DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Sheridan VA Medical Center in Wyoming

CHIP REPORT | REPORT #21-00255-200 | AUGUST 9, 2021

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Figure 1. *Sheridan VA Medical Center in Wyoming.*
Source: https://vaww.va.gov/directory/guide/ (*accessed January 7, 2021*).

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
COVID-19	coronavirus disease
ED	emergency department
FY	fiscal year
OIG	Office of Inspector General
PCMH	patient-centered medical home
QSV	quality, safety, and value
RN	registered nurse
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Sheridan VA Medical Center, which includes multiple outpatient clinics in Wyoming. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high quality and timely VA healthcare services. The inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus each year.

The OIG team looks at leadership and organizational risks, and at the time of the inspection, focused on the following additional areas:

1. COVID-19 pandemic readiness and response[1]
2. Quality, safety, and value
3. Registered nurse credentialing
4. Medication management (targeting remdesivir use)[2]
5. Mental health (focusing on emergency department and urgent care center suicide risk screening and evaluation)
6. Care coordination (spotlighting inter-facility transfers)
7. High-risk processes (examining the management of disruptive and violent behavior)

The OIG conducted an unannounced virtual review of the Sheridan VA Medical Center during the week of December 7, 2020. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG review. Although it is difficult to quantify the risk of patient harm, the findings in this

[1] "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It," World Health Organization, accessed August 25, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 (coronavirus disease) is an infectious disease caused by the "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)."

[2] The OIG's review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the Sheridan VA Medical Center because medical center staff did not administer remdesivir during the review period.

report may help this medical center and other Veterans Health Administration (VHA) facilities identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG noted opportunities for improvement in several areas reviewed and issued three recommendations to the Medical Center Director, Chief of Staff, and Associate Director for Patient Care Services. These opportunities for improvement are briefly described below.

Leadership and Organizational Risks

At the time of the OIG's virtual review, the medical center's leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care Services, and Associate Director. Organizational communications and accountability were managed through a committee reporting structure, with Executive Leadership Board oversight of several working groups. Leaders monitored patient safety and care through the Quality Safety Value Board, which was responsible for tracking and trending quality of care and patient outcomes.

When the team conducted this inspection, the medical center's leaders had worked together for over two years. The Director, who was permanently assigned in August 2017, was the most tenured leader. The Chief of Staff, Associate Director for Patient Care Services, and Associate Director had served in their positions since May, June, and August 2018, respectively.

During an interview with the OIG, the Director indicated the FY 2020 budget increase helped the medical center expand services by opening a psychiatric clinic in the community living center and a new outpatient clinic in Casper, Wyoming. However, the Director also described various hiring and recruitment challenges and subsequent strategies used to address them.

Employee survey responses revealed satisfaction with leadership and a workplace where staff felt respected and discrimination was not tolerated. Patient experience survey data for male veterans implied general satisfaction with the inpatient care provided. Patient-centered medical home survey results revealed opportunities to improve satisfaction for both genders, while specialty care survey responses highlighted opportunities to improve satisfaction for male veterans.[3] Inpatient survey data for female veterans were not available due to the small number of respondents.

[3] Inpatient survey data for female veterans are not available due to the small number of respondents.

The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify substantial organizational risk factors.[4]

The VA Office of Operational Analytics and Reporting adopted the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[5]

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and medical center-level factors contributing to poor performance on specific SAIL and Community Living Center SAIL measures.[6] In individual interviews, executive leadership team members were able to speak about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and patient experiences.

COVID-19 Pandemic Readiness and Response

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[7]

Quality, Safety, and Value

The OIG found general compliance with requirements for the Quality Safety Value Board and Systems Redesign and Improvement Program. However, the OIG noted a concern with the peer review process.[8]

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[4] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

[5] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center, accessed March 6, 2020, https://vssc.med.va.gov. (This is an internal website not publicly accessible.)

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

[7] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19*, Report No. 21-01699-175, July 7, 2021.

[8] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a "critical review of care, performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements.

Registered Nurse Credentialing

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

Care Coordination

The medical center generally met expectations for an inter-facility transfer policy and monitoring and evaluation of inter-facility transfers. However, the OIG noted deficiencies with the completion of the VA *Inter-Facility Transfer Form*, transmission of pertinent medical records, and communication between nurses at sending and receiving facilities.[9]

High-Risk Processes

The medical center met many of the requirements for the management of disruptive and violent behavior, including the development of a local policy, implementation of an employee threat assessment team, and use of the Disruptive Behavior Reporting System. However, the OIG identified a deficiency with Disruptive Behavior Committee members' attendance of required meetings.

Conclusion

The OIG conducted a detailed inspection across seven key areas (two administrative and five clinical) and subsequently issued three recommendations for improvement to the Medical Center Director, Chief of Staff, and Associate Director for Patient Care Services. However, the number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for medical center leaders to use the recommendations to help guide improvements in operations and clinical care. The recommendations address issues that may eventually interfere with the delivery of quality health care.

[9] A completed VA *Inter-Facility Transfer Form* or an equivalent note communicates critical information to facilitate and ensure safe, appropriate, and timely transfer. Critical elements include documentation of patients' informed consent, medical and/or behavioral stability, mode of transportation and appropriate level of care required, identification of transferring and receiving physicians, and proposed level of care after transfer.

Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes G and H, pages 49–50, 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 for the open recommendations until they are completed.

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Sheridan VA Medical Center and the related outpatient clinics examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so that informed decisions can be made to improve care.[1]

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[2] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[3] Figure 2 illustrates the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

Because of the COVID-19 pandemic, the OIG converted this site visit to a virtual review, paused physical inspection steps (especially those involved in the environment of care-focused review topic), and initiated a COVID-19 pandemic readiness and response evaluation.

As such, to examine risks to patients and the organization, the OIG focused on core processes in the following eight areas of administrative and clinical operations (see figure 2):[4]

1. Leadership and organizational risks
2. COVID-19 pandemic readiness and response[5]
3. Quality, safety, and value (QSV)
4. Registered nurse (RN) credentialing

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[1] VA administers healthcare services through a network of 18 regional offices nationwide referred to as the Veterans Integrated Service Network.

[2] Anam Parand et al., "The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review," *British Medical Journal*, 4, no. 9, (September 5, 2014), https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae Sfantou et al., "Importance of Leadership Style Towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4, (December 2017): 73, https://doi.org/10.3390/healthcare5040073.

[4] Virtual CHIP site visits address these processes during fiscal year 2021 (October 1, 2020, through September 30, 2021); they may differ from prior years' focus areas.

[5] "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It," World Health Organization, accessed August 25, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 (coronavirus disease) is an infectious disease caused by the "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)."

5. Medication management (targeting remdesivir use)[6]
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7. Care coordination (spotlighting inter-facility transfers)
8. High-risk processes (examining the management of disruptive and violent behavior)

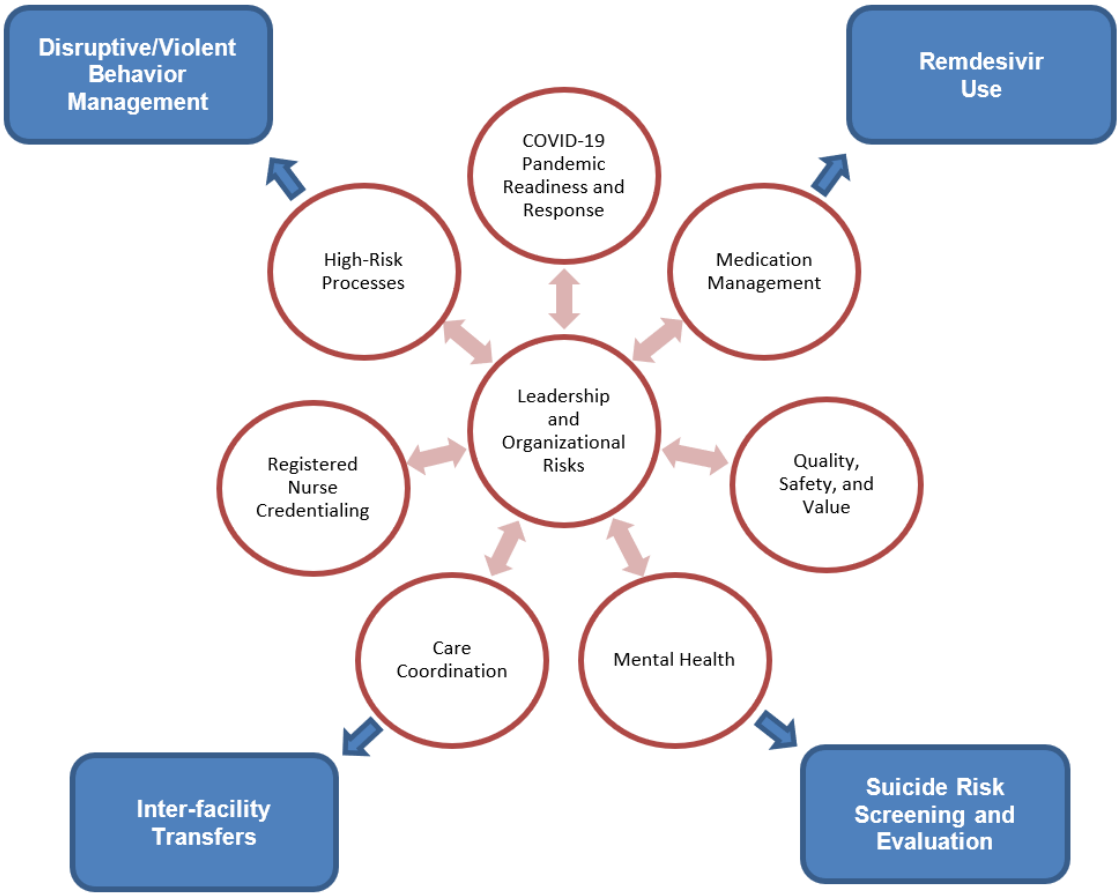


Figure 2. *Fiscal year (FY) 2021 comprehensive healthcare inspection of operations and services. Source: VA OIG.*

[6] The OIG's review of medication management focused on the administration of remdesivir under Emergency Use Authorization from May 8 through October 21, 2020. This review was not performed at the Sheridan VA Medical Center because medical center staff did not administer remdesivir during the review period.

