US DEPARTMENT OF VETERANS AFFAIRS
**OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

## VETERANS HEALTH ADMINISTRATION

# Healthcare Facility Inspection of the Sheridan VA Health Care System in Wyoming

| Healthcare Facility Inspection | 24-00615-163 | July 10, 2025 |
|---|---|---|

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To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

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# Executive Summary

The Office of Inspector General's (OIG's) mission is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs (VA). Furthering that mission, and building on prior evaluation methods, the OIG established the Healthcare Facility Inspection cyclical review program. Healthcare Facility Inspection teams review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle to measure and assess the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, as well as the well-being of patients and staff.

## What the OIG Found

The OIG physically inspected the Sheridan VA Health Care System (facility) from August 20 through 22, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

### Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Executive leaders identified system shocks as a patient suicide, and the COVID-19 vaccine requirement for VA staff that resulted in 30 percent of the nursing staff resigning.[2]

Leaders reported using a just culture approach to investigate the events surrounding the patient suicide.[3] In response to the investigation results, leaders changed the policy on what personal items patients can keep in the medical unit and which staff must complete an inventory.

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[1] See appendix A for a description of the OIG's inspection methodology. Additional information about the facility can be found in the Facility in Context graphic below, with a detailed description of data displayed in appendix B.

[2] The OIG published a report related to the patient suicide with four recommendations. VA OIG, *Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming*, Report No. 23-03159-204, July 25, 2024.

[3] "Just culture is an environment that balances the need for an open and honest reporting environment with the end goal of organizational and behavioral improvement. While the organization has a duty and responsibility to employees (and ultimately to Veterans), all employees are held responsible for the quality of their choices. Just culture requires a change in focus from errors and outcomes to systems design and management of the behavioral choices of all employees." VHA Directive 1003, *VHA Veteran Patient Experience,* April 14, 2020.

A leader described traveling up to five hours to recruit new staff at the only four-year university in the state and using a scholarship program as a recruitment tool. Leaders also discussed the scarcity of specialty services in the area due to the facility's geographic location, as well as their efforts to increase access to services by using telemedicine and partnering with another VA medical system.

Leaders acknowledged the importance of communicating with supervisors and staff through town halls and meetings in their work areas to discuss issues. Leaders discussed sharing successes by implementing a Great Catch award, designed to recognize staff for reporting a significant concern and working with others to resolve it. The Director also reported meeting regularly with veterans service organization representatives to share information.[4] Patient advocates stated that leaders were responsive to veterans' concerns.

## Environment of Care

The OIG examined the general entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also physically inspected patient care areas and compared findings from prior inspections to determine if there were recurring issues.

During the physical inspection, the OIG found the main entrance to be clean, well-maintained, and welcoming, with complimentary coffee and cookies. The OIG also found clinical and nonclinical areas had personal protective equipment available and medications and supplies secured.

The OIG found there were no cameras or emergency call boxes in patient and visitor parking lots, which could delay response times in the case of an emergency. While VHA does not require cameras and emergency call boxes, the OIG suggests leaders add them to enhance safety. Additionally, the OIG found the facility lacked navigational cues, such as braille text and audio instructions for veterans with sensory impairments. The OIG made one related recommendation.

## Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. Although leaders had processes for staff to communicate test results to providers, they had not developed workflows for each service that describe team members' roles

[4] Veterans service organizations are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families. Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

in communicating results to patients, as required.[5] The facility policy also did not outline a way to monitor the effectiveness of the patient notification process. The OIG made two recommendations.

The OIG also reviewed its oversight report and the 2022 Joint Commission survey and found no open recommendations related to the communication of test results.[6] However, the facility had two open recommendations from the OIG hotline inspection about a veteran's suicide, published less than a month before the site visit.[7]

## Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act affected the primary care delivery structure and new patient appointment wait times.[8]

Facility leaders and staff reported shortages of providers, nurses, and telehealth clinical technicians. Leaders attributed the shortages to lack of nursing programs, as well as the high cost of living in Wyoming. Leaders also stated the consolidation of human resources staff at the Veterans Integrated Service Network contributed to hiring and onboarding delays.[9] However, facility leaders had offered special salary rates and other incentives to recruit and retain staff.

Primary care team members shared concerns related to scheduling issues at the Veterans Integrated Service Network's centralized call center. Primary care leaders described communicating regularly with Veterans Integrated Service Network staff to address call center concerns. The OIG found that overall enrollment at the facility did not increase since implementation of the PACT Act, and primary care staff stated veterans screened for toxic exposures were satisfied with follow-up services and access to VA benefits.

## Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff

[5] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[6] VA OIG, *Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center in Wyoming*, Report No. 23-00122-118, March 26, 2024.

[7] VA OIG, *Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming*.

[8] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022).

[9] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/.

identify and enroll veterans and to assess how well the programs meet veterans' needs. Program staff conducted mobile stand down events and worked with community partners to obtain housing for homeless veterans.[10] However, staff described a lack of affordable housing for veterans. The Homeless Team Supervisor discussed a local nonprofit facility that had 11 individual rooms dedicated for veterans.

## What the OIG Recommended

The OIG made three recommendations.

1. Facility leaders implement tools to help sensory-impaired veterans navigate the facility.
2. Facility leaders ensure the facility has a policy for test result communication that includes methods to monitor the effectiveness of the patient notification process.
3. Facility leaders ensure staff develop workflows for the communication of test results for each service.

## VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

[10] "Stand Downs are an outreach strategy to engage homeless Veterans and present them with longer-term treatment and housing opportunities. The 1- to 3-day events provide homeless Veterans a temporary refuge where they can obtain food, housing assistance, supplies and a range of community and VA assistance. In many locations, Stand Downs provide health screenings, referral and access to housing and treatment services, benefits counseling, ID cards and access to other programs to meet a Veteran's immediate needs." VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

# Abbreviations

| | |
|---|---|
| FY | fiscal year |
| HCHV | Health Care for Homeless Veterans |
| HRO | high reliability organization |
| OIG | Office of Inspector General |
| PACT | Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |
| VSO | veterans service organization |

# FACILITY IN CONTEXT

**Sheridan VA Health Care System**
**Sheridan, Wyoming**
Level 3-Low Complexity
Sheridan County
Hospital Referral Region: Billings, Montana

## Description of Community

### POPULATION

| | |
|---|---|
| Female **357,971** | Male **366,783** |
| Veteran Female **5,949** | Veteran Male **47,728** |

Homeless - State **648**
Homeless Veteran -State **68**

### MEDIAN INCOME

**$55,418**

### EDUCATION

**94%** Completed High School
**66%** Some College

### VIOLENT CRIME

Reported Offenses per 100,000 **202**

### SUBSTANCE USE

**39.7%** Driving Deaths Involving Alcohol
**23.9%** Excessive Drinking
**64** Drug Overdose Deaths

### UNEMPLOYMENT RATE

**3%** Unemployed Rate 16+
**2%** Veterans Unemployed in Civilian Workforce

### TRANSPORTATION

| | |
|---|---|
| Drive Alone | 268,246 |
| Carpool | 32,002 |
| Work at Home | 28,986 |
| Walk to Work | 17,360 |
| Other Means | 6,554 |
| Public Transportation | 2,653 |

### AVERAGE DRIVE TO CLOSEST VA

| | |
|---|---|
| Primary Care | **67 Minutes, 67.5 Miles** |
| Specialty Care | **114.5 Minutes, 116.5 Miles** |
| Tertiary Care | **412 Minutes, 493 Miles** |

