personnel and fiscal management; of the legislative process; of public administration; and of the principles of management and supervision. Skill in planning, organizing and directing the work of others; in planning and coordinating program requirements; in establishing effective working relationships with others; and in communicating effectively, both orally and in writing.

EDUCATION AND EXPERIENCE:

Requires a minimum of a master's degree and five (5) years of professional level experience in public administration, health or hospital administration; or an equivalent combination of education and experience, substituting one (1) additional year of qualifying experience for each year of the required education.

NOTE: Professional experience in the fields listed must have been the primary job responsibility to be considered as qualifying. Incidental performance of professional work in any area shall not be considered.

SPECIAL REQUIREMENTS:

Applicants must be willing and able to fulfill all job related travel normally associated with this position.

APPENDIX D

ODVA Standard Operating Procedure #1046

Title: L.E.A.P. – Career Development/Mentorship Program

Summary of Policy:

The LEAP (Learn – Empower – Achieve – Produce) program has been approved by the Office of Personnel Management and provides for a skill-based pay incentive for individuals in the classified Patient Care Assistant job family. Employees in that classification who successfully complete the career development and mentorship program will receive certification and a one time payment of $1,000. The Oklahoma Department of Veterans Affairs has a significantly high turnover rate in Patient Care Assistants (Certified Nurse Aides). The agency is implementing this incentive program to provide additional training and monetary rewards, which in turn as an added benefit will help with recruitment and retention, in addition to reducing the turnover rate. LEAP is a comprehensive workforce development program for nurses and certified nurse assistants working in long-term care. In this training program, PCA's learn effective communication skills, physical inspection skills, care team building, building family and resident relationships, and mentoring techniques for new nurse assistants.

Procedure:

The Agency has amended the Salary Administration Plan to include the granting of a lump sum payment of $1,000 for possession of the certification for completion of the L.E.A.P - Growing the Heart of Care - Career Development for Certified Nurse Assistants / Mentorship Program. The long-term care resident is the central focus of the LEAP workforce initiative. This is a 7-week (minimum of 2 hours each week) workshop which focuses on the development of highly qualified, and effective long term care leaders and staff which will benefit the quality of life and well-being for our residents.

In accordance with Title 74: 840-2.17, use of any pay movement mechanisms is subject to use of funds available in the Agency's budget for the current and subsequent fiscal year without the need for additional funding. The Department of Veterans Affairs has sufficient funding available in the current fiscal year budget and next year's fiscal budget to accommodate the utilization of the skill-based pay movement mechanism described in this request.

Training Program / Certification:

LEAP training will be set up at each facility and be provided at least once a year. Notices of upcoming training will be posted on in-house bulletin boards at least two weeks prior to the scheduled training. An employee must meet the minimum requirements to be eligible to apply for training, as follows:

1. Permanent classified Patient Care Assistant;

2. Three years experience in providing patient care;

3. Current certification by the OK Department of Health as a Long Term Care Nursing Aide;

4. Completion of LEAP application;

5. Possess a letter of recommendation from an ODVA staff LPN;

6. Possess a letter of recommendation from an ODVA co-worker, and

7. Completion of interview process.

Applicant employees will be interviewed by a team of at least three supervisors and/or managers. The interview questions will be standardized throughout the agency. Time and attendance records will be considered as part of the interview process. The number of employees selected for training will depend upon the class size in the upcoming certification class.

For an employee to successfully complete the training and qualify for the skill-based pay; he/she must attend all required classes and score 60% or above on the post-test. After successful completion of the training, the employee will receive certification and the lump-sum payment. An employee approved to receive a skill-based payment will receive one payment for initial certification only, regardless of the number of times the person may be re-certified. At the conclusion of the training and certification process, the Director of Nurses shall submit the names of the employees who have successfully completed the LEAP Career Development/Mentorship program to the Veterans Center Administrator. The Administrator will review the information and submit the names to the Central Office Human Resources Programs Manager for payroll processing. Applicable taxes will be withheld from the payment, as with any other wages paid to the employee.

Mentor Positions:

Each facility will establish Level III Patient Care Assistants (Mentor) positions, not to exceed ten on the day shift, eight on the evening shift, and eight on night shift. The Administrator has sole discretion as to the number of positions required for their respective facility not to exceed the limits set herein. Positions will be posted in accordance with agency policy providing notice to eligible employees. To be eligible to apply, the applicant must be a permanent classified employee with the agency and have LEAP certification, in addition to the minimum requirements of the Y10C, Patient Care Assistant, Level III job family descriptor.

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