Methodology

The Sheridan VA Medical Center also provides care through multiple outpatient clinics in Wyoming. Additional details about the types of care provided by the medical center can be found in appendixes B and C.

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality and clinical functions, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports.[7] The team also interviewed executive leaders and discussed processes, validated findings, and explored reasons for noncompliance with staff.

The inspection examined operations from December 15, 2018, through December 11, 2020, the last day of the unannounced multiday evaluation.[8] Following the virtual site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline management team for further review.

The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[9]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[10] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the medical center completes corrective actions. The Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that medical center leaders developed based on the reasons for noncompliance.

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

[7] The OIG did not review VHA's internal survey results and instead focused on OIG inspections and external surveys that affect medical center accreditation status.

[8] The range represents the time period from the prior CHIP site visit to the completion of the unannounced, multiday virtual CHIP visit in December 2020.

[9] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19*, Report No. 21-01699-175, July 7, 2021.

[10] Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA medical center. Leadership and organizational risks can affect a medical center's ability to provide care in the clinical focus areas.[11] To assess this medical center's risks, the OIG considered several indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Staffing
4. Employee satisfaction
5. Patient experience
6. Accreditation surveys and oversight inspections
7. Identified factors related to possible lapses in care and the medical center response
8. VHA performance data (medical center)
9. VHA performance data (community living center (CLC))[12]

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this medical center's reported organizational structure. The medical center had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. The Chief of Staff and ADPCS oversaw patient care, which required managing service directors and chiefs of programs and practices.

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

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

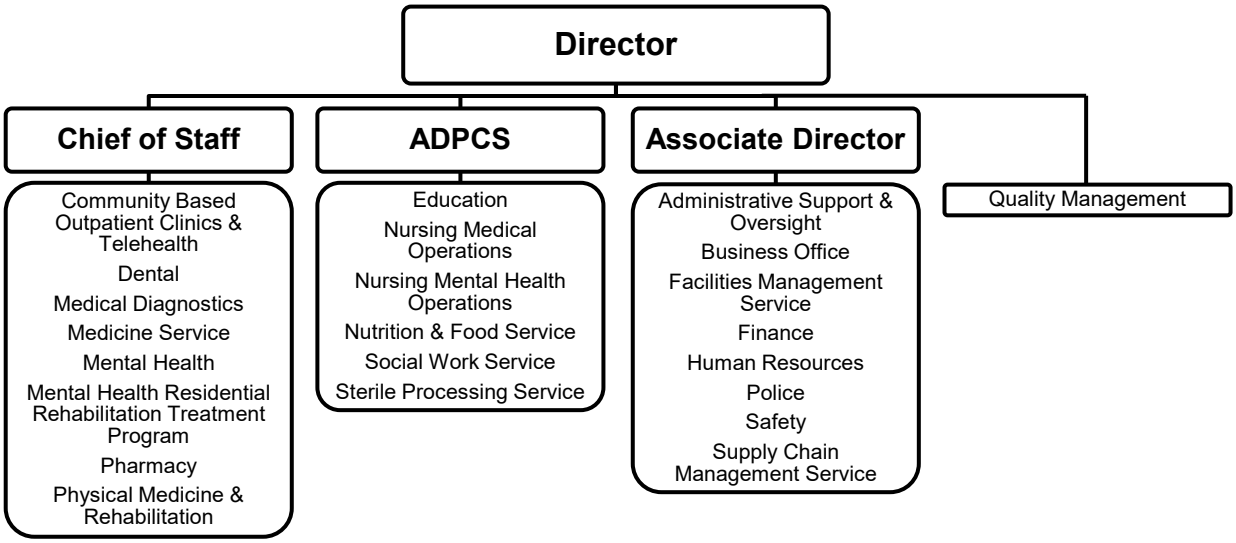


Figure 3. *VA medical center organizational chart.*

Source: Sheridan VA Medical Center (received December 7, 2020).

At the time of the OIG inspection, the executive team appeared stable and had worked together for over two years (see table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Medical Center Director	August 20, 2017
Chief of Staff	May 13, 2018
Associate Director for Patient Care Services	June 10, 2018
Associate Director	August 19, 2018

Source: VISN 19's Strategic Business Partner–Human Resources (received December 8, 2020).

To help assess the medical center executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, ADPCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

The executive leaders were knowledgeable within their scope of responsibilities about VHA data and system-level factors contributing to poor performance on specific medical center Strategic Analytics for Improvement and Learning (SAIL) measures and CLC SAIL measures. In individual interviews, the executive leadership team members were able to speak in depth about actions taken during the previous 12 months to maintain or improve organizational performance, employee satisfaction, and patient experiences. These are discussed in greater detail below.

The Director served as the chairperson of the Executive Leadership Board, which had the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board oversaw various working groups such as the Medical and Patient Care Executive Boards. These leaders monitored patient safety and care through the Quality Safety Value Board, which was responsible for tracking and trending quality of care and patient outcomes and reported to the Executive Leadership Board (see figure 4). The Director chaired the Quality Safety Value Board and had an extensive quality management background, having served as Chief of Quality at another VA medical center for six years.

Figure 4. *VA medical center committee reporting structure.*
Source: Sheridan VA Medical Center (received December 7, 2020).

Budget and Operations

The medical center's FY 2020 annual medical care budget of $176,969,118 increased by nearly 35 percent compared to the previous year's budget of $131,324,386.[13] When asked about the effect of this change on the medical center's operations, the Director indicated the budget increase helped the medical center expand services by opening a psychiatric clinic in the CLC and a new outpatient clinic in Casper, Wyoming.

[13] VHA Support Service Center.

Staffing

The Veterans Access, Choice, and Accountability Act of 2014 required the OIG to determine, on an annual basis, the VHA occupations with the largest staffing shortages.[14] Under the authority of the VA Choice and Quality Employment Act of 2017, the OIG conducts annual determinations of clinical and nonclinical VHA occupations with the largest staffing shortages within each medical facility.[15] In addition, the OIG has demonstrated a linkage between staffing shortages and negative effects on patient care delivery.[16]

Table 2 provides the top facility-reported clinical and nonclinical occupational shortages as noted in the *OIG Determination of Veteran Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.[17] The executive leaders confirmed that occupations listed in table 2 were the top clinical and nonclinical shortages at the time of the OIG inspection. To address occupational shortages, the executive leadership team implemented multiple strategies to improve recruitment and retention. Leaders requested special salary rates for psychiatrists, psychologists, police, and custodial workers. At the time of the site visit, medical center leaders had hired a new police chief, reported ongoing recruitment efforts for additional police officers, and filled most vacant psychiatrist and psychologist positions. The Director reported that the medical center consistently had housekeeping vacancies that required them to continuously recruit. To address nursing shortages, the medical center leaders partnered with a local community college to continually recruit licensed practical nurses completing the RN program. The medical center hired difficult-to-recruit boiler plant operators by creating a technical training program and recruiting from a local hospital. Due to the high cost of living in Sheridan, medical center leaders implemented other strategies for recruitment and retention such as advertising, participating in job fairs, and offering on-site housing for key positions. Despite these efforts, executive leaders reported ongoing hiring challenges for nurses, pharmacy technicians, custodial workers, and police.

[14] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

[15] VA Choice and Quality Employment Act of 2017, Pub. L. No. 115-46 (2017). VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*, Report No. 20-01249-259, September 23, 2020.

[16] VA OIG, *Critical Deficiencies at the Washington DC VA Medical Center*, Report No. 17-02644-130, March 7, 2018.

[17] VA OIG, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2020*.

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

Top Clinical Staffing Shortages	Top Nonclinical Staffing Shortages
1. Nurse	1. Police
2. Psychology	2. Custodial Worker
3. Psychiatry	3. Boiler Plant Operator
4. Practical Nurse	4. Food Service Worker
5. Pharmacy Technician	5. Human Resources Management

Source: VA OIG.

Employee Satisfaction

The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." Since 2001, the instrument has been refined several times in response to VA leaders' inquiries on VA culture and organizational health.[18] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical center leaders.

To assess employee attitudes toward medical center leaders, the OIG reviewed employee satisfaction survey results from VHA's All Employee Survey from October 1, 2018, through September 30, 2019.[19] Table 3 provides relevant survey results for VHA, the medical center, and selected executive leaders. It summarizes employee attitudes toward the leaders as expressed in VHA's All Employee Survey. The OIG found the medical center averages for the selected survey leadership questions were similar to the VHA average.[20] The Director, Chief of Staff, and Associate Director's scores were consistently higher than those for VHA and the medical center. Although similar to both the VHA and medical center averages, the ADPCS scores were based on all respondents aligned under patient care services, which differ from scores based on respondents who directly reported to the other medical center leaders.

[18] "AES Survey History," VA Workforce Surveys Portal, VHA Support Service Center, accessed May 3, 2021, http://aes.vssc.med.va.gov/Documents/04_AES_History_Concepts.pdf. (This is an internal website not publicly accessible.)