## Access to Health Care

### ACCESS

VA Medical Center Telehealth Patients **4,460**

| | |
|---|---|
| Veterans Receiving Telehealth (VHA) | 41% |
| Veterans Receiving Telehealth (Facility) | 40% |
| <65 without Health Insurance | 17% |

# Health of the Veteran Population

**VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY**

2,837

**95** VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

**AVERAGE INPATIENT HOSPITAL LENGTH OF STAY**

5.77 Days

**30-DAY READMISSION RATE**

9%

**SUICIDE RATE PER 100,000**

| Suicide Rate (state level) | Veteran Suicide Rate (state level) |
|---|---|
| 40 | 80 |

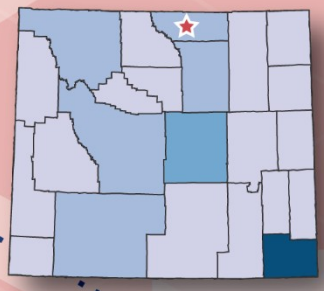
# Health of the Facility


**UNIQUE PATIENTS**

| | |
|---|---|
| Unique Patients VA and Non-VA Care | 13K |
| Unique Patients VA Care | 12K |
| Unique Patients Non-VA Care | 9K |

**COMMUNITY CARE COSTS**

| | |
|---|---|
| Unique Patient $11,184 | Outpatient Visit $426 |
| Line Item $1,410 | Bed Day of Care $239 |



**STAFF RETENTION**

| | |
|---|---|
| Onboard Employees Stay <1 Yr | 11.98% |
| Facility Total Loss Rate | 13.19% |
| Facility Retire Rate | 3.61% |
| Facility Quit Rate | 7.78% |
| Facility Termination Rate | 1.67% |

★ VA MEDICAL CENTER

VETERAN POPULATION

0.38% 5.24% 10.10% 14.96% 19.82% 24.61%

See Appendix B: Facility in Context Data Definitions for a detailed description of data displayed.

# Contents

# Background and Vision

The Office of Inspector General's (OIG's) mission is to conduct meaningful independent oversight of the Department of Veterans Affairs (VA). The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care to over nine million veterans through 1,321 healthcare facilities.[1] VHA's vast care delivery structure, with its inherent variations, necessitates sustained and thorough oversight to ensure the nation's veterans receive optimal care.

The OIG established the Healthcare Facility Inspection (HFI) cyclical review program to help accomplish its mission. HFI teams routinely evaluate VHA medical facilities on an approximately three-year cycle. Each cyclic review is organized around a set of content domains (culture, environment of care, patient safety, primary care, and veteran-centered safety net) that collectively measure the internal health of the organization and the resulting quality of care, set against the backdrop of the facility's distinct social and physical environment. Underlying these domains are VHA's high reliability organization (HRO) principles, which provide context for how facility leaders prioritize the well-being of staff and patients.


***Figure 1.*** *VHA's high reliability organization framework. Source: Department of Veterans Affairs, "VHA's Journey to High Reliability."*

HFI reports illuminate each facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. These reports are intended to provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care received; and increase engagement for facility leaders and staff by noting

[1] "About VHA," Department of Veterans Affairs, accessed May 29, 2024, https://www.va.gov/health/aboutvha.

specific actions they can take to improve patient safety and care.

## High Reliability Organization Framework

HROs focus on minimizing errors "despite highly hazardous and unpredictable conditions," such as those found in healthcare delivery settings.[2] The aviation and nuclear science industries used these principles before the healthcare sector adopted them to reduce the pervasiveness of medical errors.[3] The concept of high reliability can be equated to "persistent mindfulness" that requires an organization to continuously prioritize patient safety.[4]


***Figure 2.*** *Potential benefits of HRO implementation. Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

In 2018, VHA officially began the journey to become an HRO with the goals of improving accountability and reliability and reducing patient harm. The HRO framework provides the blueprint for VHA-wide practices to stimulate and sustain ongoing culture change.[5] As of 2020, VHA implemented HRO principles at 18 care sites and between 2020 and 2022, expanded to all VHA facilities.[6]

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient outcomes.[8] The OIG's inspectors observed how facility

[2] Stephanie Veazie, Kim Peterson, and Donald Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles," *Evidence Synthesis Program*, May 2019.

[3] Veazie, Peterson, and Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles."

[4] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/high-reliability.

[5] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*, March 2020, revised in April 2023.

[6] "VHA Journey to High Reliability, Frequently Asked Questions," Department of Veterans Affairs, https://dvagov.sharepoint.com/sites/vhahrojourney/SitePages/FAQ_Home.aspx. (This web page is not publicly accessible.)

[7] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality.

[8] Stephanie Veazie et al., "Implementing High-Reliability Principles Into Practice: A Rapid Evidence Review," *Journal of Patient Safety 18*, no. 1 (January 2022): e320–e328, https://doi.org/10.1097/pts.0000000000000768.

leaders incorporated high reliability principles into their operations. Although not all facilities have formally piloted VHA's HRO framework, it is vital that facility leaders emphasize patient safety in their operational and governance decisions.

## PACT Act

In August 2022, the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act became law, which expanded VA health care and benefits to veterans exposed to toxic substances.[9] The PACT Act is "perhaps the largest health care and benefit expansion in VA history."[10] As such, it necessitates broad and sustained efforts to help new veteran patients navigate the system and receive the care they need. Following the enactment, VHA leaders distributed operational instructions to medical facilities on how to address this veteran population's needs.[11] As of April 2023, VA had logged over three million toxic exposure screenings; almost 42 percent of those screenings revealed at least one potential exposure.[12] The OIG reviewed how PACT Act implementation may affect facility operations and care delivery.

[9] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022).

[10] "The PACT Act and Your VA Benefits," Department of Veterans Affairs, accessed April 21, 2023, https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.

[11] Assistant Secretary for Management and Chief Financial Officer; Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness; Assistant Secretary for the Office of Enterprise Integration, "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding," October 21, 2022. Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," October 31, 2022. Director VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," November 22, 2022.

[12] "VA PACT Act Performance Dashboard," VA. On May 1, 2023, VA's website contained this information (it has since been removed from their website).

# Content Domains


***Figure 3.*** *HFI's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
*Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(1), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 17, 2024; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.*

The OIG evaluates each VHA facility across five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The evaluations capture facilities' successes and challenges with providing quality care to veterans. The OIG also considered how facility processes in each of these domains incorporated HRO pillars and principles.

The Sheridan VA Medical Center, part of the Sheridan VA Health Care System (facility), opened in 1922 to serve veterans returning from World War I. At the time of the inspection, the facility's executive leaders included the Medical Center Director (Director), Chief of Staff, Associate Director for Patient Care Services, and Associate Director. The Director, assigned in August 2017, was the most tenured executive leader. The Associate Director, assigned in January 2022, was the least tenured. The facility had 102 operating beds (19 inpatient, 48 domiciliary, and 35 community living center), and a fiscal year (FY) 2023 budget of approximately $224 million.[13]


A 2019 study of struggling healthcare systems identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[14] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[15] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[16]

[13] A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed December 2, 2024, https://www.va.gov/homeless/dchv.asp. "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed December 2, 2024, https://www.va.gov/VA_CLC.

[14] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality and Safety* 28 (2019): 74–84, https://doi.org/10.1136/bmjqs-2017-007573.