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

[20] The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

Table 3. Survey Results on Employee Attitudes toward Medical Center Leaders (October 1, 2018, through September 30, 2019)

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average*	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite.*	0–100 where higher scores are more favorable	72.6	70.7	86.9	91.7	71.7	78.3
All Employee Survey: *In my organization, senior leaders generate high levels of motivation and commitment in the workforce.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.4	3.4	4.5	4.1	3.4	4.0
All Employee Survey: *My organization's senior leaders maintain high standards of honesty and integrity.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	3.6	4.5	4.2	3.6	4.3
All Employee Survey: *I have a high level of respect for my organization's senior leaders.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.6	3.7	4.5	4.3	3.6	4.3

Source: VA All Employee Survey (accessed November 4, 2020).

**ADPCS scores include the results for all respondents aligned under patient care services.*
The Servant Leader Index is a summary measure based on respondents' assessments of their supervisors' listening, respect, trust, favoritism, and response to concerns.

Table 4 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The medical center average for the selected survey questions was similar to the VHA average. Scores related to the Director, Chief of Staff, and Associate Director were consistently higher than those for VHA and the medical center. [21]

[21] Ratings are based on responses provided only by employees who directly report to the Director, Chief of Staff, and Associate Director whereas scores for the ADPCS are based on all staff aligned under the patient care services.

Table 4. Survey Results on Employee Attitudes toward the Workplace (October 1, 2018, through September 30, 2019)

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average*	Assoc. Director Average
All Employee Survey: *I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.8	4.8	4.8	3.7	4.3
All Employee Survey: *Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).*	1 (Strongly Disagree) –5 (Strongly Agree)	3.7	3.6	4.5	4.0	3.7	4.0
All Employee Survey: *In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?*	0 (Never)– 6 (Every Day)	1.4	1.5	1.1	1.0	1.5	0.5

Source: VA All Employee Survey (accessed November 4, 2020).

**ADPCS scores include the results for all respondents aligned under patient care services.*

VHA leaders have articulated that the agency "is committed to a harassment-free healthcare environment." To this end, executive leaders reported implementing strategies from VA's "End Harassment" and "Stand Up to Stop Harassment Now!" campaigns to help create a culture of

safety where staff and patients feel secure and respected.[22] In addition, the Director reported incorporating training in new employee orientation and initiating "VA Voices."[23]

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

Table 5. Survey Results on Employee Attitudes toward Workgroup Relationships (October 1, 2018, through September 30, 2019)

Questions/Survey Items	Scoring	VHA Average	Medical Center Average	Director Average	Chief of Staff Average	ADPCS Average*	Assoc. Director Average
All Employee Survey: *People treat each other with respect in my workgroup.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.7	4.6	4.2	3.8	4.0
All Employee Survey: *Discrimination is not tolerated at my workplace.*	1 (Strongly Disagree) –5 (Strongly Agree)	4.0	4.1	4.9	4.6	4.1	4.0
All Employee Survey: *Members in my workgroup are able to bring up problems and tough issues.*	1 (Strongly Disagree) –5 (Strongly Agree)	3.8	3.7	4.6	4.1	3.7	4.0

Source: VA All Employee Survey (accessed November 4, 2020).

**ADPCS scores include the results for all respondents aligned under patient care services.*

[22] "Stand Up to Stop Harassment Now!" Department of Veterans Affairs, accessed December 8, 2020, https://vaww.insider.va.gov/stand-up-to-stop-harassment-now/. Executive in Charge, Office of Under Secretary for Health Memorandum, *Stand Up to Stop Harassment Now*, October 23, 2019.

[23] VA Voices is a program that engages employees and promotes collaboration to achieve the shared mission of serving veterans.

Patient Experience

To assess patient experiences with the medical center, which directly reflect on its leaders, the OIG reviewed survey results from October 1, 2019, through July 31, 2020. VHA's Patient Experiences Survey Reports provide results from the Survey of Healthcare Experiences of Patients program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences with their health care and support benchmarking its performance against the private sector.

VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (PCMH), and Specialty Care surveys. The OIG reviewed responses to three relevant survey questions that reflect patients' attitudes toward their healthcare experiences. Table 6 provides relevant survey results for VHA and the medical center.[24] Patients scored the medical center's inpatient and specialty care similar to or higher than the VHA average but scored PCMH care lower than the VHA average. The Director and Chief of Staff reported forming partnerships with Veteran Service Officers and enlisting assistance from the Reporting, Analytics, Performance and Deployment Healthcare Improvement Center to evaluate the ongoing struggle to improve the patient experience with PCMH care. To address the lower PCMH score, the Chief of Staff discussed implementing "Commit to Sit," where providers make a commitment to sit and engage with patients for a significant amount of time.

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	69.6	78.4
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	82.8	79.6

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

Questions	Scoring	VHA Average	Medical Center Average
Survey of Healthcare Experiences of Patients (outpatient specialty care): *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*	The response average is the percent of "Very satisfied" and "Satisfied" responses.	85.0	84.9

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 4, 2020).

In 2019, women were estimated to represent 10.1 percent of the total veteran population in the United States, and it is projected that women will represent 17.8 percent of living veterans by 2048.[25] For these reasons, it is important for VHA to provide accessible and inclusive care for women veterans. At the time of the OIG review, the Director reported that the Women Veterans Program Manager's outreach efforts have resulted in a gradual increase in the number of female veterans using the medical center's services over the last two years.

The OIG reviewed selected responses to several additional relevant questions that reflect patients' experiences by gender (see tables 7–9), including Inpatient, PCMH, and Specialty Care surveys.

While male patients appeared generally satisfied with their inpatient care and would recommend the hospital to their friends and family, the OIG noted an opportunity to improve perceptions of nurses treating patients with courtesy and respect. In outpatient settings, results revealed opportunities to improve PCMH patient experiences for both genders and specialty care experiences for male veterans. The ADPCS attributed low patient experience scores to small survey sample sizes and noted that it is typically unhappy patients who take surveys. To obtain more accurate information and identify areas that needed improvement, the ADPCS reported that nurse managers placed communication boards in each room and warmly invited all veterans, both happy and unhappy, to take the survey. To improve low female veteran PCMH scores, the Director and ADPCS discussed hiring a new Women Veterans Program Manager and enhancing female veteran outreach.

[25] "Veteran Population," Table 1L: VetPop2018 Living Veterans by Age Group, Gender, 2018-2048, National Center for Veterans Analysis and Statistics, accessed November 30, 2020, https://www.va.gov/vetdata/Veteran_Population.asp.

Table 7. Inpatient Survey Results on Experiences by Gender (October 1, 2019, through July 31, 2020)

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average‡
Would you recommend this hospital to your friends and family?	The measure is calculated as the percentage of responses in the top category (Definitely yes).	69.8	64.9	78.4	–
During this hospital stay, how often did doctors treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	84.5	85.5	84.8	–
During this hospital stay, how often did nurses treat you with courtesy and respect?	The measure is calculated as the percentage of responses that fall in the top category (Always).	85.1	82.9	80.7	–

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 4, 2020).

**The VHA averages are based on 40,127–40,617 male and 1,938–1,962 female respondents, depending on the question.*

The medical center averages are based on 26–27 male respondents, depending on the question.

‡*Data are not available due to the small number of respondents.*

Table 8. Patient-Centered Medical Home Survey Results on Patient Experiences by Gender (October 1, 2019, through July 31, 2020)

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	51.6	44.7	50.7	70.6
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	60.0	53.2	63.8	48.4

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	74.1	69.6	72.2	54.6

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 4, 2020).

**The VHA averages are based on 62,558–187,954 male and 5,096–11,416 female respondents, depending on the question.*

The medical center averages are based on 251–719 male and 13–38 female respondents, depending on the question.

Table 9. Specialty Care Survey Results on Patient Experiences by Gender (October 1, 2019, through July 31, 2020)

Questions	Scoring	VHA*		Medical Center	
		Male Average	Female Average	Male Average	Female Average
In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	50.8	46.2	40.3	–‡
In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	The measure is calculated as the percentage of responses that fall in the top category (Always).	57.7	54.0	54.5	85.3
Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).	75.1	72.1	79.0	73.7

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 4, 2020).

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

The medical center averages are based on 99–329 male and 1–17 female respondents, depending on the question.

‡*Data are not available due to the small number of respondents.*

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys—including those conducted for cause—by oversight and accrediting agencies to gauge how well leaders responded to identified problems.[26] Table 10 summarizes the relevant medical center inspections most recently performed by the OIG and The Joint Commission (TJC).[27] At the time of the OIG review, the medical center had closed all but two recommendations for improvement issued during the previous inspection in December 2018. The Chief of QSV provided action plans addressing these remaining open recommendations.[28]

The OIG also noted the medical center's accreditation by the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.[29] Additional results included the Long Term Care Institute's inspection of the medical center's CLC.[30]

[26] "Profile Definitions and Methodology: Joint Commission Accreditation," *American Hospital Directory*, accessed December 12, 2020, https://www.ahd.com/definitions/prof_accred.html. "The Joint Commission conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization."

[27] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017. TJC provides an "internationally accepted external validation that an organization has systems and processes in place to provide safe and quality-oriented health care." TJC "has been accrediting VA medical facilities for over 35 years." Compliance with TJC standards "facilitates risk reduction and performance improvement."

[28] VA OIG, *Comprehensive Healthcare Inspection of the Sheridan VA Medical Center, Wyoming*, Report No. 18-04681-228, September 26, 2019.

[29] VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs,* May 9, 2017. The Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment "is supported through a system-wide, long-term joint collaboration with CARF [Commission on Accreditation of Rehabilitation Facilities] to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs." "About the College of American Pathologists," College of American Pathologists, accessed February 20, 2019, https://www.cap.org/about-the-cap. According to the College of American Pathologists, for 75 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." Additionally, as stated in VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

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

Table 10. Office of Inspector General Inspection/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (*Comprehensive Healthcare Inspection of the Sheridan VA Medical Center, Wyoming*, Report No.18-04681-228, September 26, 2019)	December 2018	22	2*
TJC Hospital Accreditation	November 2019	36	0
TJC Behavioral Health Care Accreditation		5	0
TJC Home Care Accreditation		14	0

Source: OIG and TJC (inspection/survey results received from the Accreditation Specialist on December 7, 2020).