[15] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

[16] For more information on the OIG's data collection methods, see appendix A. For additional information about the facility, see the Facility in Context graphic above and associated data definitions in appendix B.

## System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[17] An example of a planned system shock is the implementation of a new electronic health record system. An example of an unplanned system shock is a patient suicide on a VHA medical facility campus. By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[18]

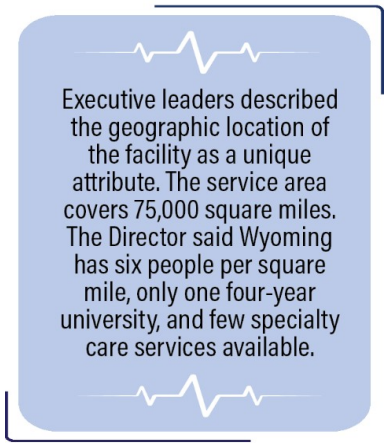



***Figure 4.*** *Facility systems shocks. Source: OIG interviews.*

The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks. In an interview, facility leaders identified the COVID-19 vaccine mandate and a 2023 veteran suicide as two system shocks.[19]

A leader said the vaccine requirement led to the resignation of 30 percent of the nursing staff, resulting in bed closures and realignment of services; the Urgent Care Center closed in 2022, and the number of Community Living Center beds decreased from 55 in 2020 to 20 in 2022. The leader stated that because of Wyoming's small population, the number of qualified professionals available to fill vacant positions was limited. A leader also reported traveling up to five hours to recruit new staff from the only four-year university in the state. One leader added they offer the Health Professional Scholarship Program, which provides scholarships for trainees or students in healthcare-related fields in exchange for working in a VA facility.

To ensure veterans had the best possible access to specialty services, leaders discussed using national telemedicine and VA regional resources. A leader shared that they hired a part-time cardiologist who is based in Florida to provide care through telemedicine to veterans at the facility. The leader also explained that there is a full-time podiatrist who cares for veterans in VA clinics and conducts house calls throughout the facility's service region. The facility did not have surgical services, so leaders partnered with the Montana VA Healthcare System so the podiatrist

[17] Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies."

[18] Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies"; Department of Veterans Affairs, *VHA HRO Framework.*

[19] All VA staff were required to provide evidence they received a complete series of COVID-19 vaccinations or request an exception based on medical or religious reasons. VA Notice 22-01, *Mandatory Coronavirus Disease 2019 (COVID-19) Vaccination Program for VA Employees,* October 4, 2021.

could perform surgical procedures at that location on veterans assigned to the Sheridan VA Health Care System.

A veteran died by suicide on a medical unit in 2023.[20] Leaders reported using a just culture approach to identify factors that may have contributed to the patient's death by suicide.[21] As a result of the investigation, leaders changed the policy about prohibited personal items that veterans could use to harm themselves in the medical unit, as well as which staff are responsible for completing the personal item inventory. Based on an interview, the OIG determined the leadership team emphasizes patient safety and continuous improvement.

## Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[22] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[23] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[24] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine

**EXECUTIVE LEADER COMMUNICATION**

Executive leaders stated they communicate with staff during online town halls held at least twice a month. During these events, the leaders respond to previously submitted anonymous questions and allow staff to ask questions during open microphone sessions. The town halls are recorded and posted to the facility intranet page.

**EXECUTIVE LEADER INFORMATION SHARING**

Executive leaders said they share information through their Daily Management System huddle, where they meet with supervisors to discuss action plans that are due, any police or patient safety reports from the previous day, and other items of interest. About 40 to 50 supervisors attend this huddle along with the executive leaders.

***Figure 5.*** *Leader communication with staff.*
*Source: OIG interviews with facility leaders.*

[20] The OIG reviewed this incident and published a report with four recommendations. VA OIG, *Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming*, Report No. 23-03159-204, July 25, 2024.

[21] "Just culture is an environment that balances the need for an open and honest reporting environment with the end goal of organizational and behavioral improvement. While the organization has a duty and responsibility to employees (and ultimately to Veterans), all employees are held responsible for the quality of their choices. Just culture requires a change in focus from errors and outcomes to systems design and management of the behavioral choices of all employees." VHA Directive 1003, *VHA Veteran Patient Experience,* April 14, 2020.

[22] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*, September 2022.

[23] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*; Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[24] The five key systems support hospital wide practices and include using data, planning, communicating, changing performance, and staffing. The Joint Commission, *Standards Manual*, E-dition, LD.03.04.01, January 14, 2024.

how they demonstrated transparency, communicated with staff, and shared information.[25]

The facility's All Employee Survey scores for senior leaders' communication, transparency, and information sharing increased from FY 2021 to FY 2023, although they were lower than VHA averages. In an interview, leaders said they were aware of the scores and described their actions to improve communication with staff. A leader highlighted meeting with staff to discuss issues in their work areas. Leaders also visited every community-based outpatient clinic to meet with staff and address their concerns.

A leader also stated they expect supervisors to communicate with their staff through meetings and publish the meeting minutes on teams' internal web pages. Additionally, leaders hold online town halls at least twice a month and use staff's attendance to gauge the success of their communication efforts.

Leaders also said they recognize staff with Great Catch awards for reporting significant concerns and working with other team members to resolve them. The Chief of Staff described a staff member who received the award for reporting a problem with a facility building's foundation, notifying other staff and veterans, evacuating the building, and making repairs before there was a significant threat. Upon investigation, they found a construction crew had removed a load-bearing beam during the construction of a new clinical area, compromising the entire structure.

[25] The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development.

## Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[26] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[27] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences.