**As of July 2021, one recommendation remained open.*

Identified Factors Related to Possible Lapses in Care and Medical Center Responses

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms.

Table 11 lists the reported patient safety events from December 15, 2018 (the prior OIG CHIP site visit), through December 7, 2020.[31]

[31] It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (The Sheridan VA Medical Center is a low complexity (3) affiliated system as described in appendix B.) According to VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, a sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life." Additionally, as stated in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an "administrative disclosure") as "a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." Lastly, in VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as "notifications") as "a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue."

Table 11. Summary of Selected Organizational Risk Factors (December 15, 2018, through December 7, 2020)

Factor	Number of Occurrences
Sentinel Events	4
Institutional Disclosures	7
Large-Scale Disclosures	0

Source: Sheridan VA Medical Center's Risk Manager (received December 9, 2020).

The Director spoke knowledgeably about serious adverse event reporting processes, including the review of patient safety incidents through the medical center's daily management system and discussion of cases with executive leaders and the Patient Safety Manager. The OIG's review of the medical center's sentinel events and disclosures did not identify substantial organizational risk factors.

Veterans Health Administration Performance Data for the Medical Center

The VA Office of Operational Analytics and Reporting adopted the SAIL Value Model to help define performance expectations within VA with "measures on healthcare quality, employee satisfaction, access to care, and efficiency." Despite noted limitations for identifying all areas of clinical risk, the data are presented as one way to understand the similarities and differences between the top and bottom performers within VHA.[32]

Figure 5 illustrates the medical center's quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2020. Figure 5 shows the Sheridan VA Medical Center's performance in the first through fifth quintiles. Those in the first and second quintiles (blue and green data points, respectively) are better-performing measures (for example, in the areas of mental health (MH) continuity (of) care, stress discussed, and All Employee Survey (AES) data use). Metrics in the fourth and fifth quintiles are those that need improvement and are denoted in orange and red, respectively (for example, rating (of) primary care (PC) provider, specialty care (SC) care coordination, and health care (HC) associated (assoc) infections).[33]

[32] "Strategic Analytics for Improvement and Learning (SAIL) Value Model," VHA Support Service Center, accessed on March 6, 2020, https://vssc.med.va.gov. (This is an internal website not publicly accessible.)

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

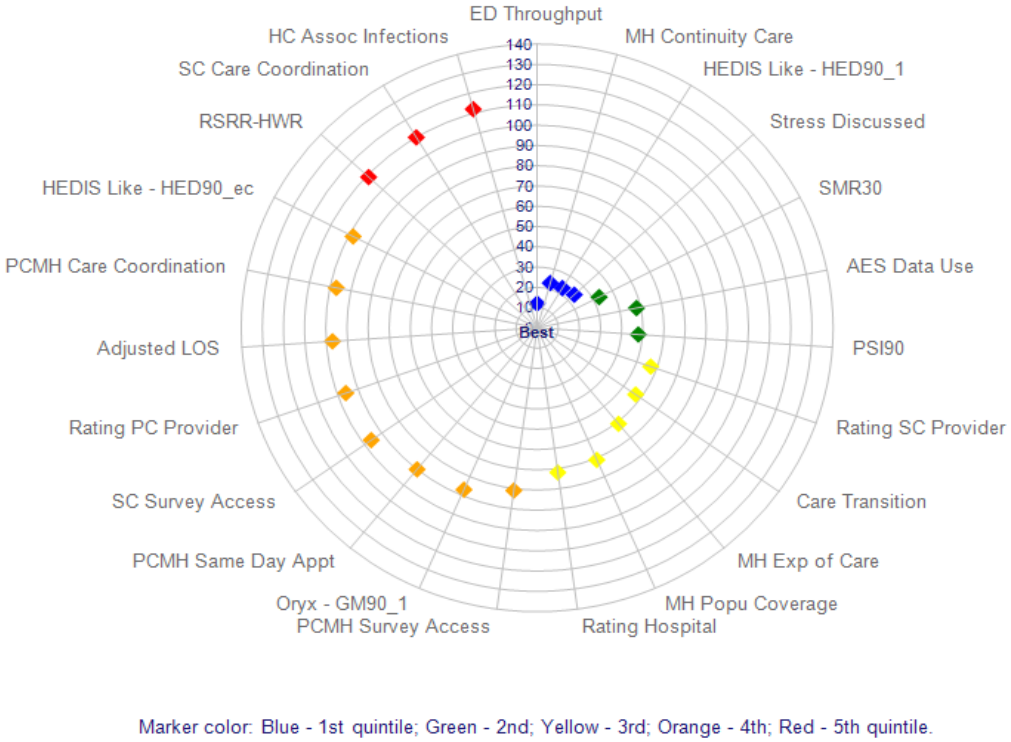


Figure 5. *System quality of care and efficiency metric rankings for FY 2020 quarter 3 (as of June 30, 2020).*

Source: VHA Support Service Center.

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

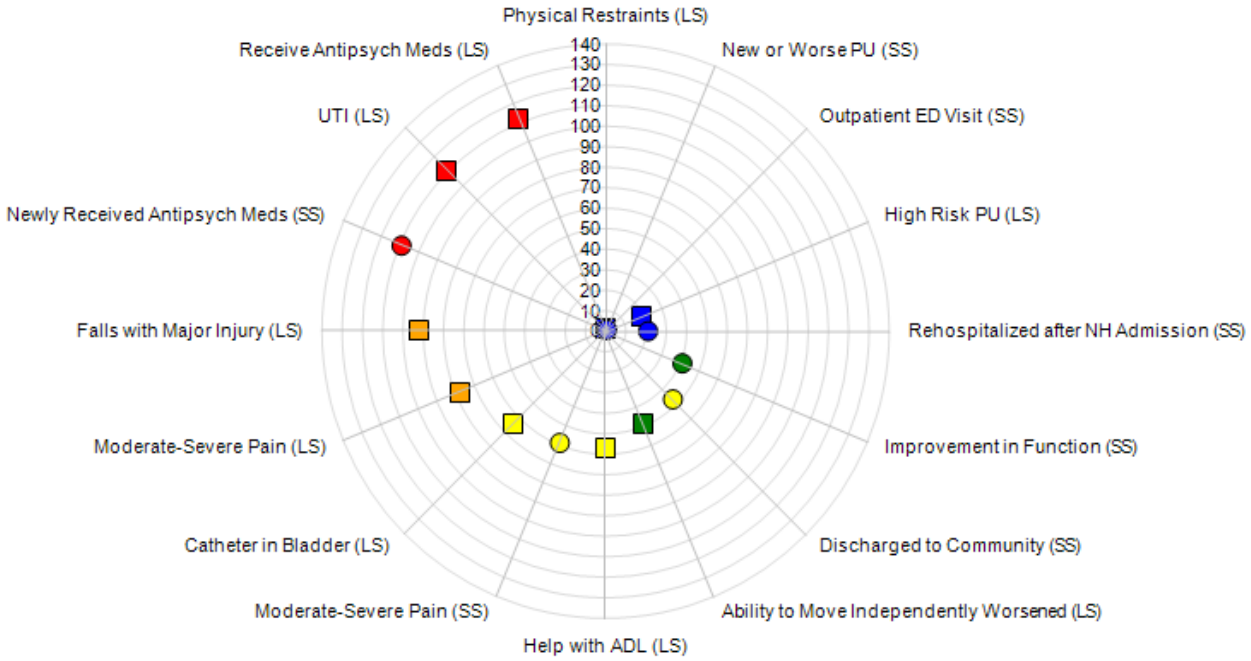
Veterans Health Administration Performance Data for the Community Living Center

The CLC SAIL Value Model is a tool to "summarize and compare performance of CLCs in the VA." The model "leverages much of the same data" used in the Centers for Medicare & Medicaid Services' (CMS) *Nursing Home Compare* and provides a single resource "to review quality measures and health inspection results."[34]

Figures 6 illustrates the medical center's CLC quality rankings and performance compared with other VA CLCs as of June 30, 2020. Figure 6 displays the Sheridan VA Medical Center's CLC metrics with high performance (blue and green data points) in the first and second quintiles (for

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

example, in the areas of new or worse pressure ulcer (PU)–short-stay (SS), outpatient emergency department (ED) visit (SS), and improvement in function (SS)). Metrics in the fourth and fifth quintiles need improvement and are denoted in orange and red (for example, falls with major injury–long-stay (LS), newly received antipsychotic (antipsych) medications (meds) (SS), and urinary tract infections (UTI) (LS)).[35]



Blue – 1st Quintile; Green – 2nd; Yellow - 3rd; Orange – 4th; Red – 5th Quintile.

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

LS = Long-Stay Measure SS = Short-Stay Measure

Source: VHA Support Service Center.

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

Leadership and Organizational Risks Findings and Recommendations

The medical center's executive leadership team appeared stable and had worked together for more than two years. The medical center managed organizational communications and accountability through a committee reporting structure, with the Executive Leadership Board overseeing several working groups, including the Quality Safety Value Board. Leaders monitored patient safety and care through the Quality Safety Value Board, which tracked and trended quality of care and patient outcomes.

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

The FY 2020 budget increase helped the medical center expand services by opening a psychiatric clinic in the CLC and a new outpatient clinic in Casper, Wyoming. However, the Director also described various hiring and recruitment challenges and the strategies taken to address them.

Selected employee survey responses revealed satisfaction with leadership and a workplace where staff feel respected and discrimination is not tolerated. Male patient experience survey data implied general satisfaction with the inpatient care provided, although an opportunity to improve patients' perceptions of nurses treating patients with courtesy and respect was noted. In outpatient settings, survey results highlighted opportunities to improve PCMH satisfaction for both genders and specialty care experiences for male veterans. The OIG's review of the medical center's accreditation findings, sentinel events, and disclosures did not identify substantial organizational risk factors. The leadership team was knowledgeable within their scope of responsibility about medical center and CLC SAIL measures but should continue to take actions to improve performance. The OIG made no recommendations.

COVID-19 Pandemic Readiness and Response

On March 11, 2020, due to the "alarming levels of spread and severity" of COVID-19, the World Health Organization declared a pandemic.[36] VHA subsequently issued its *COVID-19 Response Plan* on March 23, 2020, which presents strategic guidance on prevention of viral transmission among veterans and staff and appropriate care for sick patients.[37]

During this time, VA continued providing care to veterans and engaged its fourth mission, the "provision of hospital care and medical services during certain disasters and emergencies" to persons "who otherwise do not have VA eligibility for such care and services."[38] "In effect, VHA facilities provide a safety net for the nation's hospitals should they become overwhelmed—for veterans (whether previously eligible or not) and non-veterans."[39]

Due to VHA's mission-critical work in supporting both veteran and civilian populations during the pandemic, the OIG conducted an evaluation of the pandemic's effect on the medical center and its leaders' subsequent responses. The OIG analyzed performance in the following domains:

- Emergency preparedness
- Supplies, equipment, and infrastructure
- Staffing
- Access to care
- CLC patient care and operations

The OIG also surveyed medical center staff to solicit their feedback and potentially identify any problematic trends and/or issues that may require follow-up. The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.[40]

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[36] "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 - 11 March 2020," World Health Organization, accessed December 8, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

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

[38] 38 U.S.C. § 1785. VA's missions include serving veterans through care, research, and training. 38 C.F.R. § 17.86 outlines VA's fourth mission, the provision of hospital care and medical services during certain disasters and emergencies: "During and immediately following a disaster or emergency…VA under 38 U.S.C. § 1785 may furnish hospital care and medical services to individuals (including those who otherwise do not have VA eligibility for such care and services) responding to, involved in, or otherwise affected by that disaster or emergency."

[39] VA OIG, *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness*, *March 19–24, 2020*, Report No. 20-02221-120, March 26, 2020.

[40] VA OIG, *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19*, Report No. 21-01699-175, July 7, 2021.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.[41] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[42] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[43]

To determine whether VHA facilities have implemented and incorporated OIG-identified key processes for quality and safety into local activities, the inspection team evaluated the medical center's committee responsible for quality, safety, and value (QSV) oversight functions; its ability to review data, information, and risk intelligence; and its ability to ensure that key QSV functions are discussed and integrated on a regular basis. Specifically, OIG inspectors examined the following requirements:

- Review of aggregated QSV data
- Recommendation and implementation of improvement actions
- Monitoring of fully implemented improvement actions

The OIG also assessed the medical center's processes for its Systems Redesign and Improvement Program, which supports "VHA's transformation journey to become a High Reliability Organization." Systems redesign and improvement processes drive organizational change toward the goal of "zero harm" and can create strong cultures of safety. VHA implemented systems redesign and improvement programs to "optimize Veterans' experience by providing services to develop self-sustaining improvement capability."[44] The OIG team examined various requirements related to systems redesign and improvement:

- Designation of a systems redesign and improvement coordinator
- Tracking of facility-level performance improvement capability and projects
- Participation on the facility quality management committee and VISN Systems Redesign Review Advisory Group
- Staff education on performance improvement principles and techniques

[41] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[42] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.
[43] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence.*
[44] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

Next, the OIG assessed the medical center's processes for conducting protected peer reviews of clinical care.[45] Protected peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[46] Peer reviews are "intended to promote confidential and non-punitive" processes that consistently contribute to quality management efforts at the individual provider level.[47] The OIG team examined the completion of the following elements:

- Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit[48]
- Completion of final reviews within 120 calendar days
- Implementation of improvement actions recommended by the Peer Review Committee for Level 3 peer reviews[49]
- Quarterly review of the Peer Review Committee's summary analysis by the Executive Committee of the Medical Staff

Finally, the OIG assessed VHA facilities' compliance with selected surgical program requirements. The medical center did not have a surgical program; therefore, this review was not conducted at the Sheridan VA Medical Center.

The OIG reviewers interviewed senior managers and key QSV employees and evaluated meeting minutes, systems redesign and improvement documents and reports, protected peer reviews, and other relevant information.[50]

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[45] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is "a critical review of care, performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. In the context of protected peer reviews, "protected" refers to the designation of review as a confidential quality management activity under 38 U.S.C. § 5705 as "a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department for improving the quality of medical care or the utilization of health-care resources in VA facilities."

[46] VHA Directive 1190.

[47] VHA Directive 1190.

[48] VHA Directive 1190.

[49] VHA Directive 1190. A peer review is assigned a Level 3 when "most experienced and competent clinicians would have managed the case differently."

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

Quality, Safety, and Value Findings and Recommendations

The medical center complied with selected requirements for the Quality Safety Value Board and Systems Redesign and Improvement Program. However, the OIG noted a concern with the peer review process.

VHA requires the Peer Review Committee to complete a final review of peer review cases and recommend "non-punitive, non-disciplinary actions to improve the quality of health care delivered."[51] The OIG found no evidence that the committee recommended improvement actions for the medical center's one Level 3 peer review, which likely prevented positive adjustments in the provider's patient care practices. The Risk Manager stated that the Peer Review Committee did not recommend individual improvement actions because committee members generally perceived any actions resulting from peer reviews as punitive.

Recommendation 1

1. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that the Peer Review Committee recommends improvement actions for Level 3 peer reviews.

Medical center concurred.

Target date for completion: August 15, 2021

Medical center response: The Medical Center Director considered the reasons for noncompliance when developing the action plan. The Peer Review Action Forms for final level 2 and level 3 ratings include a section for non-punitive and non-disciplinary actions recommended by Peer Review Committee for the service chief to act upon when receiving the final level to review with the appropriate employees. The Risk Manager has updated their action item tracker to include tracking these actions to completion. The Peer Review Committee approved these changes on December 22, 2020. [Ninety percent] 90% of all Peer Reviews that receive a final level 2 or level 3 rating will have non-punitive and non-disciplinary actions recommended when possible. Compliance will be reported through QSV until 90% compliance has been reached for 6 consecutive months.

[51] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

Registered Nurse Credentialing

VHA has defined procedures for the credentialing of registered nurses (RNs) that include verification of "professional education, training, licensure, certification, registration, previous experience, including documentation of any gaps (greater than 30 days) in training and employment, professional references, adverse actions, or criminal violations, as appropriate."[52] Licensure is defined by VHA as "the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration."[53]

VA requires all RNs to hold at least one active, unencumbered license.[54] Individuals who hold a license in more than one state are not eligible for RN appointment if a state has terminated the license for cause or if the RN voluntarily relinquished the license after written notification from the state of potential termination for cause.[55] When an action has been "taken against [an] applicant's sole license or against any of the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, must be completed to determine whether the applicant satisfies VA's licensure requirements," and documented as required.[56] Additionally, all current and previously held licenses must be verified from the primary or original source and documented in VetPro, VHA's electronic credentialing system, prior to appointment to a VA medical facility.[57]

The OIG assessed compliance with VA licensure requirements by conducting interviews with key managers and reviewing relevant documents for 19 RNs hired from January 1 through October 26, 2020. The OIG determined whether

- the RNs were free from potentially disqualifying licensure actions, or
- the Chief, Human Resources Management Service or Regional Counsel determined that the RNs met VA licensure requirements.

The OIG also reviewed the RNs' credentialing files to determine whether medical center staff completed primary source verification prior to the appointment.

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

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

[54] VA Directive 2012-030. "Definition of *Unencumbered license,"* Law Insider, accessed December 3, 2020, https://www.lawinsider.com/dictionary/unencumbered-license. An unencumbered license is "a license that is not revoked, suspended, or made probationary or conditional by the licensing or registering authority in the respective jurisdiction as a result of disciplinary action."

[55] 38 U.S.C. § 7402.

[56] VHA Directive 2012-030.

[57] VHA Directive 2012-030.

Registered Nurse Credentialing Findings and Recommendations

The OIG determined that RNs hired from January 1 to October 26, 2020, were free from potentially disqualifying licensure actions. However, primary source verification of each RN's license was not consistently completed prior to appointment.

VHA requires that individuals' licensure credentialing information must be verified from primary sources prior to initial appointment or before transfer from another VA medical facility.[58] The OIG found 2 of 19 credentialing files lacked evidence of primary source verification for all licenses held by each RN. Further, of the 17 RNs who had each license verified, 2 did not have their licenses verified prior to the appointment. This could have led to the inappropriate hiring of nurses and subsequently affected the quality of care. The Dependent Credentialing and Privileging Program Specialist explained that when the medical center hired several nurses at once, some primary source verifications were inadvertently missed in attempting to quickly credential staff.

Recommendation 2

2. The Medical Center Director evaluates and determines any additional reasons for noncompliance and ensures that credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment.

Medical center concurred.

Target date for completion: December 31, 2021

Medical center response: The Medical Center Director considered the reasons for noncompliance when developing the action plan: The Sheridan VAMC [VA Medical Center] Medical Staff Office will demonstrate 90% compliance for 6 consecutive months with primary source verification prior to initial appointment of all relevant licenses for RN additions to the health system for a period of 180 days, with monthly audits performed by the Credentialing and Privileging Program Manager. Results will be reported to the QSV committee [Board] jointly by both Medical Staff office program specialist and the program manager.