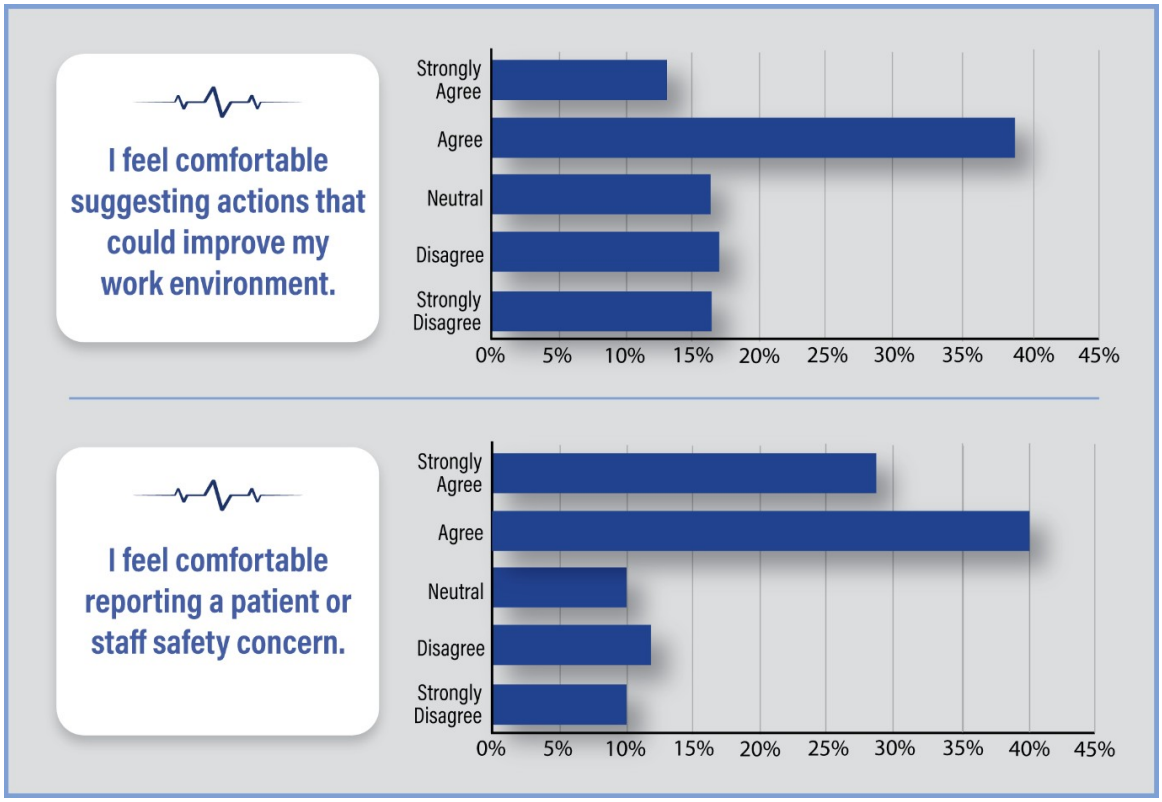



***Figure 6.*** *Employee and leaders' perceptions of facility culture.*
*Source: OIG analysis of questionnaire responses.*

The OIG found the All Employee Survey scores for no fear of reprisal and supervisor trust improved from FYs 2021 to 2023. The scores for best places to work worsened from FY 2021 to FY 2022 but improved for FY 2023. However, facility scores in all three categories were below

[26] "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

[27] Ravinder Kang et al., "Association of Hospital Employee Satisfaction with Patient Safety and Satisfaction within Veterans Affairs Medical Centers," *The American Journal of Medicine* 132, no. 4 (April 2019): 530–534, https://doi.org/10.1016/j.amjmed.2018.11.031.

VHA averages each year. Leaders suggested that responses may reflect disagreement with national guidance, such as the COVID-19 vaccination mandate.

The OIG also reviewed survey questions and leaders' interview responses related to psychological safety. Leaders said that after they identified continuing low psychological safety scores in one service, they requested assistance from the VHA National Center for Organization Development, which led to a series of improvements.[28] Leaders also said they require every supervisor to develop action plans to address the priorities identified by their employees in the All Employee Survey. They also require new supervisors to receive training on communicating with their employees and other supervisors. However, leaders acknowledged they still had opportunities for improvement in this area.

## Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[29] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[30] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

One patient advocate stated there were specific mechanisms for veterans to provide direct feedback to facility leaders, who were responsive to the concerns. In an OIG-administered questionnaire, the patient advocates noted some of veterans' more common complaints were related to access to care, lack of response from care teams, and delays in medication orders or refills.

The Director reported meeting with VSO representatives every other month to share information related to the PACT Act, care in the community, or other topics of interest to veterans.[31] Facility leaders reported patient advocates shared veterans' complaints or questions at daily leadership meetings. Leaders shared several recent complaints related to changes in the Veterans Integrated Service Network's (VISN's) centralized call center: veterans had been unable to reach their

[28] "VHA's National Center for Organization Development (NCOD) collaboratively works with leaders throughout VA to improve organizational outcomes by supporting the development of an engaged workforce." "VHA National Center for Organization Development," Department of Veterans Affairs, accessed September 23, 2024, https://dvagov.sharepoint.com/VHANCOD. (This website is not publicly accessible.)

[29] "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/.

[30] Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

[31] "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "Community Care," Department of Veterans Affairs, accessed February 19, 2025, https://www.va.gov/communitycare/.

providers or had calls dropped.[32] In response, leaders employed Public Affairs staff to share updates about the call center on the facility's internet home page, including work underway to resolve the issues.

# ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[33] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

***Figure 7.*** *Facility photo.*
*Source: Photo taken by OIG inspector.*

## Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[34] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[35]

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[32] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/.

[33] VHA Directive 1608(1).

[34] Roger S. Ulrich et al., "A Review of the Research Literature on Evidence-Based Healthcare Design," *HERD: Health Environments Research & Design Journal* 1, no. 3 (Spring 2008): 61-125, https://doi.org/10.1177/193758670800100306.

[35] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage Design Guide*, December 2012; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised November 1, 2022; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* January 2024; Access Board, *Architectural Barriers Act (ABA) Standards,* 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

## Transit and Parking

The ease with which a veteran can reach the facility's location is part of the healthcare experience. The OIG expects the facility to have sufficient transit and parking options to meet veterans' individual needs.

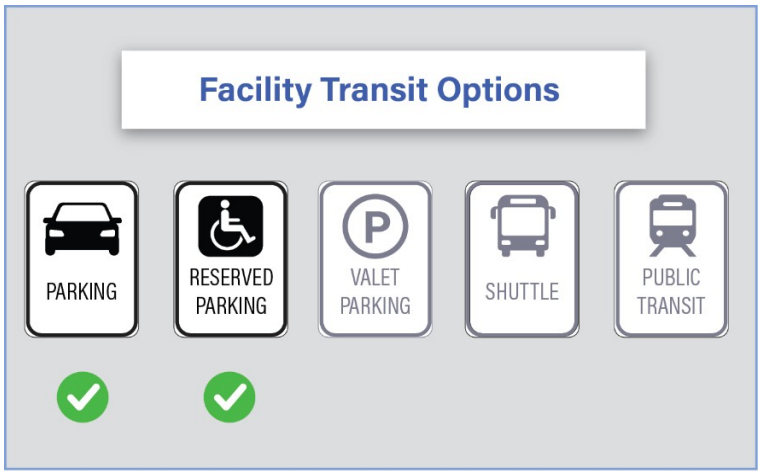


***Figure 8.*** *Transit options for arriving at the facility.*
*Source: OIG analysis of documents and interviews.*

The OIG noted that patient and visitor parking lots had no cameras or emergency call boxes, which could delay emergency response times. Although cameras and emergency call boxes are not required at VHA facilities, the OIG requests leaders consider adding them to enhance safety.

Additionally, there were no shuttle services from the parking areas to the main entrance, and no public transportation serving the facility. Facility leaders addressed the lack of public transportation by hiring three drivers to transport veterans to the facility and back to their homes. Staff explained that during the last six months of FY 2023, the drivers completed 4,505 trips, for approximately 86,000 passenger-miles.

## Main Entrance

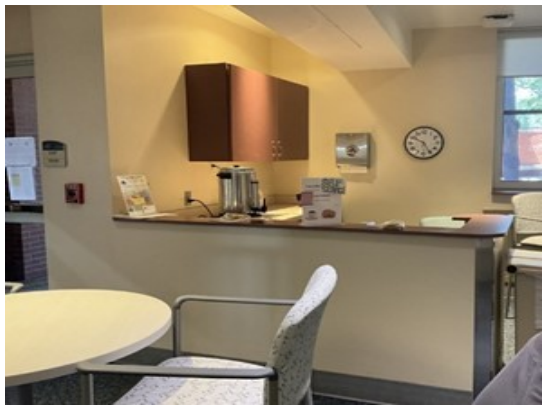

***Figure 9.*** *Main lobby complimentary coffee service area.*
*Source: Photo taken by OIG inspector.*

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[36]

The main entrance has a covered passenger loading zone; power-assisted doors; and wheelchairs, staff, and volunteers to assist veterans. In addition, the main entrance was clean and welcoming, with natural and artificial light. According to staff, the food service and coffee shops were closed due to staffing issues, so they offered complimentary coffee

[36] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

and cookies in the waiting area and had a store with packaged hot food items available.

## Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[37]

The OIG located the facility easily using its website for directions. The website did not have campus maps; however, maps were posted on the facility walls in common areas and hallways. The Chief of Quality and Patient Safety said staff submitted maps for online publication, but they had not been posted at the time of the OIG visit.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[38] The OIG observed sound-absorbing ceiling tiles and a generally low echo environment that facilitated audio communication, as well as adequate staff and volunteers available to assist visually impaired individuals navigate the facility. However, the OIG noted a lack of braille text and audio instructions for visually impaired individuals. The OIG recommends facility leaders implement tools to help sensory-impaired veterans navigate the facility.


***Figure 10.*** *Accessibility tools available to veterans with sensory impairments.*
*Source: OIG observations and interviews.*

## Toxic Exposure Screening Navigators

VA recommends that each facility identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility

[37] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

[38] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; "Best Practices Guide for Hospitals Interacting with People Who Are Blind or Visually Impaired," American Foundation for the Blind, accessed May 26, 2023, https://www.afb.org/research-and-initiatives/serving-needs-individuals-visual-impairments-healthcare-setting; Anjali Joseph and Roger Ulrich, *Sound Control for Improved Outcomes in Healthcare Settings*, The Center for Health Design Issue Paper, January 2007.

based on VA's guidelines.[39] The OIG noted the facility had sufficient space for staff to conduct walk-in toxic exposure screenings, although they screen most veterans during primary and mental health care visits. During OIG interviews, the navigators said they completed several outreach events to encourage veterans to get toxic exposure screenings.

## Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[40] The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues. The OIG did not identify repeat findings from any of these sources.

## General Inspection

Maintaining a safe healthcare environment is an integral component to VHA providing quality care and minimizing patient harm. The OIG's physical inspection of areas in the inpatient, outpatient, and community living center settings focused on safety, cleanliness, infection prevention, and privacy.

The OIG found clinical and nonclinical areas, and a unit in the community living center to be safe, with readily available personal protective equipment. All inspected medical equipment had evidence of current inspections, and no protected patient information was visible. The OIG also found secure and unexpired medications and supplies.

However, in the community living center, the OIG found a wound care cart stored in a closet that was not considered clean. Staff must take infection prevention measures to prevent harm to patients and themselves. The Medical Unit Nurse Manager reported being unaware staff had stored the cart in that closet because it had a designated storage location. Staff relocated the cart to an appropriate location while the OIG was on the unit.

[39] Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN), October 31, 2022; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

[40] Department of Veterans Affairs, *VHA HRO Framework*.


The OIG explored VHA facilities' patient safety processes. The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement.

## Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[41] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[42] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

Patient safety staff said the facility had processes that establish staff's responsibility to notify the ordering provider of test results, identify a backup provider when needed, and indicate which abnormal test results required follow-up. However, the OIG determined leaders did not have written workflows (describing the team members' roles in the communication process) for each service area for the communication of test results to patients and a facility policy that includes a method to monitor the effectiveness of the patient notification process, as required.[43]

During an interview with executive leaders and quality management staff, the Chief of Staff said the Associate Chief of Staff for Medicine had developed a workflow for the communication of test results that identified which team members would provide the results to patients. However, other service leaders had not created workflows. Additionally, the Chief of Quality and Patient Safety told the OIG that staff could not extract data from the electronic health record system to analyze when patients are notified of test results to monitor the communication process; however, staff said they use patient feedback to gauge communication timeliness. The OIG recommends facility leaders ensure the facility has a policy for test result communication that includes methods to monitor the effectiveness of the patient notification process. The OIG also

[41] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[42] Daniel Murphy, Hardeep Singh, and Leonard Berlin, "Communication Breakdowns and Diagnostic Errors: A Radiology Perspective," *Diagnosis* 1, no. 4 (August 19, 2014): 253-261, https://doi.org/10.1515/dx-2014-0035.

[43] VHA required facility policies to include these workflows and methods by July 2024. VHA Directive 1088(1).

recommends facility leaders ensure staff develop workflows for the communication of test results for each service.

## Action Plan Implementation and Sustainability


***Figure 11.*** *Status of prior OIG recommendations. Source: VA OIG.*

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[44] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

Less than one month before the site visit, the OIG published a hotline healthcare inspection report about a veteran's suicide.[45] The facility was in the process of implementing action plans for its two open recommendations. The OIG reviewed its most recent comprehensive healthcare inspection report and a 2022 Joint Commission survey and found no open recommendations related to the communication of test results.[46]

## Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[47] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[48] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

The OIG found the facility's focus on process improvement to be collaborative. Quality and patient safety staff said they identify safety concerns when they visit staff in their work areas to discuss quality and patient safety initiatives. They also ensure staff implement any identified action plans from these visits and monitor them for continued compliance as needed. Quality and

[44] VA OIG Directive 308, *Comments to Draft Reports*, April 10, 2014.

[45] VA OIG, *Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming*.

[46] VA OIG, *Comprehensive Healthcare Inspection of the Cheyenne VA Medical Center in Wyoming*, Report No. 23-00122-118, March 26, 2024.

[47] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*.

[48] VHA Directive 1050.01(1).

patient safety staff indicated this collaborative approach promotes positive interactions with staff and increases reporting of patient safety concerns.

Quality and patient safety staff mentioned they update executive leaders on improvement actions from previous surveys and review patient safety events from the previous day during regularly scheduled meetings. They also said they instituted a patient safety forum to educate staff about the root cause analysis process.[49] The forum initially met every other month but then expanded to every month. Additionally, staff discussed their high reliability collaboration group to reduce duplication of process improvement efforts and foster better communication between groups.


The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[50] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

## Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[51] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[52] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The OIG found primary care teams had position vacancies for providers, nurses, and telehealth clinical technicians who support care in outpatient clinics. Facility leaders told the OIG that recruitment had been challenging, primarily due to the rising cost of living and lack of nursing programs in Wyoming; however, leaders used special salary rates, hiring incentives, and education debt repayment to recruit staff.

[49] A root cause analysis is a review used to identify factors that caused or contributed to adverse events or close calls. VHA Directive 1050.01(1).

[50] VHA Directive 1406(1); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017, and February 29, 2024.

[51] Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2018 to 2033* (Washington, DC: Association of American Medical Colleges, June 2020).

[52] VA OIG, *OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023*, Report No. 23-00659-186, August 22, 2023.

Primary care leaders said budget constraints also affected their ability to hire staff. They shared that VISN 19 leaders had to approve their hiring requests, which extended the process. Facility leaders reported that although they did not receive approval to hire for some positions they determined were critical, VISN leaders were generally supportive of requests for primary care staff. However, both primary care and facility leaders shared that the consolidation of human resources staffing at the VISN level contributed to hiring and onboarding delays, which resulted in increased workload for primary care teams covering vacancies. The OIG found staffing shortages affected primary care team workflows; however, facility and primary care leaders were aware of the issue and had taken steps to address it, such as using internal and regional staff to provide care via telemedicine.

Panel size, or the number of patients assigned to a care team, reflects a team's workload; an optimally sized panel helps to ensure patients have timely access to high-quality care.[53] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[54]

VHA expects panel sizes of approximately 1,200 patients for primary care teams, with a full-time provider and adequate space and support staff. Due to staffing levels and available space, primary care panels were largely between 1,000 to 1,400 patients. The OIG found several primary care teams had panels that were notably smaller than other teams. Primary care leaders shared that some providers were assigned to multiple panels at different care sites, such as community-based outpatient clinics, and the combined number of patients across the locations was within VHA expectations.

## Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[55] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

Primary care team members identified scheduling practices at the VISN's centralized call center as an issue affecting workflow efficiency. The call center presented challenges because scheduling staff were not always familiar with the nuances of operations at each site, so facility staff sometimes had to reschedule patient appointments. For example, local leaders approved longer appointment slots for some veterans with complex medical needs; however, primary care

[53] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. On April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website).

[54] VHA Directive 1406(1).

[55] VHA Handbook 1101.10(2).

staff said schedulers often offered the first available appointment regardless of length. Providers explained that when primary care staff were unable to reschedule veterans to appropriate slots, they had to address complex health issues in the shorter appointment slot, which disrupted their workflow and extended the workday. Primary care leaders were aware of the concerns and said they routinely communicate with VISN staff to resolve call center scheduling issues.

## The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. Primary care leaders had discussed the potential effect of PACT Act enrollment prior to its implementation; however, enrollment did not increase overall, and the facility was able to provide care for patients within existing primary care panels. The average appointment wait time for new patients in FY 2023 was 9.1 days, which improved to 6.4 days in the first two quarters of FY 2024.

However, primary care team members stated that completing toxic exposure screenings had increased appointment times because they involved providing additional education and support to veterans. Despite the additional workload, primary care leaders said the PACT Act had been beneficial for veterans and their feedback was generally positive. Specifically, veterans expressed satisfaction with follow-up care and access to VA benefits.


The OIG reviewed the Health Care for Homeless Veterans (HCHV), Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG analyzed enrollment and performance data and interviewed program staff.

## Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[56]

[56] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

## Identification and Enrollment of Veterans

VHA measures HCHV program success by the percentage of unsheltered veterans who receive a program intake assessment (performance measure HCHV5).[57] VA uses the Department of Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[58]

The facility met the target for FY 2023 but did not for the first and second quarters of FY 2024. The Homeless Team Supervisor attributed missing the targets to the large, rural, and mountainous geography of the service area, staffing shortages, and lack of referrals. To address these barriers and identify veterans for program enrollment, the supervisor reported conducting direct outreach through mobile stand-downs and community outreach to homeless shelters.[59] Facility primary care providers, social workers, and residential case managers also identify homeless veterans and share their contact information with homeless program staff to provide services.

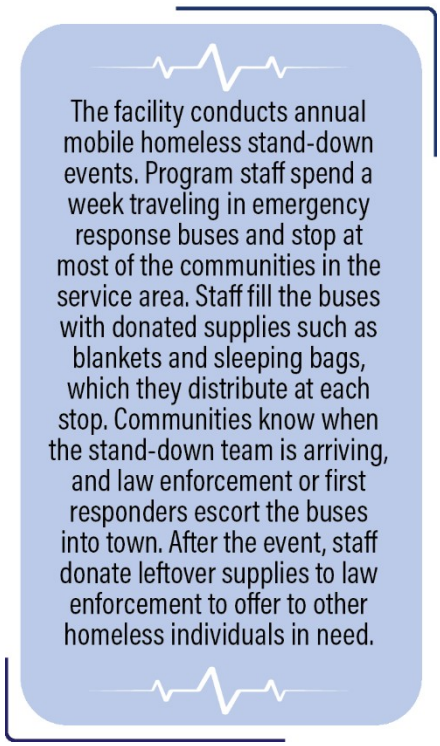


***Figure 12.*** *Best practice for veteran engagement.*
*Source: OIG analysis of documents and interviews.*

The supervisor stated staffing shortages limited their ability to develop and maintain relationships with community homeless shelters. During FY 2023, relationships improved with staff at two homeless shelters who referred more veterans to the program as a result. However, because the program lost staff in FY 2024, they were unable to maintain the relationships, leading to decreased referrals.

[57] VHA sets targets at the individual facility level. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures,* October 1, 2022.

[58] Local Department of Housing and Urban Development offices administer the annual point-in-time count. The count includes those living in shelters and transitional housing each year. Every other year, the count also includes unsheltered individuals. "VA Homeless Programs, Point-in-Time (PIT) Count," Department of Veterans Affairs, accessed May 30, 2023, https://www.va.gov/homeless/pit_count.

[59] "Stand Downs are an outreach strategy to engage homeless Veterans and present them with longer-term treatment and housing opportunities. The 1- to 3-day events provide homeless Veterans a temporary refuge where they can obtain food, housing assistance, supplies and a range of community and VA assistance. In many locations, Stand Downs provide health screenings, referral and access to housing and treatment services, benefits counseling, ID cards and access to other programs to meet a Veteran's immediate needs." VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

### Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[60] At the time of the OIG site visit, the facility was not working with contracted residential services and therefore did not report on the performance measures.[61]

The Homeless Team Supervisor reported meeting veterans' needs for residential and transitional housing through community partners, such as a local nonprofit facility with 11 beds dedicated for veterans. At this facility, veterans had individual rooms with shared living spaces, including a kitchen, that offered a stable environment to identify and complete goals toward permanent housing.

## Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[62] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[63]

### Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[64] The facility did not meet the target for FY 2023. The Veterans Justice Outreach Coordinator attributed this to a prior staff member not entering information into the database, and the coordinator position being vacant from September 2022 until June 2023. The coordinator reported currently entering information into the database.

The coordinator identified veterans for the program through outreach to jails and detention centers, lists of incarcerated persons provided by jail administration staff and on court schedules, and referrals from facility residential programs and family members. The coordinator conducted

[60] VHA sets targets for HCHV1 and HCHV2 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above and the HCHV2 (negative exits) target was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[61] HCHV1 and HCHV2 measures include veterans who are discharged from contracted residential services (community-based agencies that contract with local VA facilities to provide short-term residential treatment).

[62] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report.*

[63] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[64] VHA sets escalating targets for this measure at the facility level each year, with the goal to reach 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

outreach to incarcerated veterans in county facilities, and VISN program staff conducted outreach to state facilities. The large mountainous service area prevents the coordinator from completing frequent outreach to incarcerated veterans located long distances from the main facility.

The coordinator reported focusing efforts to increase awareness of the program and engagement with community partners over the year prior to the OIG site visit. The coordinator visited jails and trained individuals on the program at multiple national and local conferences and training events. The coordinator also attended Sheridan County Circuit Court hearings for eligible veterans, held meetings with judges to coordinate cases, and arranged care with VA services when appropriate. Recently, the coordinator began working with a new local court to educate staff on the program and VA services for court-required treatment.

### Meeting Veteran Needs

The Veterans Justice Outreach Coordinator meets with incarcerated veterans to coordinate their needs, communicates with primary care providers for their care, and shares information with the courts on their involvement in required treatments. The coordinator also acts as a liaison between courts, attorneys, probation and parole agents, jail and prison staff, and family representatives.

The coordinator increased services provided to homeless veterans by completing court-ordered substance use severity assessments at the facility, previously done for a fee by community providers in three counties and submitted treatment plan recommendations to the courts. The coordinator indicated that in addition to long travel times, there are time-consuming administrative tasks, such as reviewing weekly jail rosters and entering information into databases, that create barriers to meeting veterans' needs. At the time of the OIG site visit, the coordinator did not have dedicated administrative support staff to assist in these duties.