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

Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation

Suicide prevention remains a top priority for VHA. Suicide is the 10th leading cause of death, with over 47,000 lives lost across the United States in 2019.[59] The suicide rate for veterans was 1.5 times greater than for non-veteran adults and estimated to represent approximately 13.8 percent of all suicide deaths in the United States during 2018.[60] However, suicide rates among veterans who recently used VHA services decreased by 2.4 percent between 2017 and 2018.[61]

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA has adopted a three-phase process to screen and assess for suicide risk in most clinical settings. The phases include primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers begins with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening is positive.[62] The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed all required elements.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.[63] The medical center was assessed for its adherence to the following requirements for suicide safety plans:

- Completion of suicide safety plans by required staff
- Completion of mandatory training by staff who develop suicide safety plans

To determine whether VHA facilities complied with selected requirements for suicide risk screening and evaluation within emergency departments and urgent care centers, the OIG inspection team interviewed key employees and reviewed

- Relevant documents;

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

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

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

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

[63] DUSHOM Memorandum, *Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives*, October 17, 2019.

- The electronic health records of 46 randomly selected patients who were seen in the urgent care center from December 1, 2019, through August 31, 2020; and[64]
- Staff training records.

Mental Health Findings and Recommendations

The medical center generally met the requirements listed above. The OIG made no recommendations.

[64] The Sheridan VA Medical Center does not have an emergency department; therefore, only urgent care center records were reviewed.

Care Coordination: Inter-facility Transfers

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring the patient when his or her needs can be better managed at another facility.[65]

VHA medical facility directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients." Further, VHA staff are required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.[66]

The medical center was assessed for its adherence to various requirements:

- Existence of a facility policy for inter-facility transfers
- Monitoring and evaluation of inter-facility transfers
- Completion of all required elements of the *Inter-Facility Transfer Form* or facility-defined equivalent by the appropriate provider(s) prior to patient transfer
- Transmission of patient's active medication list and advance directive to the receiving facility
- Communication between nurses at sending and receiving facilities

To determine whether the medical center complied with OIG-selected inter-facility transfer requirements, the inspection team reviewed relevant documents and interviewed key employees. The team also reviewed the electronic health records of 28 patients who were transferred from the medical center due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

Care Coordination Findings and Recommendations

Generally, the medical center met expectations for an inter-facility transfer policy and monitoring and evaluation of inter-facility transfers. However, the OIG noted deficiencies with the completion of the VA *Inter-Facility Transfer Form*, transmission of pertinent medical records, and communication between nurses at sending and receiving facilities.

VHA requires the Chief of Staff and ADPCS to ensure that providers complete requisite elements of the VA *Inter-Facility Transfer Form* or an equivalent note, which includes an

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

[66] VHA Directive 1094. A completed VA *Inter-Facility Transfer Form* or an equivalent note communicates critical information to facilitate and ensure safe, appropriate, and timely transfer. Critical elements include documentation of patients' informed consent, medical and/or behavioral stability, mode of transportation and appropriate level of care required, identification of transferring and receiving physicians, and proposed level of care after transfer.

assessment of the patient's medical and behavioral stability, prior to the inter-facility transfer. VHA also requires the Chief of Staff and ADPCS to ensure that patients' active medication lists and advance directives are sent to the receiving facility.[67] The OIG determined that providers did not complete the VA *Inter-Facility Transfer Form* or an equivalent note prior to transfer for 6 of 28 (21 percent) patients. The OIG also found that providers did not address medical and/or behavioral stability prior to transfer for 5 of 28 (18 percent) patients. In addition, staff did not send the medication list and advanced directives to the receiving facility for 14 of 28 (50 percent) and 8 of 9 (89 percent) patients, respectively.[68] These deficiencies could have resulted in unsafe patient transfers and treatment decisions that compromise patient safety.

The Urgent Care Director and Accreditation Specialist reported that providers felt patients' emergent conditions took precedence over timely documentation, were unaware of the need to complete a transfer note for patients who traveled by private vehicle, and did not know where to access advance directive information in the medical record.

VHA states that nurse-to-nurse communication during the inter-facility transfer process is essential and allows for questions and answers from staff at both the sending and receiving facility.[69] The OIG did not find evidence of nurse-to-nurse communication for 4 of 28 (14 percent) inter-facility transfers.[70] This could have resulted in receiving staff lacking the information needed to care for patients. The Urgent Care Nurse Manager and Accreditation Specialist reported misunderstanding that the requirement also applied to patients taking private vehicles to the receiving facility and stated that temporarily assigned urgent care staff were not familiar with urgent care center processes.

The OIG made no recommendations for these review elements due to the low number of identified patients.

[67] VHA Directive 1094.

[68] Confidence intervals are not included because the data represents every patient in the study population.

[69] VHA Directive 1094.

[70] Confidence intervals are not included because the data represents every patient in the study population.

High-Risk Processes: Management of Disruptive and Violent Behavior

VHA defines disruptive behavior as "behavior by any individual that is intimidating, threatening, dangerous, or that has, or could, jeopardize the health or safety of patients, Department of Veterans Affairs (VA) employees, or individuals at the facility."[71] Balancing the rights and healthcare needs of violent and disruptive patients with the health and safety of other patients, visitors, and staff pose a significant challenge for VHA facilities. VHA has "committed to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety."[72] The OIG examined various requirements for the management of disruptive and violent behavior:

- Development of a policy for reporting and tracking disruptive behavior
- Implementation of an employee threat assessment team[73]
- Establishment of a disruptive behavior committee or board that holds consistently attended meetings[74]
- Use of the Disruptive Behavior Reporting System to document the decision to implement an Order of Behavioral Restriction[75]
- Patient notification of an Order of Behavioral Restriction
- Completion of the annual Workplace Behavioral Risk Assessment with involvement from required participants[76]

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

[72] VHA Directive 2012-026.

[73] VHA Directive 2012-026. An employee threat assessment team is "a facility-level, interdisciplinary team whose primary charge is using evidence-based and data-driven practices for addressing the risk of violence posed by employee-generated behavior(s), that are disruptive or that undermine a culture of safety."

[74] VHA Directive 2012-026. VHA defines a disruptive behavior committee or board as "a facility-level, interdisciplinary committee whose primary charge is using evidence-based and data-driven practices for preventing, identifying, assessing, managing, reducing, and tracking patient-generated disruptive behavior."

[75] DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018. VA requires each medical facility's disruptive behavior committee "to use the Disruptive Behavior Reporting System (DBRS) to document a decision to implement an Order of Behavioral Restriction (OBR) and to document notification of a patient when an OBR is issued."

[76] DUSHOM Memorandum, *Workplace Behavioral Risk Assessment (WBRA)*, October 19, 2012. The Workplace Behavioral Risk Assessment is a "data-driven process that evaluates the unique constellation of factors that affect workplace safety. It enables facilities to make informed, supportable decisions regarding the level of PMDB [Prevention and Management of Disruptive Behavior] training needed to sustain a culture of safety in the workplace."

VHA also requires that all staff complete part 1 of the prevention and management of disruptive behavior training within 90 days of hire. The Workplace Behavioral Risk Assessment results are used to assign additional levels of training. When the assessment results deem a facility location as low or moderate risk, staff working in the area are also required to complete part 2 of the training. When results indicate high risk, staff are required to complete parts 1, 2, and 3 of the training.[77] VHA also requires that employee threat assessment team members complete the appropriate team-specific training.[78] The OIG assessed staff compliance with the completion of required training.

To determine whether VHA facilities implemented and incorporated OIG-identified key processes for the management of disruptive and violent behavior, the inspection team examined relevant documents and training records and interviewed key managers and staff.

High-Risk Processes Findings and Recommendations

The medical center generally met requirements for the management of disruptive and violent behavior. However, the OIG found a deficiency with Disruptive Behavior Committee members' attendance.

VHA requires that the Chief of Staff and Nurse Executive (ADPCS) establish a disruptive behavior committee or board that includes a senior clinician as the chairperson; administrative support staff; patient advocate; and representatives from the Prevention and Management of Disruptive Behavior Program, VA police, patient safety and/or risk management, and Union Safety Committee.[79]

The OIG found that the Disruptive Behavior Committee held 23 meetings from December 2019 through December 2020. Of those, representatives from the Prevention and Management of Disruptive Behavior Program did not attend 3 meetings (13 percent), patient safety and/or risk management did not attend 4 meetings (17 percent), and VA police and the patient advocate did not attend 5 meetings (22 percent). This could have resulted in a lack of knowledge and expertise when assessing patients' disruptive behavior. The Disruptive Behavior Committee Chair, Prevention and Management of Disruptive Behavior Coordinator, Chief of Police, and Patient Safety Manager cited competing priorities for the inconsistent attendance.

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

[78] DUSHOM Memorandum, *Actions Needed to Ensure Medical Facility Workplace Violence Prevention Programs (WVPP) Meet Agency Requirements*, July 20, 2018.

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

Recommendation 3

3. The Chief of Staff and Associate Director for Patient Care Services evaluate and determine any additional reasons for noncompliance and ensure all required members consistently attend Disruptive Behavior Committee meetings.

Medical center concurred.

Target date for completion: January 31, 2022

Medical center response: The Chief of Staff and Associate Director for Patient Care Services considered the reasons for noncompliance when developing the action plan. The Disruptive Behavior Committee (DBC) updated its charter to reflect the required members for each meeting. The members will be expected to attend at least 90% of meetings. The DBC meeting minutes were also updated with a new tracking metric that includes the required members and record of their participation for each meeting. Both documents were updated by 1/5/2021 for implementation by the DBC Chair after approval at the DBC meeting. Compliance will be reported through QSV until 90% required attendance rate to DBC is maintained for 6 consecutive months.

Report Conclusion

The OIG acknowledges the inherent challenges of operating VA medical facilities, especially during times of unprecedented stress on the U.S. healthcare system. To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed review of seven clinical and administrative areas and provided three recommendations on issues that may adversely affect patients. While the OIG's recommendations are not intended to serve as a comprehensive assessment of the caliber of services delivered at this medical center, they illuminate areas of concern and guide improvement efforts. A summary of recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines three OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events. The recommendations are attributable to the Director, Chief of Staff, and ADPCS. The intent is for these leaders to use the recommendations to help guide improvements in operations and clinical care. The recommendations address findings that, if left unattended, may potentially interfere with the delivery of quality health care."

Table A.1. Summary Table of Recommendations

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Leadership and Organizational Risks	• Executive leadership position stability and engagement • Budget and operations • Staffing • Employee satisfaction • Patient experience • Accreditation surveys and oversight inspections • Identified factors related to possible lapses in care and medical center response • VHA performance data (medical center) • VHA performance data (CLC)	• None	• None
COVID-19 Pandemic Readiness and Response	• Emergency preparedness • Supplies, equipment, and infrastructure • Staffing • Access to care • CLC patient care and operations • Staff feedback	The OIG reported the results of the COVID-19 pandemic readiness and response evaluation for this medical center and other facilities in a separate publication to provide stakeholders with a more comprehensive picture of regional VHA challenges and ongoing efforts.	

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• QSV committee • Systems redesign and improvement • Protected peer reviews	• Peer Review Committee recommends improvement actions for Level 3 peer reviews.	• None
RN Credentialing	• RN licensure requirements • Primary source verification	• Credentialing staff complete primary source verification of all registered nurses' licenses prior to initial appointment.	• None
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	• Columbia-Suicide Severity Rating Scale initiation and note completion • Suicide safety plan completion • Staff training requirements	• None	• None
Care Coordination: Inter-facility Transfers	• Inter-facility transfer policy • Inter-facility transfer monitoring and evaluation • Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer • Patient's active medication list and advance directive sent to receiving facility • Nurse-to-nurse communication between facilities	• None	• None

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Management of Disruptive and Violent Behavior	• Policy for reporting and tracking of disruptive behavior • Employee threat assessment team implementation • Disruptive behavior committee or board establishment • Disruptive Behavior Reporting System use • Patient notification of an Order of Behavioral Restriction • Annual Workplace Behavioral Risk Assessment with involvement from required participants • Mandatory staff training	• None	• All required members consistently attend Disruptive Behavior Committee meetings.

Appendix B: Medical Center Profile

The table below provides general background information for this low complexity (3) affiliated medical center reporting to VISN 19.[1]

Table B.1. Profile for Sheridan VA Medical Center (666)
(October 1, 2017, through September 30, 2020)

Profile Element	Medical Center Data FY 2018*	Medical Center Data FY 2019	Medical Center Data FY 2020‡
Total medical care budget	$121,561,371	$131,324,386	$176,969,118
Number of:			
• Unique patients	12,521	12,665	12,717
• Outpatient visits	124,325	129,165	116,771
• Unique employees§	543	514	549
Type and number of operating beds:			
• Community living center	40	40	55
• Domiciliary	101	115	115
• Medicine	10	10	10
• Mental health	20	20	20
Average daily census:			
• Community living center	29	32	29
• Domiciliary	70	74	48
• Medicine	4	4	5
• Mental health	9	11	10

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse.

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

*****October 1, 2017, through September 30, 2018.*
October 1, 2018, through September 30, 2019.
‡*October 1, 2019, through September 30, 2020.*
§*Unique employees involved in direct medical care (cost center 8200).*

[1] An affiliated healthcare system is associated with a medical residency program. VHA facilities are classified according to a facility complexity model; a designation of "3" indicates a facility with "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs."

Appendix C: VA Outpatient Clinic Profiles

The VA outpatient clinics in communities within the catchment area of the medical center provide primary care integrated with women's health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table C.1. provides information relative to each of the clinics.[1]

Table C.1. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2019, through September 30, 2020)

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Casper, WY	666GB	3,719	1,605	Anesthesia Cardiology Endocrinology Gastroenterology General surgery Nephrology Orthopedics Poly-Trauma Rehab physician	EKG	Nutrition Pharmacy Weight management

[1] Includes outpatient clinics in the community that were in operation as of August 27, 2019. VHA Directive 1230(4), *Outpatient Scheduling Processes And Procedures*, July 15, 2016, amended January 7, 2021. An encounter is a "professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition." Specialty care services refer to non-primary care and non-mental health services provided by a physician. Electrocardiogram (EKG) diagnostic services are provided. Ancillary services include nutrition, pharmacy, and weight management.

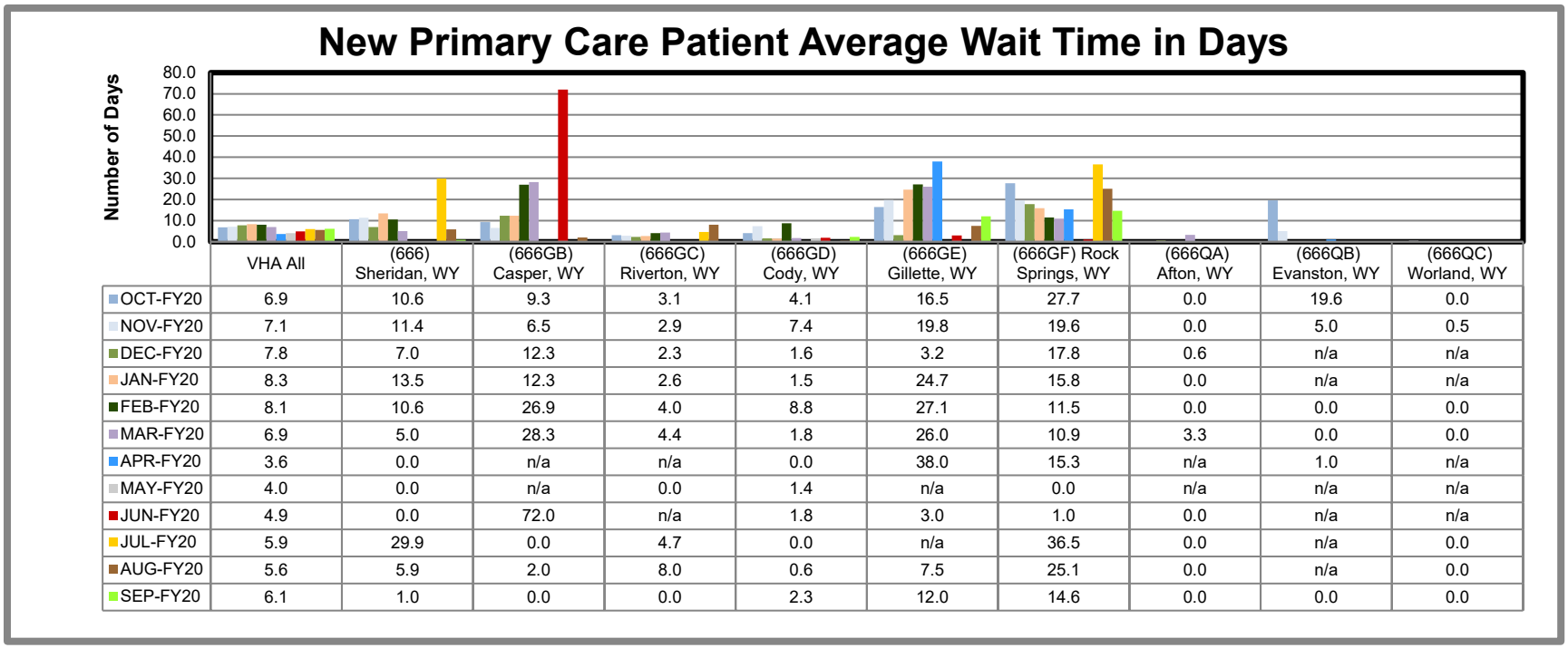
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Riverton, WY	666GC	2,252	636	Anesthesia Cardiology Dermatology Gastroenterology GYN Orthopedics Poly-Trauma Rehab physician Rheumatology	EKG	Pharmacy Weight management
Cody, WY	666GD	2,166	356	Cardiology Endocrinology Poly-Trauma Rehab physician Rheumatology	EKG	Pharmacy Weight management
Gillette, WY	666GE	1,726	387	Anesthesia Cardiology Dermatology Endocrinology Nephrology Orthopedics Rehab physician Rheumatology	EKG	Pharmacy Nutrition Weight management

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Rock Springs, WY	666GF	2,087	589	Cardiology Dermatology Endocrinology Gastroenterology Poly-Trauma Rehab physician	EKG	Pharmacy Weight management
Afton, WY	666QA	1,021	88	Anesthesia Cardiology Gastroenterology Poly-Trauma Rehab physician	EKG	Pharmacy Weight management
Evanston, WY	666QB	403	82	–	EKG	Pharmacy Weight management
Worland, WY	666QC	482	74	Anesthesia Cardiology Nephrology Rehab physician	EKG	Pharmacy

Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

Appendix D: Patient Aligned Care Team Compass Metrics

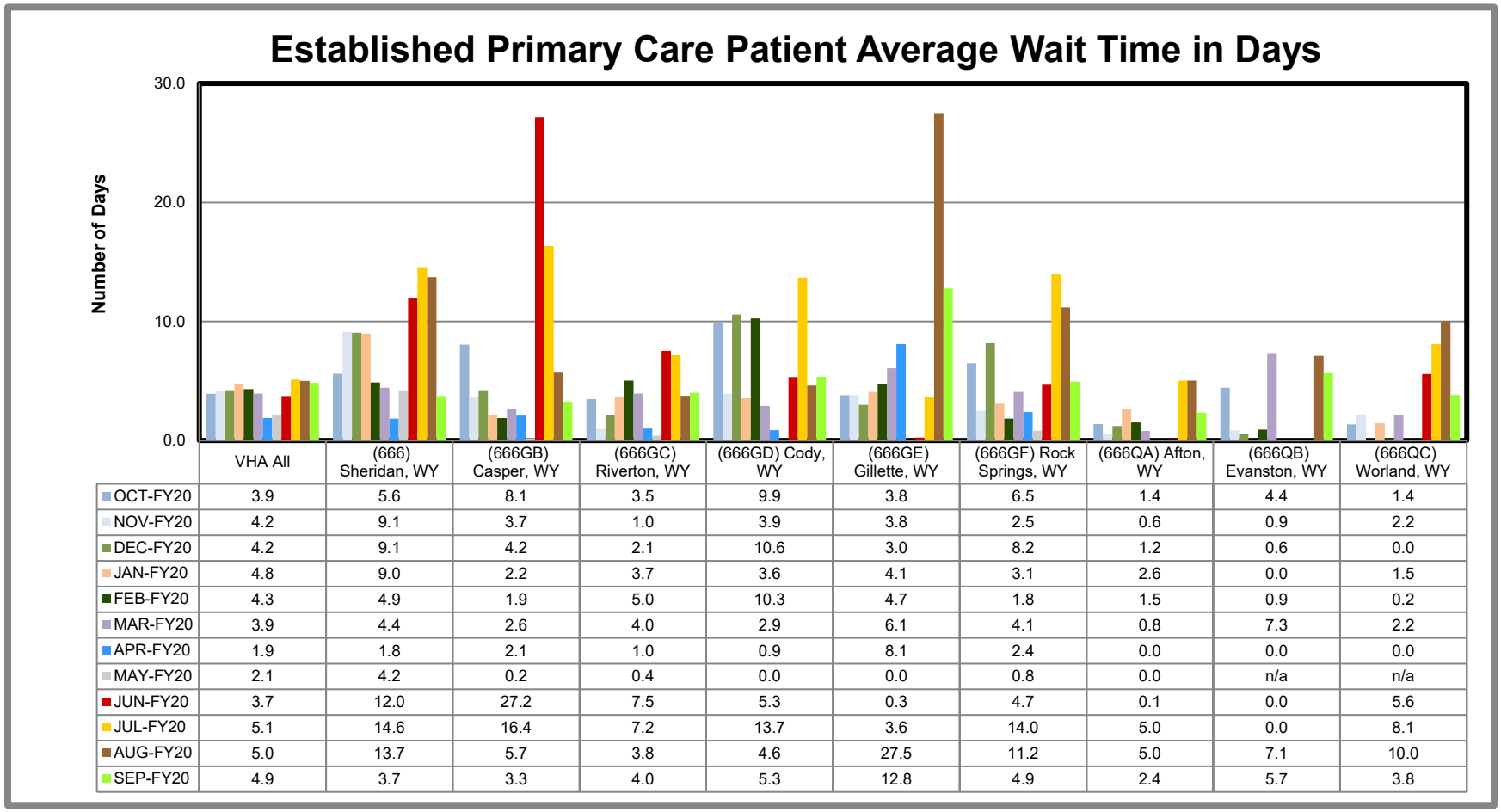


	VHA All	(666) Sheridan, WY	(666GB) Casper, WY	(666GC) Riverton, WY	(666GD) Cody, WY	(666GE) Gillette, WY	(666GF) Rock Springs, WY	(666QA) Afton, WY	(666QB) Evanston, WY	(666QC) Worland, WY
OCT-FY20	6.9	10.6	9.3	3.1	4.1	16.5	27.7	0.0	19.6	0.0
NOV-FY20	7.1	11.4	6.5	2.9	7.4	19.8	19.6	0.0	5.0	0.5
DEC-FY20	7.8	7.0	12.3	2.3	1.6	3.2	17.8	0.6	n/a	n/a
JAN-FY20	8.3	13.5	12.3	2.6	1.5	24.7	15.8	0.0	n/a	n/a
FEB-FY20	8.1	10.6	26.9	4.0	8.8	27.1	11.5	0.0	0.0	0.0
MAR-FY20	6.9	5.0	28.3	4.4	1.8	26.0	10.9	3.3	0.0	0.0
APR-FY20	3.6	0.0	n/a	n/a	0.0	38.0	15.3	n/a	1.0	n/a
MAY-FY20	4.0	0.0	n/a	0.0	1.4	n/a	0.0	n/a	n/a	n/a
JUN-FY20	4.9	0.0	72.0	n/a	1.8	3.0	1.0	0.0	n/a	n/a
JUL-FY20	5.9	29.9	0.0	4.7	0.0	n/a	36.5	0.0	n/a	0.0
AUG-FY20	5.6	5.9	2.0	8.0	0.6	7.5	25.1	0.0	n/a	0.0
SEP-FY20	6.1	1.0	0.0	0.0	2.3	12.0	14.6	0.0	0.0	0.0

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019.

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the medical center's explanation for the increased wait times for the community-based outpatient clinics in Casper, Gillette, and Rock Springs, Wyoming.

Data Definition: "The average number of calendar days between a New Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL)), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." Prior to FY 2015, this metric was calculated using the earliest possible create date. The absence of reported data is indicated by "n/a."



	VHA All	(666) Sheridan, WY	(666GB) Casper, WY	(666GC) Riverton, WY	(666GD) Cody, WY	(666GE) Gillette, WY	(666GF) Rock Springs, WY	(666QA) Afton, WY	(666QB) Evanston, WY	(666QC) Worland, WY
OCT-FY20	3.9	5.6	8.1	3.5	9.9	3.8	6.5	1.4	4.4	1.4
NOV-FY20	4.2	9.1	3.7	1.0	3.9	3.8	2.5	0.6	0.9	2.2
DEC-FY20	4.2	9.1	4.2	2.1	10.6	3.0	8.2	1.2	0.6	0.0
JAN-FY20	4.8	9.0	2.2	3.7	3.6	4.1	3.1	2.6	0.0	1.5
FEB-FY20	4.3	4.9	1.9	5.0	10.3	4.7	1.8	1.5	0.9	0.2
MAR-FY20	3.9	4.4	2.6	4.0	2.9	6.1	4.1	0.8	7.3	2.2
APR-FY20	1.9	1.8	2.1	1.0	0.9	8.1	2.4	0.0	0.0	0.0
MAY-FY20	2.1	4.2	0.2	0.4	0.0	0.0	0.8	0.0	n/a	n/a
JUN-FY20	3.7	12.0	27.2	7.5	5.3	0.3	4.7	0.1	0.0	5.6
JUL-FY20	5.1	14.6	16.4	7.2	13.7	3.6	14.0	5.0	0.0	8.1
AUG-FY20	5.0	13.7	5.7	3.8	4.6	27.5	11.2	5.0	7.1	10.0
SEP-FY20	4.9	3.7	3.3	4.0	5.3	12.8	4.9	2.4	5.7	3.8

Source: VHA Support Service Center. Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, https://vssc.med.va.gov, accessed October 21, 2019.

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

Data Definition: "The average number of calendar days between an Established Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." The absence of reported data is indicated by "n/a."

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

Measure	Definition	Desired Direction
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
AES Data Use	Composite measure based on three individual All Employee Survey (AES) data use and sharing questions	A higher value is better than a lower value
Care Transition	Care transition (inpatient)	A higher value is better than a lower value
ED Throughput	Composite measure for timeliness of care in the emergency department	A lower value is better than a higher value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS like – HED90_1	Healthcare Effectiveness Data and Information Set (HEDIS) composite score related to outpatient behavioral health screening, prevention, immunization, and tobacco	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS composite score related to outpatient care for diabetes and ischemic heart disease	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx – GM90_1	ORYX inpatient composite of global measures	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value

Measure	Definition	Desired Direction
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
PSI90	Patient Safety and Adverse Events Composite (PSI90) focused on potentially avoidable complications and events	A lower value is better than a higher value
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center.

Appendix F: Community Living Center (CLC) Strategic Analytics for Improvement and Learning (SAIL) Measure Definitions

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
Discharged to Community (SS)	Short-stay measure: percentage of short-stay residents who were successfully discharged to the community.
Falls with major injury (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
High risk PU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
Improvement in function (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Moderate-severe pain (SS)	Short-stay measure: percent of residents who self-report moderate to severe pain.
New or worse PU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
Newly received antipsych meds (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Outpatient ED visit (SS)	Short-stay measure: percent of short-stay residents who have had an outpatient emergency department (ED) visit.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.

Measure	Definition
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
Rehospitalized after NH Admission (SS)	Short-stay measure: percent of residents who were re-hospitalized after a nursing home admission.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

Source: VHA Support Service Center.

Appendix G: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 14, 2021

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

Subj: Comprehensive Healthcare Inspection of the Sheridan VA Medical Center in Wyoming

To: Director, Office of Healthcare Inspections (54CH01)

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

1. I have reviewed the findings, recommendations, and action plan of the Sheridan VA Medical Center, Wyoming. I agree with the above.

(Original signed by:)

Sunaina Kumar-Giebel, VISN 19 Deputy Director

for Ralph Gigliotti

Network Director, VISN 19

Appendix H: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: June 8, 2021

From: Director, Sheridan VA Medical Center (666/00)

Subj: Comprehensive Healthcare Inspection of the Sheridan VA Medical Center in Wyoming

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

2. On behalf of the Sheridan VA Health Care System, Sheridan Wyoming, I concur with the findings and recommendations of this Office of Inspector General Report.

3. Included herein is an outline of improvement actions taken, in progress, or planned in response to these recommendations. We believe these changes will further enhance key systems and processes throughout our healthcare system.

(Original signed by:)

Pamela S. Crowell, MPA

Director

Sheridan VA Health Care System

OIG Contact and Staff Acknowledgments

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