## Housing and Urban Development–Veterans Affairs Supportive Housing

Housing and Urban Development–Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[65] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by individualized services, including healthcare and employment assistance, necessary to maintain housing.[66]

[65] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.
[66] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

## Identification and Enrollment of Veterans

VHA's Housing and Urban Development–Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[67] The facility did not meet the target from June 1, 2021, through March 31, 2024. The Homeless Team Supervisor attributed missing the target in part to staffing vacancies and lack of affordable housing in some areas. The supervisor also noted that during the pandemic, another VA program housed homeless veterans, therefore, limiting the need for program vouchers.

The supervisor identified veterans through outreach to homeless shelters and referrals from facility services and community partners. Additionally, staff participated in monthly meetings with representatives from Supportive Services for Veteran Families and public housing authorities to coordinate services for veterans. Staff also attended and represented the program at local events, such as meetings of local nonprofit agencies that support veterans, to increase future referrals and collaboration. A lack of transportation for veterans was a barrier to enrolling veterans in the program. The supervisor reported relying on a local nonprofit organization that offered driving services, but its availability was inconsistent.

## Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[68] The facility did not meet the target for FY 2023. The Homeless Team Supervisor attributed this to insufficient staffing, a large percentage of the program's participants being retired and unable or unwilling to work, having only one facility compensated work therapy program, and employers who were unwilling to accommodate veterans with criminal records or history of substance abuse.[69]

[67] VHA sets the HMLS3 target at the national level each year. The FY 2023 target was 90 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[68] VHA sets the VASH3 target at the national level. For FY 2023, the target was 50 percent or above. VHA Homeless Programs, *Technical Manual: FY 2023 Homeless Performance Measures*.

[69] The Compensated Work Therapy-Transitional Residence program "provides time-limited transitional housing with supportive employment services to homeless Veterans with mental health and substance use disorders, co-occurring medical concerns and psychosocial needs including homelessness and unemployment." VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

# Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and provided recommendations on systemic issues that may adversely affect patient care. Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

# OIG Recommendations and VA Response

**Finding:** The OIG noted the lack of braille text and audio instructions for visually impaired veterans navigating the facility.

## Recommendation 1

The OIG recommends facility leaders implement tools to help sensory-impaired veterans navigate the facility.

__X__ Concur

____ Nonconcur

Target date for completion: June 30, 2026

### Director Comments

The Sheridan Veterans Affairs Health Care System Chief of Facilities Management Services will identify a local team to evaluate signage for Veterans with sensory impairments to navigate the facility. Coordinating with interior design and the Veterans Health Education Coordinator, the Chief of Facilities Management Services will update directory signage at the main entrances to meet the needs of Veterans with sensory impairments. The Chief of Facilities Management Services will meet with the local team to identify resources for Veterans with sensory impairments by October 31, 2025. Pamphlets will be developed with information for sensory impairment and distributed throughout the health care system by November 30, 2025. Information regarding sensory impairment resources will be added in an employee newsletter by October 31, 2025.

Monitoring and sustainment: The Chief of Facilities Management Services or designee will complete monthly environmental rounds to monitor signage and features. Rounds data will be reported monthly to the Quality and Patient Safety Board for leadership oversight until 90% compliance is achieved for six consecutive months. The numerator is the number of sites or areas with compliant signage or aids for Veterans with sensory impairment, and the denominator is the number of rounding sites visited via Environment of Care rounds each month.

**Finding:** The OIG determined leaders had not updated the facility policy to include methods to monitor the effectiveness of the patient notification process, as required.

## Recommendation 2

The OIG recommends facility leaders ensure the facility has a policy for test result communication that includes methods to monitor the effectiveness of the patient notification process.

__X__ Concur

____ Nonconcur

Target date for completion: June 30, 2026

### Director Comments

The Sheridan Veterans Affairs Health Care System Executive Leadership Team will review facility processes related to the communication of test results and update, publish, and implement a policy for communicating test results in compliance with Veterans Health Administration Directive 1088. Relevant staff will be educated, and the education will be confirmed by Talent Management System acknowledgment. The Chief of Quality and Patient Safety will collaborate with appropriate departments to develop and implement a randomized medical record audit process to monitor the timeliness and effectiveness of patient notification of all noncritical test results that require action by July 31, 2025.

Monitoring and sustainment: The Chief Informatics Officer lab result audits will be reported monthly to the Quality and Patient Safety Board for leadership oversight until >90% compliance is achieved for six consecutive months. The numerator is confirmed communication of outpatient laboratory test results; the denominator is total outpatient laboratory results. Additionally, the Quality and Patient Safety department monthly will randomly sample twenty additional medical records not included in the Chief Informatics Officer report (to include, but not limited to radiology reports and inpatient tests). The Accreditation Specialist will report monthly to the Quality and Patient Safety Board for leadership oversight until >90% compliance is achieved for six consecutive months. The numerator is the confirmed communication of test results, and the denominator is the total results audited.

**Finding:** The OIG determined leaders had not developed workflows for the communication of test results for all services, as required.

## Recommendation 3

The OIG recommends facility leaders ensure staff develop workflows for the communication of test results for each service.

__X__ Concur

____ Nonconcur

Target date for completion: December 31, 2025

### Director Comments

Sheridan Veterans Affairs Health Care System will develop workflows for communication of test results for each service in compliance with VHA Directive 1088, “Communicating Test

Results to Providers and Patients," dated July 11, 2023. Relevant staff will be educated on new workflows, and the education will be confirmed by Talent Management System acknowledgement.

Monitoring and sustainment: The accreditation specialist will report monthly to the Quality and Patient Safety Board for leadership oversight until >90% compliance is achieved for education of all ordering providers and direct care Registered Nurse staff. Numerator: ordering providers and direct care Registered Nurse staff who completed Talent Management System acknowledgement; Denominator: total number of ordering providers and direct care Registered Nurse staff.

In addition, the Accreditation Specialist will also report to the Quality and Patient Safety Board the number of services with workflows completed and published until 100% compliance is achieved. Numerator: number of services with completed and published workflows; Denominator: total number of services requiring workflows for communication of test results.

# Appendix A: Methodology

## Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to VSOs. Additionally, the OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. Finally, the OIG inspected selected areas of the medical facility.

The OIG's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[2]

Potential limitations include self-selection bias and response bias of respondents.[3] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel discussion; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from August 20 through 22, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issues.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[4] The OIG reviews available evidence within a specified

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2021, through September 30, 2023.

[2] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

[3] Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants "give inaccurate answers for a variety of reasons." Dirk M. Elston, "Participation Bias, Self-Selection Bias, and Response Bias," *Journal of American Academy of Dermatology* (2021): 1-2, https://doi.org/10.1016/j.jaad.2021.06.025.

[4] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

# Appendix B: Facility in Context Data Definitions

**Table B.1. Description of Community***

| Category | Metric | Metric Definition |
|---|---|---|
| **Population** | Total Population | Population estimates are from the US Census Bureau and include the calculated number of people living in an area as of July 1. |
| | Veteran Population | 2018 through 2022 veteran population estimates are from the Veteran Population Projection Model 2018. |
| | Homeless Population | Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night. |
| | Veteran Homeless Population | Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night. |
| **Education** | Completed High School | Persons aged 25 years or more with a high school diploma or more, and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people whose highest degree was a high school diploma or its equivalent. People who reported completing the 12th grade but not receiving a diploma are not included. |
| | Some College | Persons aged 25 years or more with a high school diploma or more and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people who attended college but did not receive a degree, and people who received an associate's, bachelor's, master's, or professional or doctorate degree. |
| **Unemployment Rate** | Unemployed Rate 16+ | Labor force data are from the Bureau of Labor Statistics' Local Area Unemployment Statistics File for each respective year. Data are for persons 16 years and older, and include the following: Civilian Labor Force, Number Employed, Number Unemployed, and Unemployment Rate. Unemployment rate is the ratio of unemployed to the civilian labor force. |
| | Veteran Unemployed in Civilian Work Force | Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. Veterans are men and women who have served in the US Merchant Marines during World War II; or who have served (even for a short time), but are not currently serving, on active duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard. People who served in the National Guard or Reserves are classified as veterans only if they were ever called or ordered to active duty, not counting the 4-6 months for initial training or yearly summer camps. |

| Category | Metric | Metric Definition |
|---|---|---|
| **Median Income** | Median Income | The estimates of median household income are from the US Census Bureau's Small Area Income Poverty Estimates files for the respective years. |
| **Violent Crime** | Reported Offenses per 100,000 | Violent crime is the number of violent crimes reported per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault. |
| **Substance Use** | Driving Deaths Involving Alcohol | Alcohol-impaired driving deaths directly measures the relationship between alcohol and motor vehicle crash deaths. |
| | Excessive Drinking | Excessive drinking is a risk factor for several adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes. |
| | Drug Overdose Deaths | Causes of death for data presented in this report were coded according to International Classification of Diseases (ICD) guidelines described in annual issues of Part 2a of the National Center for Health Statistics Instruction Manual (2). Drug overdose deaths are identified using underlying cause-of-death codes from the Tenth Revision of ICD (ICD–10): X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined). |
| **Access to Health Care** | Transportation | Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. People who used different means of transportation on different days of the week were asked to specify the one they used most often or for the longest distance. |
| | Telehealth | The annual cumulative number of unique patients who have received telehealth services, including Home Telehealth, Clinical Video Telehealth, Store-and-Forward Telehealth and Remote Patient Monitoring - patient generated. |
| | < 65 without Health Insurance | Estimates of persons with and without health insurance, and percent without health insurance by age and gender data are from the US Census Bureau's Small Area Health Insurance Estimates file. |
| | Average Drive to Closest VA | The distance and time between the patient residence to the closest VA site. |

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

## Table B.2. Health of the Veteran Population*

| Category | Metric | Metric Definition |
|---|---|---|
| **Mental Health Treatment** | Veterans Receiving Mental Health Treatment at Facility | Number of unique patients with at least one encounter in the Mental Health Clinic Practice Management Grouping. An encounter is a professional contact between a patient and a practitioner with primary responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting. Contact can include face-to-face interactions or telemedicine. |
| **Suicide** | Suicide Rate | Suicide surveillance processes include close coordination with federal colleagues in the Department of Defense (DoD) and the Centers for Disease Control and Prevention (CDC), including VA/DoD searches of death certificate data from the CDC's National Death Index, data processing, and determination of decedent Veteran status. |
| | Veterans Hospitalized for Suicidal Ideation | Distinct count of patients with inpatient diagnosis of ICD10 Code, R45.851 (suicidal ideations). |
| **Average Inpatient Hospital Length of Stay** | Average Inpatient Hospital Length of Stay | The number of days the patient was hospitalized (the sum of patient-level lengths of stay by physician treating specialty during a hospitalization divided by 24). |
| **30-Day Readmission Rate** | 30-Day Readmission Rate | The proportion of patients who were readmitted (for any cause) to the acute care wards of any VA hospital within 30 days following discharge from a VA hospital by total number of index hospitalizations. |
| **Unique Patients** | Unique Patients VA and Non-VA Care | Measure represents the total number of unique patients for all data sources, including the pharmacy-only patients. |
| **Community Care Costs** | Unique Patient | Measure represents the Financial Management System Disbursed Amount divided by Unique Patients. |
| | Outpatient Visit | Measure represents the Financial Management System Disbursed Amount divided by the number of Outpatient Visits. |
| | Line Item | Measure represents the Financial Management System Disbursed Amount divided by Line Items. |
| | Bed Day of Care | Measure represents the Financial Management System Disbursed Amount divided by the Authorized Bed Days of Care. |
| **Staff Retention** | Onboard Employees Stay < 1 Year | VA's AES All Employee Survey Years Served <1 Year divided by total onboard. Onboard employee represents the number of positions filled as of the last day of the most recent month. Usually one position is filled by one unique employee. |
| | Facility Total Loss Rate | Any loss, retirement, death, termination, or voluntary separation that removes the employee from the VA completely. |

| Category | Metric | Metric Definition |
|---|---|---|
| | Facility Quit Rate | Voluntary resignations and losses to another federal agency. |
| | Facility Retire Rate | All retirements. |
| | Facility Termination Rate | Terminations including resignations and retirements in lieu of termination but excluding losses to military, transfers, and expired appointments. |

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

# Appendix C: VISN Director Comments

## Department of Veterans Affairs Memorandum

Date: May 29, 2025

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

Subj: Healthcare Facility Inspection of the Sheridan VA Health Care System in Wyoming

To: Director, Office of Healthcare Inspections (54HF01)

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

1. Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the Sheridan VA Healthcare System in Wyoming.
2. Based upon a thorough review of the report by VISN 19 leadership, I concur with the findings, recommendations and submitted action plans of Sheridan VA Healthcare System. As we remain committed to ensuring our Veterans receive exceptional care, VISN 19 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.
3. If you have any questions or require further information, please contact the VISN 19 Quality Management Officer.

*(Original signed by:)*

Sunaina Kumar-Giebel, MHA
Director, VA Rocky Mountain Network (10N19)

# Appendix D: Facility Director Comments

## Department of Veterans Affairs Memorandum

Date: May 22, 2025

From: Director, Sheridan VA Health Care System (666)

Subj: Healthcare Facility Inspection of the Sheridan VA Health Care System in Wyoming

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

1. We appreciate the opportunity to work with the Office of the Inspector General as we continuously strive to improve the quality of healthcare for America's Veterans.
2. The status update is on the attached tracking template, including supporting documents where appropriate.
3. We thank the Office of Inspector General for its thorough review, which assists us in improving the care we provide Veterans. Please contact the Sheridan Chief of Quality and Patient Safety with any questions.

*(Original signed by:)*

Duane B. Gill, FACHE
SVAHCS Interim Director

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| **Contact** | For more information about this report, please contact the Office of Inspector General at (202) 461-4720. |
| **Inspection Team** | Miquita Hill-McCree, MSN, RN, Director<br>Megan Magee, MSN, RN<br>Carol Manning, MSW, MPH<br>Cheryl Walsh, MS, RN |
| **Other Contributors** | Kevin Arnhold, FACHE<br>Jolene Branch, MS, RN<br>Richard Casterline<br>Alicia Castillo-Flores, MBA, MPH<br>Kaitlyn Delgadillo, BSPH<br>LaFonda Henry, MSN, RN<br>Cynthia Hickel, MSN, CRNA<br>Amy McCarthy, JD<br>Scott McGrath, BS<br>Sachin Patel, MBA, MHA<br>Ronald Penny, BS<br>Joan Redding, MA<br>Larry Ross Jr., MS<br>April Terenzi, BA, BS<br>Dave Vibe, MBA<br>Dan Zhang, MSc |

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